Northumberland
Clinical Commissioning Group

ANNUAL REPORT
AND ACCOUNTS
2021/22

Improving healthcare for the people of Northumberland

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PERFORMANCE REPORT

Mark Adams
Accountable Officer
20 June 2022

Performance Overview

Statement from Accountable Officer and Clinical Chair

Welcome to NHS Northumberland Clinical Commissioning Group's 2021-22 Annual Report.

2021/22 saw the National Health Service continue to experience some of the most, challenging years in its history as the evolution of the Coronavirus pandemic and the emergence of the Delta and Omicron variants saw a continuation of the unprecedented pressures on health and social care services in Northumberland and across England.

It is only right that this year's report should start by paying tribute to the most incredible courage, commitment and creativity of so many colleagues in the NHS and wider healthcare system, who have now been working under such immense pressure from the COVID-19 pandemic, and the associated challenges presented by the backlog of routine activity, for over 2 years now. Their resilience and dedication to providing the best possible care for our patients and public is so commendable, and we continue to be incredibly grateful for all of their efforts.

The system response to COVID-19 has seen partners from across health and care come together to work more closely with each other than ever before to provide a co-ordinated pandemic response and ensure that our patients and public have been able to continue to access essential services for elective surgery, cancer care, and mental health & wellbeing.

Hospital staff have had to balance caring for large numbers of COVID-19 patients alongside continuing to provide urgent and emergency care, and routine treatment to non-COVID-19 patients. General Practice teams have transformed their ways of working and models of care to keep patients and staff safe and a large programme of estates work has begun to create additional clinical space to enable our primary care teams to try and meet the increased demand from patients.

Collaboration with local authority colleagues has been vital, particularly the link with our public health colleagues who have continued to provide such incisive and resolute leadership in the fact of constant uncertainty throughout the past 12 months.

Nowhere has the 'whole system' response to the pandemic been better exemplified than through the COVID-19 vaccination programme. Having moved incredibly quickly to protect the most vulnerable patients in early 2021, in 2021/22 the programme evolved to deliver 1st and 2nd dose vaccinations to the whole adult

population, eventually moving into the vaccination of children and young people as new evidence continued to emerge.

Delivery of the booster programme was accelerated nationally following the rapid emergence of the Omicron variant and the need to 'Get Boosted Now' in December 2021 saw our vaccination teams respond phenomenally to provide the additional capacity required to ensure as many of our patients and public were able to access a jab as quickly as possible. As of 31 March 2022, over 734,000 doses of the COVID-19 vaccine have been administered to Northumberland residents.

We would like to thank all of our local NHS and health and care staff across Northumberland for all of their phenomenal work during this last year. At a time when we have all had to deal with difficult personal circumstances and unprecedented restrictions to our daily lives, staff have continually gone above and beyond to play their part in keeping patients as safe as possible. We are sincerely grateful for their continued efforts.

As a consequence of COVID-19, and the need to make significant adjustments to the way services were prioritised and delivered, performance against key metrics has deteriorated compared to previous years and the recovery from the wider impacts of COVID-19 on both service delivery, and on the health and wellbeing of our residents will be the key priority for our local NHS system in 2022.

The CCG continues to play an active part in the development of the North East and North Cumbria Integrated Care System (ICS), contributing to the development of strong local leadership and supporting the transition towards statutory status for the ICS from 1 July 2023.

The Department of Health and Social Care's white paper 'Joining up care for people, places and populations' points the way towards greater integration of health and care services at place level alongside key partners, such as the local authority and Primary Care networks.

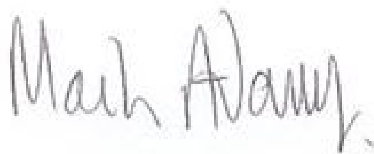
For the whole team at the CCG it is the delivery of this 'place-based' health and care that is at the forefront of everything we do. COVID-19 has exposed health inequalities across our country that require urgent attention as we all continue to recover from the impact of pandemic. NHS Northumberland CCG will continue to work tirelessly to ensure equity of access to, experience of, and outcomes from health and care services for all of our population.

Our annual report describes the vast amounts of work that have been done over the last 12 months to adapt health and care services to respond to COVID-19 and meet the needs of our population. It also addresses how NHS Northumberland Clinical Commissioning Group (hereafter referred to as the CCG), has performed during the

year including a description of the principal risks experienced and how they have been addressed. It also outlines the development and performance of the CCG against a range of national targets and metrics.

The accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended). The accounts have been prepared on the basis that the CCG is a 'going concern'. The CCG is carrying a cumulative deficit of £53.4M at 31 March 2022. However, public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is fully anticipated, as evidenced by the inclusion of financial provision for that service in public documents. Throughout the COVID-19 response the NHS has been operating within interim financial arrangements. Prior to the Coronavirus pandemic the financial allocations for the period 2020/21 to 2023/24 had been approved by parliament and there is no reason to believe that future approvals will not be forthcoming.

This annual report covers the ninth and final full year that the CCG will have been in place in Northumberland. For almost a decade now our patients and public have benefitted from clinically led commissioning of healthcare services supported by a team of experienced and dedicated managers. We would like to place on record our thanks to all of the staff who have worked for, and with, the CCG in those 9 years and who have made such an important contribution to the health and wellbeing of Northumberland's residents.



Mark Adams
Accountable Officer
20 June 2022

Graham Syers
Clinical Chair
20 June 2022

About NHS Northumberland Clinical Commissioning Group

As a statutory body, NHS Northumberland Clinical Commissioning Group (CCG) is responsible for planning and buying (commissioning) local NHS care and services to meet the needs of our local community. This includes services provided by physiotherapists and district nurses. We are mostly made up of doctors, nurses and other health professionals – with support from experienced health service managers.

We work closely with all 37 family GP practices in Northumberland which are all members of NHS Northumberland CCG and we co-commission General Practice services in collaboration with NHS England. This enables us to have close links to our patients, allowing us to develop more personalised local health services that respond to individual needs. Although we are not responsible for the contracts of dentistry, community pharmacy and optometry we work closely with NHS England who have this role.

By ensuring effective clinically led commissioning we can make a real impact on the health, wellbeing and life expectancy of our patients. We know the NHS continues to face unprecedented challenges, exacerbated by the impact of the COVID-19 pandemic, which are not unique to our area. These challenges are driven by the following:

- An ageing population with increasing health needs
- Health inequalities across the area
- Levels of smoking, alcohol consumption and obesity higher than the national average
- Over-reliance on hospital-based services
- The increasing cost of drugs and new medical technologies
- Limited growth in annual financial allocations

Our Vision

Since its inception in 2013 the CCG's vision has focused on the delivery of integrated services designed to meet the needs of local people. Our vision remains that we:

'***Ensure that the highest quality integrated care is provided, in the most efficient and sustainable way, by the most appropriate professional to meet the needs of the people in Northumberland.'***

We have four strategic objectives that support the achievement of our vision namely that we continue to:

- Ensure that the CCG makes best use of all available resources
- Ensure the delivery of safe, high quality services that deliver the best outcomes
- Create joined up pathways within and across organisations to deliver seamless care
- Deliver clinically led health services that are focused on individual and wider population needs and based on evidence

All the work we undertake is aligned to achieving this vision for the people of Northumberland. The CCG assimilates national policy, such as the NHS Long Term Plan, with the Northumberland Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy (2018-2028) and other local strategies to generate an annual operational delivery plan. The 2021/22 operational delivery plan is described in more detail later in the report.

Financial Context

Due to the continuation of the COVID-19 pandemic, the Government extended the temporary financial framework arrangements for NHS organisations for another year to cover the period to 31 March 2022.

The financial framework arrangements built upon the system-based approach to funding and planning that had been introduced in the 2020/21 financial year and related particularly to the second half of the 2020/21 year which introduced joint system planning and submissions.

The CCG continued to plan and report as part of the system allocated to the North area of the North East and North Cumbria Integrated Care System (NENC ICS) for the financial year 2021/22. The resources received, and position reported by the CCG for this financial year reflect the split of resources the CCG agreed as part of the system planning and collaboration process.

For the financial year 2021/22 the CCG has delivered its statutory obligation under these temporary framework arrangements which is to remain within the financial resource provided, both as an individual body and as part of the wider North East and North Cumbria Integrated Care System.

During the year the CCG was able to support its providers to continue to deliver services with the pressures they faced caused by the continuation of the COVID-19 pandemic.

The CCG has planned for the 2022/23 financial year again as part of the North East and North Cumbria Integrated Care System. However, with CCGs expected to merge into Integrated Care Boards (ICBs) on 1 July 2022 the CCG will only be allocated one quarter of its share of the NENC ICB planned allocation for next year to continue to report spend as a CCG up to the transfer date of 30 June 2022, whereupon any balance (surplus or deficit) from the Q1 2022/23 period will be adjusted to breakeven and any adjusted balance will be transferred to the ICS along with the CCG to be reported in the ICB financial statements for 2022/23.

The CCG will still have a requirement to meet its statutory duties for the Quarter One period of the 2022/23 financial year, as the CCG will still be a separate entity with statutory duties up to the transfer point. Therefore, the CCG will still have to complete an external audit accounts process as it would do with any other period, with the timing of the audit still to be confirmed.

CCG 2021/22 Operational Delivery Plan

The CCG prepares an operational delivery plan each year to translate national policy and local need and strategies into delivery projects that will bring about positive change for the people of Northumberland. The CCG operates a programme management office (PMO) that monitors delivery and enabling senior management to track delivery and manage emerging risks throughout the year.

The 2020/21 operational delivery plan was refreshed to take account of the next phases of the NHS Long Term Plan https://www.longtermplan.nhs.uk/**;** 2021/22 priorities and operational planning guidance**;** and also new and emerging local priorities, to form the 2021/22 operational delivery plan.

2021/22 was characterised by a continued response to COVID-19 whilst ensuring restoration of services. Within this context, the 2021/22 priorities and operational guidance set out the following objectives for the NHS:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely

admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities

The following section outlines in more detail what the CCG has achieved in relation to the above priorities.

1. **Supporting the health and wellbeing of staff and taking action on recruitment and retention**

CCG Staff Health & Wellbeing – 2021/22

The health and wellbeing of staff is a priority for the CCG. Both the national and local health and wellbeing offer of support and resources, including the NENC ICS Staff Wellbeing Hub, are highlighted at the weekly staff Team Huddle meetings and in the e-newsletter, The Huddle. Annual appraisal meetings gave staff the opportunity to discuss their personal development, the importance of a healthy work-life balance and their health and wellbeing with their line manager. Health and Wellbeing conversations also take place during regular one-to-one meetings between staff and their line managers. Following feedback from the CCG Staff Health & Wellbeing Temperature Check in April 2021, virtual staff workshops about uncertainty and change took place. The 'Living with Uncertainty' and 'Coping with Change and Uncertainty' workshops were externally facilitated and focused on practices and behaviours that can help staff handle uncertainty, challenge, and change. Staying mentally well during COVID-19 was also a high priority throughout the year, as was an emphasis on Men's health issues.

The CCG's Staff Health & Wellbeing Group was formed to discuss health and wellbeing ideas including coordinating social activities and fundraising. The Better Health at Work Award which the organisation will pursue includes an offer of training for staff who would like to become Health Advocates.

Jointly run with Northumbria Healthcare NHS Foundation Trust, Northumberland County Council and the CCG, staff now have access to nine Staff Networks:

- Autism Spectrum Disorder (ASD) Staff Network
- Black Asian and Minority Ethnic (BAME) Staff Network
- Carers Staff Network
- Cancer Support Staff Network
- Enable Disability Staff Network
- Lesbian Gay Bisexual Trans (LGBT+) Staff Network
- Menopause Staff Network
- Mental Wellbeing Staff Network
- Family Ties Staff Network

NHS National Staff Survey 2022

The national NHS Staff Survey results published on Wednesday 30 March 2021 for the 2021/22 year, showed that 79% would recommend the CCG as a place to work and 88% would be happy with the standard of care provided to a friend or relative if required. The annual survey, completed by NHS organisations across England, focuses on nine themes and provides a detailed insight into how staff feel about culture, their wellbeing, levels of engagement and motivation, equality, diversity and inclusion, safety and quality of care.

Staff satisfaction remains high at NHS Northumberland Clinical Commissioning Group (CCG) despite the pressures experienced by all during the COVID-19 pandemic.

In addition, 98% of the staff surveyed agreed that care of patients and service users is the top priority for the CCG, which plans and commissions for the county's residents hospital, community and primary care services.

For the 2021 edition, the survey was updated to align with the NHS People Promise, which aims to reflect what matters most to staff and what would make the greatest difference in improving their experience in the workplace. The CCG scored at or above average across all elements of the People Promise, and for both staff engagement and morale.

A number of areas saw a marked improvement from the 2020 scores for Northumberland CCG staff, such as the proportion of staff always knowing what their work responsibilities are rising from 77% to 84% and the proportion agreeing they have frequent opportunities to show initiative also increasing from 77% to 84%.

The 2021 NHS Staff Survey results show an excellent response rate from staff and are encouraging set against the backdrop of the ongoing pandemic and uncertainty created by the ICS transition.

Embed new ways of working and delivering care

The introduction of the Practice Link Nurse in early 2021 has created a key connection between the county's general practice nursing and clinical workforce and the CCG. The Practice Link Nurse works with the general practice nursing teams in Northumberland on a range of educational and workforce initiatives linked to continuous professional development and continuous workforce development. The postholder has been able to forge critical links across our general practice nursing teams.

The postholder has developed the General Practice Nursing (GPN) fellowship scheme in collaboration with Health Education England and has rolled this out in two GP practices with the result that several other GP practices are keen to hire newly qualified nurses. This also has the benefit of encouraging students to think about primary care as their first-choice career after qualifying with the support offered by this Fellowship programme.

A training needs analysis of GPN nursing workforce in Northumberland was undertaken in 2021, the results of which informed the development of the continuing professional development plan for the year to support the further development of our skilled workforce to meet the needs of our patients.

The role of the link nurse has created greater opportunities to work in collaboration with North Tyneside and Newcastle Gateshead CCGs to help offer a cohesive training package to the nursing teams within the area, providing support and increased access to training and better value for money.

Safeguarding Lunch and Learn Training

Recent local Domestic Homicide Reviews (DHRs) had identified learning for Primary Care. The recommendations from the DHR included reiterating to Primary Care the importance of coding health records for vulnerability and domestic abuse, to remind Primary Care of the facility to discuss complex patients in practice multi-disciplinary team meetings and for GPs to be more proactive with complex patients who repeatedly 'do not attend' or 'was not brought in' (in the case of children or those with a learning disability) and exercise professional curiosity.

Additionally, there has been an increase of domestic abuse during recent lockdowns, including an increase in male victims of abuse. Alongside sharing the learning from DHRs this training was also developed to:

- Increase knowledge and understanding of domestic abuse
- Identify signs and symptoms of domestic abuse
- Increase confidence in tasking the question with patients regarding domestic abuse
- Increase knowledge and the completion of the Safe Lives Domestic Abuse Stalking and Honour based violence (DASH) risk checklist and Multi Agency Risk Assessment Conference (MARAC) referral
- How to support victims once domestic abuse is disclosed and referral to local domestic abuse services

The training was delivered over lunch time sessions and promoted as 'Winter Training – Domestic Abuse', the rationale for this was to make the training available to all clinical and non-clinical staff in a flexible and attainable way. The training was delivered via MS Teams and additional material to support the session was attached to the invitation. This training evaluated very positively and the 'lunch and learn' model has proved to be a successful way to offer safeguarding training to primary care staff. The aim is to further develop this model to offer a range of topics delivered quarterly offering primary care staff four hours of safeguarding training per year.

Grow for the future

The supporting placements of students within primary care has been one of the key objectives for the link nurse role, and we have seen an increase in nursing placements, but also other professions such as podiatry students within Northumberland. Expanding the Higher Education Institutions that we work with is also a key aspect of the role and we are now working with Northumbria and Sunderland Universities alongside New College Durham. The coordination of nursing leads within each PCN is now in progress with the aim to provide a network of support across the region.

We have been able to run student nurse lead initiatives at Netherfield Surgery and provide health promotion events seeing over 200 patients, supported by the Practice Link Nurse. This format is now being rolled out to 10 practices in the summer to highlight the impact student nurses can have and encourage newly qualified nurses. We have been able to support practices with recruitment and development of their staff and are working closely with nurses about to qualify who are looking for a GPN post.

2. **Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19**

Throughout 2021/22 the CCG has continued to co-ordinate and support the delivery of the COVID-19 vaccination programme across Northumberland alongside working with our main providers to ensure that the needs of patients with COVID-19 are met.

Over 530,000 doses of COVID-19 vaccinations were delivered to Northumberland residents during 2021/22. Northumberland has some of the highest uptake of COVID-19 vaccination of any Upper Tier Local Authority (UTLA) area in England with over 90% of the population (aged 12+) having received at least one dose, over 86% given at least two doses, and over 72% with three or more doses.

The CCG has worked with the North East and North Cumbria System Vaccination Operations Centre (NENC SVOC) to enable the successful delivery of the programme across Northumberland via a network of vaccination sites provided by Primary Care Networks, Community Pharmacies, Hospital Hubs, Vaccination Centres, and the Northumberland Roving Vaccine Unit. Delivery of the programme throughout the constantly evolving pandemic situation has required a phenomenal effort from all of the teams involved, across multiple organisations, and with the support of thousands of staff and volunteers.

The success of the COVID-19 vaccination programme in Northumberland has only been possible due to the strength of the relationships between multiple agencies and the spirit of integration and collaboration that has underpinned them. The CCG has co-ordinated the local health and social system in delivering the programme and worked with colleagues including; Northumberland County Council - Public Health, Education, Adult and Children's Services, Highways, Estates and Communications; our Acute, Community, and Mental Health provider trusts; Primary Care Networks and General Practices; Northumberland Fire and Rescue Service; Northumbria Police; Healtwatch; the Voluntary and Community sector; and local, regional, and national NHS partners.

A COVID-19 Vaccine Equity Board was established during 2021/22, ran jointly between the CCG and Local Authority Public Health team. The work of the Board focused on monitoring and increasing uptake of vaccination in our most deprived communities and amongst minority groups who have historically been impacted by health inequalities. A number of initiatives have been progressed by the Board to increase uptake in these target groups including a successful programme of local engagement and provision of midwifery-led vaccination clinics for pregnant women. Outreach work has also taken place within minority ethnic communities across Northumberland to engage trusted voices within these communities who have helped to promote vaccine uptake. Targeted engagement has taken place across CCG, Primary Care, and Local Authority communications and social media channels to address vaccine hesitancy, complacency, and confidence.

The Northumberland Roving Vaccine Unit (RVU) was commissioned by the CCG and launched in April 2021 to provide a mobile vaccination capability. The RVU is provided by Cramlington & Seaton Valley Primary Care Network. Throughout 2021/22 the RVU has provided vaccinations across the length and breadth of Northumberland, visiting some of the most isolated and rural communities to increase access to vaccination and help overcome health inequality. The RVU has also worked with local partners to provide vaccinations to Northumberland's homeless population and patients, and staff in learning disability inpatient facilities. The RVU has also supported delivery of the vaccination programme across the wider North East and North Cumbria Integrated Care System, providing support in North Tyneside to provide surge vaccination capacity during

the outbreak of the Delta variant and across the Tees Valley CCG footprint to provide hyper-local pop-up clinics to offer vaccinations to some of the most deprived communities in our region.

The CCG has worked with both of our main providers of acute hospital services, Northumbria Healthcare NHS Foundation Trust (NHCFT) and Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) to establish Long COVID clinics in line with the nationally mandated service requirements. These clinics have supported patients suffering with the long-term effects of COVID-19 and have facilitated access to the 'Your COVID Recovery' resources to help patients monitor and manage their recovery.

The CCG has also overseen the establishment of the COVID-19 Oximetry @home pathway, working with colleagues across primary and secondary care, and the care home sector to enable remote monitoring of patients with COVID-19 in the community. This included the distribution of large numbers of Pulse Oximeters to GP Practices and Care Homes to help their patients manage their illness and monitor their condition.

In early 2022 the CCG also worked with local secondary care providers to rapidly establish COVID Medicines Delivery Units (CMDUs) to provide antibody and antiviral treatments to those people with coronavirus (COVID-19) who are at highest risk of becoming seriously ill.

As 2021/22 was drawing to a close the CCG co-ordinated and is overseeing the rollout of the Spring Booster vaccination programme to provide ongoing protection to those residents and patients most vulnerable to serious illness from COVID-19. The CCG is also working with local and regional system partners in order to develop strategic plans for the delivery of an autumn COVID-19 booster vaccination programme, should this be recommended by the Joint Committee on Vaccination and Immunisation (JCVI).

3. **Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand of mental health services**

    a. <u>Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services</u>

    The CCG has worked with our main providers, Northumbria Healthcare NHS Foundation Trust (NHCFT), Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) on comprehensive plans to ensure recovery of elective activity following the COVID-19 pandemic. The COVID-19 pandemic

has transformed the delivery and operation of Outpatient services including new and follow-up appointments with smarter ways of working. The development and subsequent implementation of plans has included using virtual/digital operational models to see patients at home instead of hospital, where appropriate. Traditional methods of service delivery have also remained available, particularly for patient groups that may find accessing digital models difficult. A good example of this is the digital dermatology pathway which has supported operation of cancer services.

As part of the recovery, providers have reviewed the waiting list and looked to understand whether prioritisation based on comorbidities could be beneficial to enhancing the care of the patient. A population health management approach has started to be formed where the health and care system considers not just the individuals' immediate issues but takes a holistic approach. This has started to capitalise on the vast amounts of data health and care organisations hold to benefit the patients.

Additional finances have been made available to providers to undertake waiting list initiatives in order to recover services as quickly as possible. CCGs and providers also combined efforts to utilise capacity in the independent sector whilst ensuring value for money and equity of access for those already on NHS providers' waiting lists.

b. <u>Restore full operation of all cancer services</u>

The impact of pandemic lockdowns in 2020/21 meant that there had been reduced patients coming forward to access services. Additionally, COVID-19 continues to impact on service capacity, with infection control procedures (IPC) and staff absences affecting service delivery. Therefore, the main areas of focus for cancer services in 2021/22 were to:

- Work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer.
- Restore cancer screening programmes.
- Extend clinical prioritization to patients on cancer diagnostic pathways
- Achieve the new Faster Diagnosis Standard.
- Improve performance against existing cancer waiting times.

The COVID-19 pandemic has continued to have a major impact on performance in 2021/22 however work has continued to streamline pathways and ensure patients receive diagnoses and treatment as timely as possible.

Digital Dermatology

Embedding the digital dermatology pathway for suspected skin cancers has successfully reduced the waiting times for diagnosis of melanomas and reduced unnecessary face-to-face attendances and travel for patients. The success of this pathway has prompted the extended use of this technology to some non-cancer dermatology conditions. Training has taken place with primary care teams to ensure the pathway is clear, safe, and efficient when referring patients on this pathway into secondary care.

Cervical Screening

Northumberland continues to perform highly overall for cervical screening uptake, however it was recognised that there was variation across the county. The CCG has therefore supported Primary Care Networks (PCNs) by targeting funding to address the variations identified. Primary care teams have implemented a range of initiatives to increase uptake within their local populations, such as increasing provision of screening clinics and increasing capacity to contact eligible patients by phone to address any potential barriers.

Raising Public Awareness of Cancer

The CCG supported several national cancer campaigns in 2021/22 aimed at building public confidence in contacting their GP if they suspect they have cancer including the *'Help Us to Help You'* campaign. The first phase encouraged early presentation of abdominal and urological cancers whilst a subsequent phase focused on encouraging eligible women to attend their cervical screening appointments. In March 2022, the national team launched a general early diagnosis campaign *'Don't let the thought of cancer play on your mind'*. The NHS also teamed up with Prostate Cancer UK to *'find the missing men'* with a national campaign targeting men over 50 and black men over 45. Primary Care were informed, and resources shared with various stakeholders.

The CCG also supported the *'Do It For Yourself'* regional lung cancer campaign, that targeted specific populations in Northumberland with higher lung cancer incidence and late or emergency presentations. As well as radio coverage and posters on buses, our local cancer awareness worker distributed campaign beer mats to local clubs and pubs. The Northern Cancer Alliance are currently working with the local cancer awareness workforce to develop a campaign to target people at higher risk of head and neck cancers, in response to an increase in late presentations.

The CCG continues to use awareness months to raise the profile of bowel and breast cancers and shares various campaigns that support our risk reduction and prevention messaging such as the Balance *'Alcohol Causes Cancer'* Campaign in November 2021 and the Fresh *'Quit Smoking'* campaign last summer.

Communication with the public in Northumberland to promote the Galleri trial is also being supported by the CCG.

c. Expand and improve mental health services and services for people with a learning disability and/or autism

Mental Health

Throughout 2021/22 we have continued to work closely with neighbouring CCGs to ensure that any potential disruption to services due to the impact of COVID-19 has been kept to a minimum. As a result, we have been able to deliver mental health services in line with the NHS Long Term Plan and ensure that quality services are provided in the right place at the right time, responding to the needs of Northumberland.

Our Community Mental Health Transformation has made good progress around the provision of services for those clients with serious mental illness (SMI). This has focused on key pathways including adult eating disorder, personality disorder, and improving physical health care. The transformation work relies on collaborative working across primary care, secondary care, the voluntary and community sector, and social care services to develop wider system working and collaborative approaches. The transformation will result in easier access to services for people with serious mental ill health offering a joined up, seamless and holistic approach in our community mental health services.

Very closely aligned to our transformation work is the development of the Northumberland Recovery College. As well as offering a range of courses, the College works closely with the voluntary sector and has been integral to the development of a voluntary sector network to support mental health initiatives. The College development groups which link in with communities across Northumberland and align with PCNs, together with the voluntary sector network ensures that awareness of mental health is promoted in our communities as well as messages around wider emotional health and wellbeing information for the population of Northumberland. The College website and resource pages provide information and advice around courses available, health information and helpful tips around looking after our mental health.

Our relationship and working arrangements with the voluntary community sector across Northumberland has continued to flourish. The sector has delivered excellent initiatives to support people with mental ill health in communities across the county and is at the forefront of providing services to clients with a range of needs which impact on mental health and wellbeing.

Linking with our crisis services and other pathways, this includes support with financial difficulties, relationships problems, housing issues and alcohol or drug dependence. The sector has continued to offer additional services for those in need of support following traumatic experiences and loss due to COVID-19, and we continued to support services offered to those people who have been affected by suicide.

We have continued to work closely with our PCNs around the Additional Roles Reimbursement Scheme (ARRS). This offers primary care an opportunity to extend the variety of care and interventions available within practices and the inclusion of mental health workers offers specialist expertise closer to communities.

Added benefits include use of skills and knowledge to streamline pathways, improve access to services, raise awareness of mental health, bring services closer to home and enhancing joint working between primary care, secondary care, and voluntary care mental health services.

Our Improving Access to Psychological Therapies (IAPT) service has been aligned with mental health secondary care services to ensure that clients experience easy transition across pathways where required. We continue to work very closely with our IAPT provider and have provided additional funding to support the reduction of waiting lists at more complex steps in the service.

We have maintained close working relationships throughout the year with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), our mental health secondary care provider, to enhance existing services including:

- Crisis and Psychiatric Liaisons services
- Specialist Perinatal services
- Early Intervention in Psychosis
- Adult Eating Disorder physical health care
- Personality Disorder service (trauma informed care)

We have also paved the way for work to be improved around:

- Individual Placement support
- Crisis alternatives
- Rehabilitation in the community

We have continued to work closely with CNTW and alternative providers to reduce waiting lists in the adult Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) pathways.

Learning Disabilities and Autism

During 2021/22 we have worked closely with our partners and providers to maintain our proactive role in avoiding unnecessary admissions to mental health hospitals for people with a learning disability or autism. To support this, we have provided safe havens to prevent hospital admission when people experience difficulties in their home environment and require some additional support for a short period of time.

We strengthened our dynamic support register and care and treatment review process to identify community alternatives closer to home rather than hospital. We also committed resources to enable earlier identification of children with complex needs who require additional support to achieve the best possible outcomes in childhood.

We have worked in collaboration with inpatient services locally and out of area to ensure individuals with a learning disability and/or autism do not remain in specialised hospitals longer than they need to, by embedding the 12-point discharge plan, ensuring discharges are timely and effective. We have developed links with other commissioning authorities during the Host Commissioner and Oversight Visit implementation, working together to make sure that individuals in specialised hospital settings are accessing the appropriate care and treatment for their needs, any restrictions applied are relevant and appropriate, and risk is assessed and reviewed regularly.

For those people in long-term segregation, we review arrangements every three months, and the use of seclusion and restraint is monitored closely. Aligned with this is the development of a process for identifying and responding to potential closed cultures within inpatient settings.

The CCG is committed to reducing the number of people in inpatient settings, by working closely with providers to develop community services. Enhancing our specialised support services to be able to provide a flexible and needs-led approach to individuals already living in the community or being discharged

from specialised inpatient settings. We continue to be committed to reducing and preventing the number of individuals being placed in out of area settings, by developing our services in Northumberland.

Our Children's Trailblazer project has seen a continued reduction in wait times to our people's autism and neurodevelopmental diagnostic service and significant investment has been made to reduce the wait time to assessment to under 18 weeks in the same adult pathways. A review of the availability of post diagnostic support and access to sensory profiling and integration was undertaken and these areas will be added to the 2022/23 planning round.

We continue to improve the transition from children's to adult services for individuals with a learning disability and autism or both. Working closely with providers to highlight the gaps and incorporate the views of families and the individuals accessing the service.

The CCG continued to review the deaths of people with a learning disability through the national Learning Disabilities Mortality Review (LeDeR) programme and embedded learning into our quality assurance programmes. An integral part of this work is being linked with the local dysphagia and oral health network and we continue to develop pathways for the prevention of aspirational pneumonia in people with a learning disability.

Our GP clinical leads have been actively involved in the learning disabilities and autism clinical networks ensuring that best practice is shared within primary care in Northumberland. This includes a pilot for a reasonable adjustments flag in patients' medical records, cancer screening and the role of autism awareness training.

Work has continued to identify our hidden population of children and adults with a learning disability and/or autism, this includes keeping the Learning Disability GP registers up-to-date and maintaining strong links with the local community.

Our GP leads worked hard over the winter period to communicate an important message about keeping well for winter, improving general health, and increasing activity levels during the recent pandemic.

We continue regional education throughout the primary care workforce, highlighting the importance of high-quality annual health checks and healthcare for children and adults with a learning disability and/or autism. The development and importance of a specific health check for people with autism is currently being discussed.

We continue to work closely with our GP leads and providers in broadening the message around the stopping over-medication for people with a learning disability and/or autism and support treatment and appropriate medication in paediatrics (STOMP/STAMP).

The CCG continues to commission advocacy services, providing the support that helps individuals with a learning disability and/or autism to make decisions and choices about the important things in their lives.

The CCG is committed to improving the lives of people with learning disabilities and autism and leads on a countywide strategy to ensure the NHS three-year plan is realised locally. This includes the setting up of an Autism Partnership Board, an inclusive approach to agreeing priorities for 2022/23 which includes a range of partners from across the health and care system and those with lived experience.

The CCG is currently developing Northumberland's Three-Year Autism Strategy, coproduced with providers and those with lived experience to ensure that we identify what is working well in Northumberland and where there may be areas for change and improvement.

Children and Young People

In 2021 the CCG launched a further *'Be You'* Mental Health Support Team (MHST) in schools trailblazer project after successfully securing funding in the third wave of the national pilot. The new team covers Bedlington and Ashington building on the work of the MHST teams already embedded in Hexham and Blyth. Whilst COVID-19 has brought challenges in terms of gaining access to schools, alternative methods of delivery were explored and the team is now settling into their designated schools. The MHST offers individual 1-to-1s, group work, general awareness raising in assemblies, more targeted work where the school has identified an issue and general advice and guidance to school staff. For more information, visit the Be You website https://www.beyounorthumberland.nhs.uk.

Building on our strong history of collaborative working and joint commissioning between health and social care, the CCG has introduced new roles of mental health practitioners within Children's Social Care teams. These roles will enable the ongoing development of a flexible, proactive, and accessible service for children and young people. This will be achieved by providing assessment and additional focus to those children identified within the social care teams as in need; ensuring person-centred care to those who may not reach the threshold for secondary mental health care services but whom would still benefit from support and intervention.

In addition, the CCG has funded extra posts within the Local Authority's Autism Service in Schools to support with the growing demand.

The CCG invested funding to establish a 24-hour crisis service for children and young people in line with national guidance and the 24 hour adult crisis team. We have also funded a dedicated Children and Young People's Practitioner within the Psychiatric Liaison Service based at Northumberland Specialist Emergency Care Hospital (NSECH). This post works with children and young people identified by nursing staff as in need of a mental health assessment and support whilst they are staying in the hospital.

As part of the Preparation for Adulthood within the health transition pathways, there is continued work to improve attendance of children and young people with a Learning Disability at their 14+ health check, as well as further development in relation to the interface and pathways between children and young people's mental health services, adult mental health and social care to enable smooth, timely and effective transitions. Work between mental health providers and education colleagues has enabled the development of a guide to support Special Education Needs Coordinators (SENCOs) in schools with managing the emotional health and wellbeing of their students as they transition through schools and age groups.

Following consultation and feedback from parents and carers the CCG began the process in 2021 of coproducing plans to develop a sensory pathway for children whose primary need is sensory processing. This offer will be expanded to adults over time.

d. <u>Deliver improvements in maternity care, including responding to the recommendations of the Ockenden Review</u>

The first Ockenden Report was published on 11 December 2020 following an independent review of the Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. This initial report of emerging findings and recommendations contained seven Immediate and Essential Actions (IEA) to improve safety in Maternity Services at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England. It has also provided a framework for transformation of local maternity services and help to bring forward lasting improvements.

In response to the Ockenden recommendations, the quality governance and oversight system had been strengthened in the North East and North Cumbria in the provider trusts, CCG, and region. The three Local Maternity Systems in the North East and North Cumbria (NENC) region has now become one single NENC Local Maternity Neonatal System (LMNS) since April 2021. It is

recognised that maternity units and hospital trusts often serve residents from a wide geographical area, and this new way of working will ensure better joined up working and accountability across different maternity services. Alongside this, a maternity quality and safety group has been set up and systems are in place to improve the gathering and interpretation of safety information and patient experience, to inform service planning and delivery. Sharing good practices and lessons learnt is also a key focus.

Patient safety has always been a top priority for the CCG. Since the publication of the Ockenden Report, the CCG has continued to build on its productive working relationship and work very closely with our maternity units to implement all the recommendations. The maternity services at Northumbria Healthcare NHS Foundation Trust (NHCFT) have achieved compliance of all seven immediate and essential safety actions required. The CCG is an active member of the LMNS and its Executive Director of Nursing, Quality and Patient Safety chairs the NENC Maternity Quality and Safety Group. There is also a vibrant Maternity Voice Partnership in Northumberland to ensure the voice and experience of mothers and families are at the heart of our maternity services. The maternity team at NHCFT regularly attend the CCG's Clinical Management Board to provide assurance and updates in relation to Ockenden and the wider maternity transformation programme. Ockenden is also a regular agenda item for assurance at our Quality Review Group meetings with the hospital trusts.

Progress to address health inequalities and improve outcomes for mothers and babies in response to the Better Births: Improving Outcomes of Maternity Services in England (2016) continues. Continuity of Carer teams are in place for mothers and babies in Northumberland, showing real improvements in outcomes in some of our most deprived communities such as rates of smoking cessation and breast feeding. As part of the wider COVID-19 offer, the CCG has worked with our GP practices and the maternity teams to promote vaccinations for mothers, and we have achieved one of the highest uptake rates in the region.

The final Ockenden Report of the Independent Review of Maternity services at The Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022. The report identifies further 15 key immediate and essential actions (IEAs) to improve all maternity services in England. As the LMNS and incoming ICB are taking over their statutory responsibilities and formal roles in perinatal quality oversight in the near future, the CCG is working with all stakeholders to ensure a managed, integrated and seamless transition for quality oversight in the coming months.

The seven IEAs referred to are:

- Enhanced Safety
- Listening to women and their families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring fetal wellbeing
- Informed consent

4. **Expanding primary care capacity to improve access, local health outcomes and address health inequalities**

The work of the CCG is focused on a combination of commissioning high quality care for all who need it, alongside equity of access and sensitivity to local outcomes and inequalities. The emergence of Primary Care Networks has provided a perfect opportunity for integrated work at neighbourhood and community levels that are meaningful geographical areas to the residents who live there. A combination of multi-disciplinary teams from across the health and care spectrum, access to linked data sets and the lived experience of families and communities mean that local outcomes can be successfully identified with a shared approach to solutions.

For example, across a number of PCNs, the importance of children having the best start in life, the issues and causes of child poverty and the unacceptable rate of self-harm in children are areas of focus. For other areas, obesity, the use of alcohol and patients who access multiple services a large number of times are important areas of work. For each of these significant areas; understanding and addressing the causes is fundamental alongside the traditional approach of treatment alone. This is very much the essence of what is called the population health management approach which at its heart aims to reduce inequalities across communities and increase healthy years of life and life expectancy. This means the NHS must become more than a treatment service and work in partnership with a huge range of stakeholders to create thriving communities.

a. Restoring and increasing access to primary care services

2021/2022 has been another challenging year for general practice, recovering from national requirements and restrictions to manage COVID-19 related infections in our communities and local health centre facilities as well as delivering multiple vaccination programmes to maintain an element of prevention against COVID-19, childhood illnesses and flu.

However, alongside workforce pressures and infection prevention control requirements, the General Practices in Northumberland have continued to prioritise the needs of their registered patients and focused on multiple national requirements to reintroduce the offer to patients for face-to-face appointments, physical health checks and long term conditions management.

The CCG has continued to work with practices to ensure business continuity arrangements and adverse weather plans ensured their premises remained open for all. The CCG continued to support primary care with development work focusing on digital transformation, estates and premises, workforce. Additionally, engagement work was undertaken relating to access to services; sustainability and quality visits continued; and support offered to primary care networks. Further details are provided below.

Primary Care Networks (PCNs)

In addition to delivering the COVID-19 vaccination programme, Northumberland's PCNs have continued to develop. Throughout 2021/22 they have continued to recruit new staff through the Additional Roles Reimbursement Scheme (ARRS). This national scheme provides investment to enable PCNs to expand their workforce and offer alternative professionals working as part of the Primary Health Care Teams.

These roles include Clinical Pharmacists, First Contact Physio, Paramedics and Social Prescribing Link Workers. Mental Health Practitioners (MHP) were also included for the first time in 2021/22. Working jointly with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) all the PCNs have recruited MHPs to support the primary mental health provision in Northumberland. Since the beginning of the ARRS scheme to the end of 2021/22 the PCNs have recruited over 100 additional whole time equivalent staff to these new roles.

During 2021/22 the CCG undertook the preparatory work for the formation of a new PCN and changes to three of the existing PCNs on 1 April 2022. The new Northumbria PCN will include the following practices run by Northumbria Primary Care – The Rothbury Practice, Haydon Bridge & Allendale Medical Practice, Cramlington Medical Group, Elsdon Avenue Surgery and Ponteland Medical Group. This has resulted in seven PCNs working across all practices in Northumberland.

Northumberland Estate Strategy

The CCG's ambition for GP estate and premises is to provide a more fit for purpose, flexible, more cost efficient and sustainable estate across

Northumberland. This estate will facilitate service transformation, sustainable delivery of high-quality health and social care services and the realisation of wider benefits for our communities.

During 2021/22 the CCG has undertaken a number of activities to improve the GP estate:

- **Rationalisation and repurposing of the current estate** was undertaken to improve capacity, access and the quality of facilities at Blyth Health Centre, Riversdale Surgery in Prudhoe, Gables Medical Group in Bedlington, Broomhill Health Centre, and Seahouses Health Centre.

- **Relocation projects** were progressed and approved for Felton Surgery and Elsdon Avenue Surgery.

- **Lease regularisation and resolution of historic payments** were agreed on 23 leases due for completion by June 2022.

- **Support to practices to digitise patient records** was undertaken so that freed up space can be turned into clinical rooms.

Following a national programme and investment to digitise patient records, the CCG, with practices, has developed a programme of works to remove paper patient records from general practice premises to secure locations and provide an opportunity to repurpose the records storage and adjacent areas to create additional clinical capacity.

Digital

During the COVID-19 pandemic there has been a major focus on the digital opportunities, supporting patients and their practices to maintain contact and consultations where needed. The CCG and its practices are conscious these changes were implemented at speed as part of the emergency response and are working to improve communication and tailoring of these digital solutions, to maximise their positive benefits for patients into the future.

In late 2021, the CCG undertook a series of workshops with each of the PCNs to understand their current digital pressures and their longer-term digital requirements from primary care digital solutions such as Online/Video Consultations, text messaging and telephony systems. The outcome informed the CCG of key work areas to support practices, and these will be used to influence the delivery of the CCGs Digital Strategy.

The digitisation of medical records programme was paused due to COVID-19 but has since resumed during 2021/22. This programme looks to address the large amounts of space taken up by paper medical records by digitising the records or placing them into long term offsite storage until the national digitisation solutions are available.

Addressing the records in this way allows additional clinical and administration space to be created within existing practice footprint avoiding the need for costly conversion works and allowing effective solution expanding the workforce. Roughly 140,000 records have been placed into secure storage allowing much needed space to be reutilised. This work will continue into 2022/23 allowing all practices to realise the benefit of the programme.

Through regional and local procurement exercises we have sustained the ability for patients to interact with practices in alternative, digital, ways. These solutions offer a choice of access and communication routes for patient/clinician interaction and help maximise the use of clinical time within practices:

- **Online Consultations –** providing the patient with the ability to access clinical services such as GPs/healthcare professionals, help and advice or administrative assistance for items such as sick notes and test results through the practice webpage and NHS App. This complements and supports the traditional methods of accessing primary care allowing alternative route to the practice.

- **Video Consultations –** rapidly deployed during early COVID-19 responses a re-procurement of a video consultation solution was combined with the procurement of the online consultation which provides a single solution allowing practices to continue to offer alternative remote consultation solutions with patients.

- **Two Way Messaging (SMS text) –** the functionality for the practice to interact with patients via text message has also been further extended allowing practices and patients to share digital content such as documents, pictures and weblinks to appropriate support materials. The solution provided also permits the ability to remind patients of their upcoming appointments and to inform of normal test results.

Improving Access

Between January and March 2022, the CCG commissioned an external company, Explain, to undertake some independent research relating to how our population feel about their access to general practice services and how

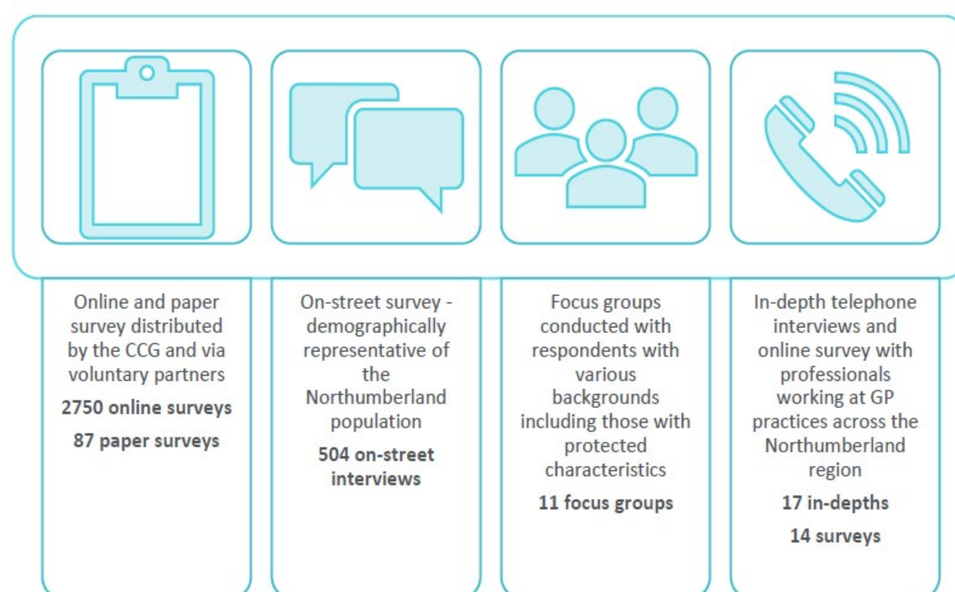
the staff working in those practices are managing the multiple challenges they face with the changes to digital access, workforce changes and consultation types.

In 2021, Healthwatch conducted a survey to look at how the pandemic has changed the way people access GPs and how this had affected people's experience of care. Their report concluded that the key area of improvement in relation to NHS services was around the availability of face-to-face appointments.

Following on from this research, the CCG wanted to delve deeper and really understand how best to allocate GP resource to improve access and meet the expectations of the wider population of Northumberland.

It was key to the CCG that research was carried out with a **robust** and **representative sample** of the Northumberland population.

To ensure robust engagement, a multi-method approach was chosen, this included:



The initial findings report has been delivered to the CCG, and some of the points to note are as follows:

- Patient satisfaction with their ability to get an appointment was 5.5 out of 10 in the online survey and 5.3 out of 10 in the on-street survey demonstrating that there is room for improvement in this area;

- There is a perception of a reduction in access since before the COVID-19 pandemic;
- Overall, health professionals reported feeling under resourced due to a number of factors including increased demand, workforce crisis, staff shortages and the aftermath of the COVID-19 pandemic;
- The most common access issue discussed in the qualitative research and most prominent in the on-street survey were issues with getting through on the telephone to make an appointment;
- Exacerbating the issues with telephone access was a lack of awareness of the ability to book appointments online, use e-consult, have communication with the practice via text through AccruRx or any other digital tools;
- The key concern around telephone consultations was largely around a perception that a health professional would not be able to correctly diagnose an issue over the telephone, and that this may lead to no resolution or a misdiagnosis.

Following this report, the CCG now plans to work with practices and the public further, developing an access programme that begins to address some of the issues identified and consider how to improve communication, give clarity to patients needing to access health and care from their practices and understand the needs of the practices in their staff when change is implemented. Also building the findings into any new services that are required as part of the national GP contract.

Primary Care Sustainability and Resilience

As part of locally commissioned services, the CCG engaged with every practice at least once to take a temperature check of quality concerns and issues in primary care. The purpose of the visiting programme was to maintain and constructively strengthen the existing relationships between practices and the CCG primary care support team. The process also allowed the CCG to proactively support practices when required, with earlier intervention helping to prevent problems from escalating. This was delivered alongside nationally allocated funding for primary care via the GP Forward View (GPFV) to support resilience in general practice by offering access to funding for the delivery of schemes that would improve practice resilience, sustainability, business change processes, change and improvement activities or training and mentorship via a group of staff with expertise in these areas.

Practices in Northumberland have all broadly been subject to the same issues as a result of the COVID-19 pandemic.

These sustainability visits have been run in tandem with the local quality assurance programme, monitoring the quality of the services practices provide. Again, this has enabled ongoing dialogue and early intervention where staff shortage due to sickness and the pandemic may have created pressures in maintaining some services to patients and prioritization of resources based on need.

Primary Care – Workforce

Primary Care Networks (Workforce and Development)

The CCG's seven PCNs have continued to recruit additional clinical professionals through the national Additional Roles Reimbursement Scheme (ARRS). This scheme provides networks with investment to expand existing workforce and skills so that our patients can access a wider number of services from physiotherapists, paramedics and clinical pharmacists closer to home. This expanded workforce delivers services across PCNs and allows work previously undertaken by GPs to be delivered by other clinicians and specialists.

GP and Nurse Fellowships

The CCG continues to attract newly qualified GPs into the county through its Fellowship Programme. Since the scheme launched in 2021, the CCG has welcomed and supported 20 new GPs in our practices. The model, which includes a programme of induction and peer support is being expanded to include a network of GP 'buddies' to support any new GPs coming to Northumberland general practices, to assist in their transition into our health and social care system.

The Northumberland scheme is now well known in our local medical schools and has been instrumental in attracting new GPs into the county. As part of our commitment to work with neighbouring CCGs, the CCG is supporting three newly qualified GP Fellows who joined practices in North Tyneside and Newcastle Gateshead CCGs in 2021/22 and will continue to support these GPs until North Tyneside and Newcastle Gateshead establish their own programmes.

In addition to the GP Fellowship Programme, the CCG has also launched nursing Fellowships. This nurse Fellowship is similar to the GP Fellowship programme and is eligible to all newly qualified clinicians and provides funded

sessions and a bursary to support professional development, offers a peer support group and an induction into primary care and the wider health and social care system. Since its launch at the beginning of the year, the programme has supported two nurses and work by the CCGs link practice nurse is paving the way for more nurses to join throughout 2022/23.

Ford Next Generation Learning (NGL) Programme

The CCG is working with the North East Local Enterprise Partnership at Northumberland College as part of their Ford Next Generation Learning (NGL). The programme, which sees students learn through engagement with local employers has seen students develop a 'leaver profile', which outlines the skills, knowledge and attributes young people need to successfully move on to further education, training or employment when they leave college.

The CCG was involved in the process with other local employers, students, parents, teachers and community groups to create the leaver profile and will see the CCG help to provide placement opportunities in general practice for the college's health and social care work level one and two students.

b. Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Within 2021/22 we developed and successfully held an *'Understanding Our Communities'* education workshop for our stakeholders (GPs, Practice Managers and PCNs) and later a Population Health Management workshop for our workforce within the CCG to help increase awareness of what Population Health Management means and encourage both our frontline workers and workforce to look at the current health care needs of our local population, help challenge ways of thinking, develop new cultures and approaches to improve health outcomes and address health inequalities. Population Health Leads have been appointed to PCNs to help drive vision and approaches forward.

5. **Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency department (ED), improve timely admission to hospital for ED patients and reduce length of stay**

a. Transforming community services and improve discharge

Community Transformation

Supporting people to age well has been a key priority in 2021/22. Several pieces of work have been undertaken with an aim of supporting older people

to stay within their own homes in the communities they choose to live in and avoid admission to hospital where appropriate.

- There was a continued promotion of Multidisciplinary Team (MDT) working where GPs, nurses, Allied Health Professionals (AHPs) and social care teams work in an integrated way to meet the needs of people to enable them to live independently in their own homes for as long as possible. This MDT working also enables people to be supported both to prevent an admission and to enable a safer discharge. A new initiative supported by national funding was the new two hour urgent community rapid response service. This new approach will enable people with either a health or social care urgent problem to receive a response within two hours of a request being made. The service started on 1 April 2022 and will be evaluated to establish a greater understanding of the support people may need and from which professional groups. A steering group has been established to enable a collaborative approach to the development of the service ensuring we share and learn our findings as the service develops.

- End of Life Strategy – we have worked with partners from across the system to review and update the End of Life Strategy. This has involved forming a task and finish group with key stakeholders including the Palliative Care Clinical Team, GPs, Healthwatch, local councillors and patient and carer representation. The group conducted a comprehensive review of data around End of Life care and developed an interactive dashboard which allows information to be viewed at ward level for indicators associated with End of Life (e.g. cause of death, demographics). A mapping exercise was completed using the National Council for End of Life Ambitions to understand what is working well and if there are any gaps across health and care provision. An engagement exercise has been completed using a broad range of methods including virtual and face-to-face settings. This information has been used to form a series of priorities and to develop plans on how to address priorities. A monitoring group is in development to oversee the delivery of these plans. The strategy has now been finalised and is expected to be published in early 2022/23.

- Supporting care homes continues to be a high priority as the integrated care homes steering group brings together professionals from across health and social care to work together to support care homes with the management of COVID-19 as well as wider initiatives linked to the enhanced health in care homes framework. This framework has increased the NHS support into care homes, with aligning PCNs to care homes and in identifying clinical leads to link into MDT working.

Hospital Discharges

Hospitals have been under unprecedented pressure during the pandemic and as a result they have needed to be able to make beds available for new patients as early as possible. To support with this, in partnership with the Local Authority, many care homes in Northumberland were contracted to provide short term discharge placements. These placements enabled patients that were medically fit but could not go immediately home to have a short stay in a care home while longer-term care plans were established. The purpose of this arrangement was to make it as easy as possible for patients to leave hospital as soon as they no longer had a medical need to be there.

In addition, support into care home models, such as discharge to assess, have been implemented where professionals complete discharge assessments within people's own homes, and following the assessments provide the necessary support from rehabilitation services such as short-term support and/or assistive equipment. This approach speeds up the hospital discharge process and makes assessments more meaningful to the patients within their own homes rather than within a hospital setting.

b. Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

NHS 111 is a crucial service in ensuring our patients can access care in the right place, first time, utilising all available options for support in a primary and community care setting to avoid unnecessary admissions to secondary care.

During 2021/22 access to NHS 111 for patients continued to be improved helping deliver better patient experience and reducing unnecessary attendances. Examples of how this was achieved were:

- Communication campaigns promoting the use of 111 significantly increased the demand for both services across the North Region.
- Implementing NHS 111 Online allowed patients to access urgent healthcare online. It also helped to manage increasing demand on NHS 111 telephony services. Patients can access the service at any time of the day.
- Further in-year developments supporting increased access are now available to patients when using NHS 111 Online. These include direct access to pharmacy and the ability to speak to a clinician as required. There is also the ability to be booked for a face-to-face appointment where appropriate.

Other initiatives that helped improve access for patients and improve the timeliness and appropriate use of emergency departments during 2021/22 were:

- **Improved access to medication schemes –** during 2021/22 all pharmacies across the North East and North Cumbria standardised their minor ailment schemes with community pharmacy. This meant that patients self-presenting at pharmacies with a minor ailment can access medication directly. An urgent medication scheme was also introduced on a pilot basis. Patients can access urgent medication directly from a pharmacy without the requirement to call 111 first. These developments have increased access for patients and consequently reduced the calls into 111 and demands on GP practices and emergency departments.

- **Implementation of NHS Pathways Streaming Tool –** the urgent care self-service tool, also known as the streaming and redirection tool, is a kiosk-based service, provided as a web application. The tool is designed to provide help and direction for patients who arrive at accident and emergency (A&E) departments and urgent care settings who did not contact a 111 service beforehand and have arrived with no pre-booked arrival time or appointment. This supported patients to access the most appropriate services. Northumbria Healthcare NHS Foundation Trust has implemented the tool in both Wansbeck and Rake Lane Urgent Treatment Centres. The rollout in Northumbria Specialist Emergency Hospital is being progressed.

- **Paramedic Pathfinder –** Paramedic Pathfinder was introduced by the North East Ambulance Service NHS Foundation Trust (NEAS) with the aim to reduce unnecessary attendance at departments. The Paramedic Pathfinder is a face-to-face clinical triage tool to support paramedics decision-making. The tool allows paramedics to confidently choose the most appropriate place for treatment. This could include referral to a patient's GP, being managed at home or by accessing Northumberland urgent care services.

- **Berwick Community Paramedic –** the pilot, which has been operating since July 2019, focused on reducing ambulance conveyance to hospitals including A&E departments and increasing the use of alternative dispositions (Hear and Treat/See and Treat) to enable patients to be treated locally. The intention was to improve both patient safety and experience along with reducing demand on the pressured ambulance and hospital resources. The pilot highlighted the value of Community Paramedics in supporting rural communities, with a significant decrease in

time to arrival, increased See and Treat rates and a reduction in emergency transfers. Northumberland Clinical Management Board reviewed the outcomes of the pilot and approved recurrent commissioning of this service.

6. **Working collaboratively across systems to deliver on these priorities**

Northumberland CCG since its inception in 2013 has had a long and productive history of collaboration across the system within Northumberland itself and also the wider geography of the North of Tyne and with the North East – at the scale of best effect for our residents and patients.

The CCG's integrated working and shared roles across the whole life spectrum from Best Start in Life to Ageing Well with Northumberland County Council mean that residents with Special Educational Needs and Disabilities, complex mental health needs and learning disabilities have access to a wide range of support and services through a single point of access. From a living well and an ageing well perspective, joint working in care homes, continuing care, primary care networks and other multi-disciplinary teams offer wide-ranging access to services and support.

From a more formal perspective, the CCG is an active member of the Health and Wellbeing Board and the CCG Clinical Chair is the vice chair of the Board. Major focus areas of the past year have included the highly successful vaccination programme, safeguarding adults and children, and developing an inequalities strategy that will drive the ambition of the Northumberland system for years to come.

The CCG has a pivotal role in the design and delivery of the System Transformation Board, which draws together all system statutory health and care partners including Healthwatch and focuses on what can be done best through system delivery rather than individual partners. Large investments in the population health management approach across the Northumberland system as well as managing through COVID-19, the logistics of managing the backlog caused by COVID-19 and supporting each other through times of significant surge and pressure have been the priorities for the Board during 2021/22.

The CCG plays an important part in other NHS footprints across the wider North East including the development and management of contracts with providers covering more than one geography (Northumbria and Newcastle Hospitals for example, as well as mental health services), planning services for the future and leading as the commissioner for ambulance services for the whole North East geography (North East Ambulance Service). This puts the CCG in a strong position for the future as it transitions to the Integrated Care System in terms of

keeping the importance of Place and the integrated work in Northumberland alongside managing economies of scale where it benefits the residents and patients most.

a. Effective collaboration and partnership working across systems

Safeguarding - SIRS

Sharing Information Regarding Safeguarding (SIRS) is a process developed by the CCG's Designated Nurse Safeguarding Children from the action identified following a Safeguarding Children's Practice Review (SCPR). The aim of the SIRS process which is embedded in primary care which aims to improve information sharing regarding fathers. Maternity services and GP practices share information regarding fathers when registered with a different GP practice to the pregnant woman. Those registered at the same practice have internal arrangements already in place to ensure information is shared, usually via multi-disciplinary team meetings.

The Child Safeguarding Practice Review Panel (National Panel) as part of their third thematic review, *'The Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers'* September 2021. Identified SIRS as emerging good practice and has generated a great deal of interest from all parts of the country who are looking at what we are doing in Northumberland and how they can implement it in their area.

Safeguarding – Named Nurse Primary Care and Supporting Families Meetings

The Named Nurse Primary Care (NNPC) aims to attend each practice at least once annually. This offers the opportunity to support, share learning, seek assurance and identify any areas for development. Additionally, this provides an opportunity to develop good links with GPs and Primary Care staff. To achieve this, the most appropriate setting is to attend the supporting families multi-disciplinary meeting where vulnerable people are discussed.

To-date the NNPC has attended 34 practices 'supporting families' meetings either face-to-face or online via Microsoft Teams. Attendance at these meetings allow the NNPC to share learning from Case Reviews and CQC inspections, to discuss any training needs or training opportunities for Primary Care staff in addition to supporting and advising on safeguarding concerns.

Safeguarding – Sharing of Police Child Concern Notifications (CCNs) with Audit

Operation Encompass is a national police initiative to ensure schools are made aware of incidents relating to domestic violence where the police are called to homes where children reside. This was rolled out in Northumberland in April 2017 and aimed at ensuring the safety and wellbeing of school age children. Additionally, Operation Endeavour, which is the sharing of police CCNs relating to children who go missing with schools, the CCG also shares these CCNs regarding missing children with GP practices. This enables relevant primary care staff to have an awareness of particularly vulnerable children registered with GP practices.

The CCG share the police CCNs with GPs, with general practice being well placed to offer support to families where domestic abuse is a concern. Furthermore, it is essential that GPs and primary care staff are aware of vulnerable children and young people who have missing episodes and the risk these missing episodes pose. It is therefore imperative that GPs and primary care staff are made aware of any risks identified for families and sharing CCNs is an ideal way to keep GPs up-to-date of any current concerns. A few neighbouring CCGs have shown interest in sharing the CCNs with Primary Care and are looking at implementing this in their area. The Interim Designated Nurse is currently completing an audit regarding the impact of sharing the CCNs with Primary Care.

Safeguarding – ICON

ICON is an NHSEI prevention programme that is designated to raise awareness and reduce the incidence of Abusive Head Trauma (AHT) in children. This intervention has been shown to be successful nationally not only because of its simple key messages but also its ability to fit into mainstream services and adaptability to be utilised across professional boundaries.

ICON was rolled out in Northumberland in September 2021 in partnership with maternity and 0-19 services. In preparation for this, the Named Nurse Primary Care shared the ICON message and touch points, specifically what this means for GPs or APNP carrying out the six week check and additional information regarding the template, Read Code and the AccuRx. This has been carried out in line with the training delivered to the Foundation Trust's 0-19 and Maternity services.

The ICON sessions were delivered at the following:-

- Four GP Locality meetings, where there was attendance from 33 practices
- Four individual GP practices at their request
- Primary Care Safeguarding Nurse Network
- Seven drop-in sessions via MS Teams

b. Develop the underpinning digital and data capability to support population-based approaches

Within 2021/22 we developed and successfully held an Importance in Data Sharing Workshop with our stakeholders (GPs, Practice Managers and PCNs). The workshop focused on the reason data sharing is important and what data will be shared with whom, along with how this fits into the local and national plan. Next steps include developing a Memorandum of Understanding with our stakeholders.

NECS is currently in the process of developing a cloud based digital platform called AXIOM, that will provide a "single version of the truth" and will be made up of secure data access environments focused on specific organisations in line with information governance. It plans to provide a private ringfenced space to access and analyse data. AXIOM is built upon the infrastructure NECS currently holds on behalf of Data Controllers across the health care system. They are combining this into one wraparound environment and improving the functionality.

RAIDR is the UK's leading health intelligence tool across the ICS and underpins our approach to Population Health Management using analytical techniques, which link and aggregate data to provide comprehensive cohort analysis. RAIDR will allow us to be in control of information and explore multiple datasets by drilling down intelligence in various ways focusing on specific themes, subject level etc. at a national, regional or local level into a single portal.

c. Develop ICSs as organisations to meet the expectations set out in Integrating Care

Integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services.

Integrated Care Systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

ICSs will absorb the responsibilities of CCGs in the future. During 2021/22, the CCG has continued to play an active part in the development of the North East and North Cumbria Integrated Care System (NENC ICS), contributing to the development of strong local leadership and supporting the transition towards statutory status for the ICS on 1 July 2022. This has included ensuring that the arrangements for the new ICS organisation build on the successful partnerships already established in Northumberland that the governance arrangements will continue to enable sufficient focus on the improvement of services for Northumberland patients. The new organisation promises to be well positioned to build on the achievements of the CCG over the past nine years.

PERFORMANCE ANALYSIS

The CCG has an ongoing performance review process that manages the NHS constitutional targets along with other key metrics and ensures that Northumberland patients are able to access a wide range of quality led health services, delivered to safe and recognised standards within a timely period.

Members of our Clinical Management Board consider performance update reports monthly. The reports summarise the performance of the CCG against the key constitutional indicators. Where there are areas of underperformance or performance concern, the reasons are outlined along with the requisite actions. Provider performance is also included, together with appropriate actions being taken in response to highlighted issues. The exception report, together with Clinical Management Board comments and actions is also presented to our Governing Body.

We also provide assurance on a regular basis to NHS England. Outside the normal review time scales we highlight emerging issues and the immediate actions being taken in response to NHSE when deemed necessary.

A continued focus for the CCG and providers in Northumberland during 2021/22 has been to recover services and improve performance amidst the continued difficulties caused by COVID-19. Along with other areas outlined within this report, the impact of COVID-19 has had a major impact on the CCG's performance along with all organisations across both the local system and across the country. In particular the impact of COVID-19 on staff absences combined with more stringent infection control procedures has caused great difficulties for services. Greater demand for services due to the pandemic, both in terms of delayed treatments and growing clinical need, have also posed greater pressure on services and made returning to previous high-achieving performance standards extremely difficult.

Table 1 overleaf shows our performance against the range of indicators mainly covering the NHS Constitution. The data presented captures the most recent position available at the time of publication. The indicators that are RAG (red, amber, green) rated have a target to compare performance against.

Table 1 - NHS Northumberland CCG Performance indicators 2021/22

Indicators	Indicator Description	Latest Data Period	CCG NHS Northumberland CCG Threshold	CCG NHS Northumberland CCG YTD	Monthly trend
Referral to treatment access times	% of patients initial treatment within 18 weeks for incomplete pathways	Mar-22	92.0%	77.0%	
	Number of patients waiting more than 52 weeks for treatment		0	12,732	
Diagnostic waits	% patients waiting more than 6 weeks for the 15 diagnostics tests (including audiology)	Mar-22	1.0%	13.8%	
A&E waits	% patients spending 4 hrs or less in A&E or minor injury unit	Mar-22	95.0%	91.5%	
	Over 12 hour trolley waits		0	0	
Cancer Waits	% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	Mar-22	93.0%	84.6%	
	% of patients seen within 2 weeks of an urgent referral for breast symptoms		93.0%	86.6%	
	% of patients treated within 62 days of an urgent GP referral for suspected cancer		85.0%	68.9%	
	% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service		90.0%	78.0%	
	% of patients treated for cancer within 62 days of consultant decision to upgrade status		N/A	55.5%	
	% of patients treated within 31 days of a cancer diagnosis		96.0%	93.1%	
	% of patients receiving subsequent treatment for cancer within 31 days - surgery		94.0%	77.5%	
	% of patients receiving subsequent treatment for cancer within 31 days - drugs		98.0%	98.5%	
	% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy		94.0%	97.0%	
	% 28-day wait for patients to be told whether or not they have cancer after an urgent referral from their GP or a cancer screening programme		*70% (shadow monitoring)*	*75.3%*	
Mental Health	Early intervention in psychosis - % with 1st episode treated within 2 weeks	Mar-22	60.0%	85.2%	
	% people with anxiety disorders and depression who access psychological therapies (IAPT)	Feb-22	20.2%	13.52%	
	% complete treatment who are moving to recovery	Feb-22	50.0%	51.4%	
	Waiting times for routine referral to CYP Eating Disorder Services - Within 4 weeks	Rolling 12 months to Q4 2021-22	95.0%	79.5%	
	Waiting times for Urgent referrals to CYP Eating Disorder Services - within 1 week		95.0%	100.0%	
HCAIs	Incidence of MRSA	Mar-22	0	1	
	Incidence of C Diff	Mar-22	71	94	
	Incidence of e-coli	Mar-22	262	269	
Ambulance (CCG)	Category 1 Response times (7 Minutes average)	Mar-22	7 minutes	00:08:11	
	Category 2 Response times (18 minutes average)		18 minutes	00:31:09	
	Category 1 Response times (90th centile)		15 minutes	00:18:23	
	Category 2 Response times (90th centile)		40 minutes	01:04:58	
	Category 3 Response times (90th centile)		2 hours	03:01:21	
	Category 4 Response times (90th centile)		3 hours	02:40:12	

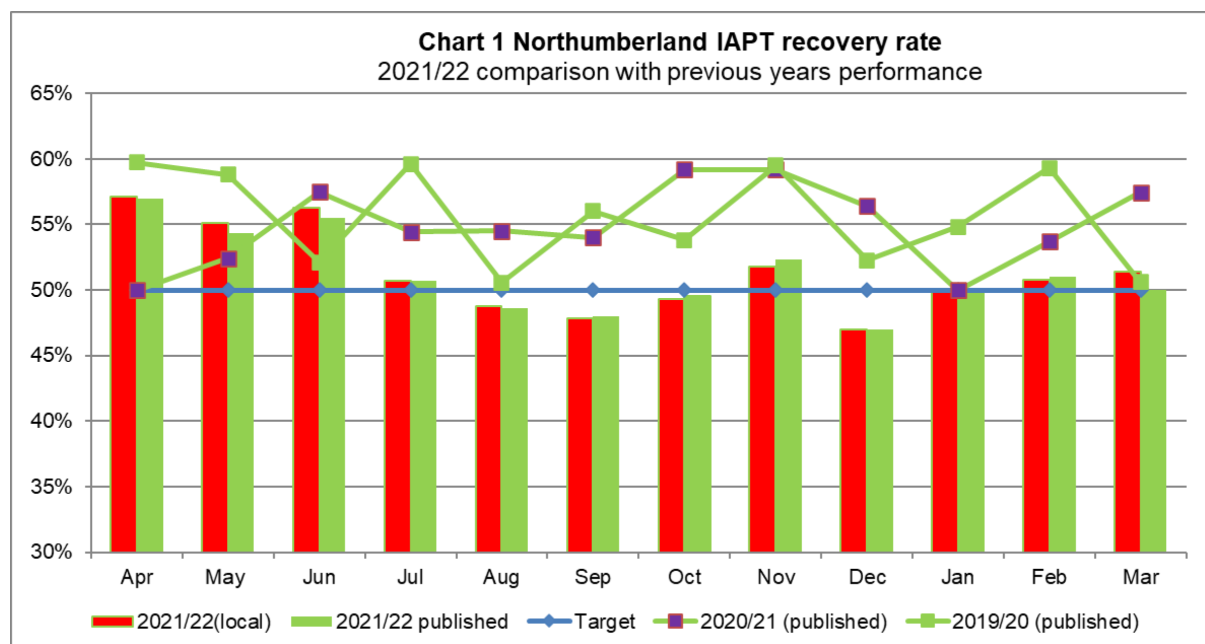
The previous section on the CCG's operational plan delivery illustrates the work undertaken to maximise achievement of the constitutional standards. The following section provides further detail about the CCG's performance against the NHS Constitutional standards and therefore how successful the CCG's operational plan was in mitigating the impact of COVID-19 on service performance.

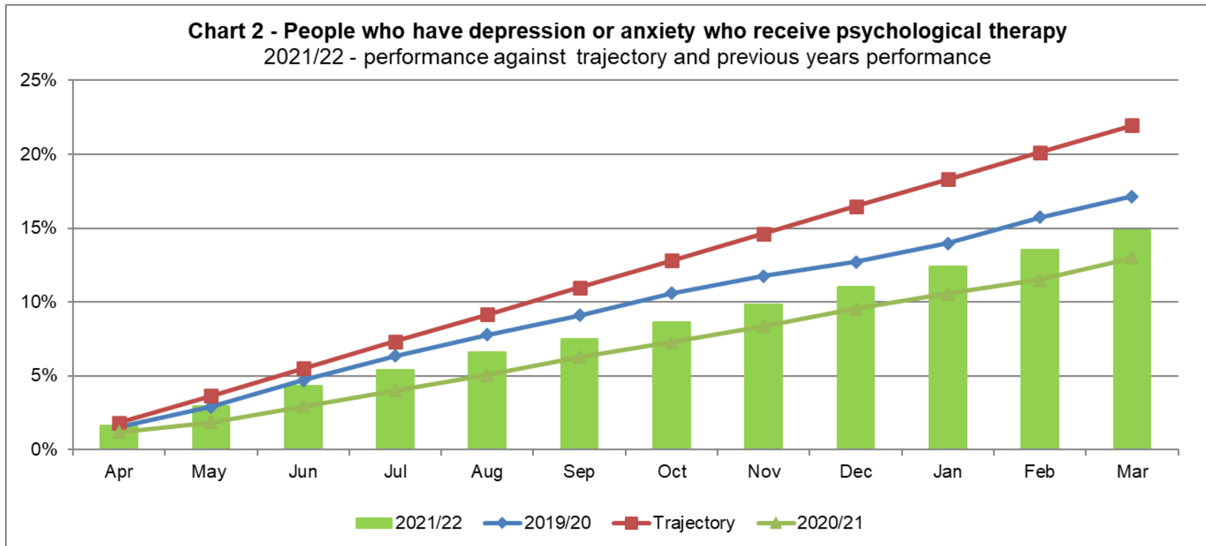
Mental Health Services

Improving Access to Psychological Therapies (IAPT)

In September 2021 the CCG recommissioned IAPT services from Cumbria, Northumberland and Tyne and Wear Mental Health Foundation Trust who continue to sub-contract to, and work in partnership with, the previous provider Talking Matters Northumberland (TMN). This arrangement enables the excellent work of TMN to continue alongside the security of a larger NHS provider which is felt will support the sustainability of services in light of workforce challenges and growing demand, particularly due to the impact of the pandemic.

The constitutional target for recovery rates is 50% of IAPT service users. Following a wide range of collaborative working between the provider and the CCG, performance during 2021/22 continued to hold around the 50% threshold each month, despite considerable pressure on the service.

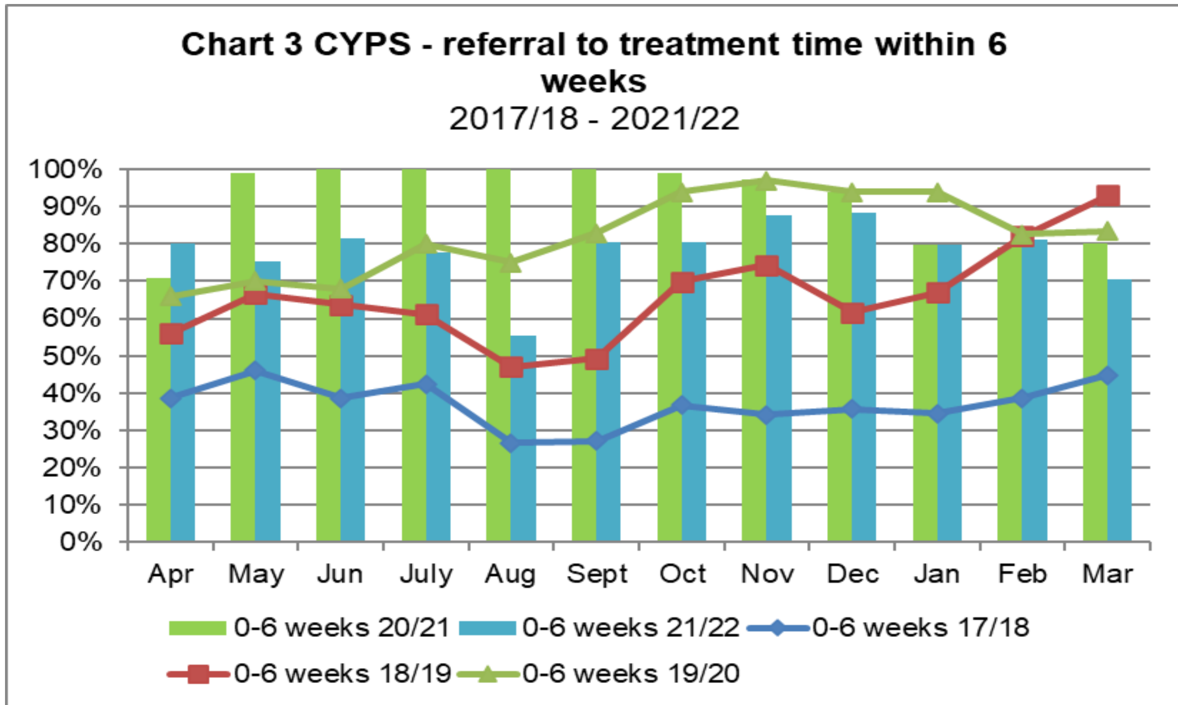




There is also an expectation that each year at least 22% of the population who experience depression and/or anxiety disorders receive treatment. Chart 2 above shows that the performance during 2021/22 is significantly below the trajectory but has improved from 2020/21 levels as patients have increasingly begun accessing services as COVID restrictions eased. This is consistent with the national and regional picture. The service along with the CCG is working collaboratively to promote the use of this service to ensure all those who need support are accessing the service.

Children and Young People's Services

Chart 3 below shows the monthly waiting times for the Children and Young Peoples' Service (CYPS). There is an expectation that no child or young person should wait longer than 18 weeks to be seen. Growing demand from the last quarter of 2020/21 continued throughout 2021/22 which meant performance reduced in 2021/22 compared to 2020/21. However, between 70-80% of all patients were treated within 6 weeks of referral throughout the year which demonstrated good, stable performance in the context of significant demand on the service.



Dementia Diagnosis Rates

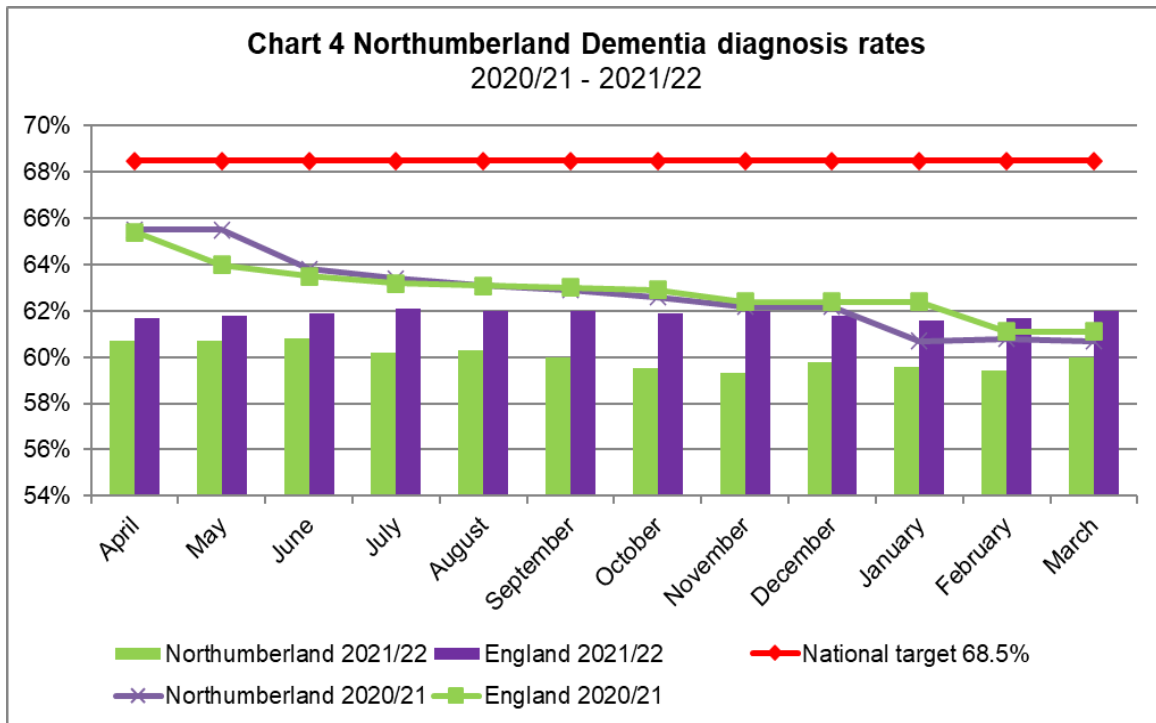


Chart 4 above shows the performance of the CCG underachieving against the 68.5% NHS Constitution standard and the England average. Dementia diagnosis rates are affected by two main issues: a lack of referrals and a lack of capacity to confirm diagnosis. Recovery from the pandemic has continued to impact on both issues but the CCG continues to work hard to increase recognition of dementia in the community and address variation in referrals to memory assessment services across GP practices. CNTW are also looking to address their capacity issues in memory assessment services including reviewing their service model.

Early Intervention in Psychosis

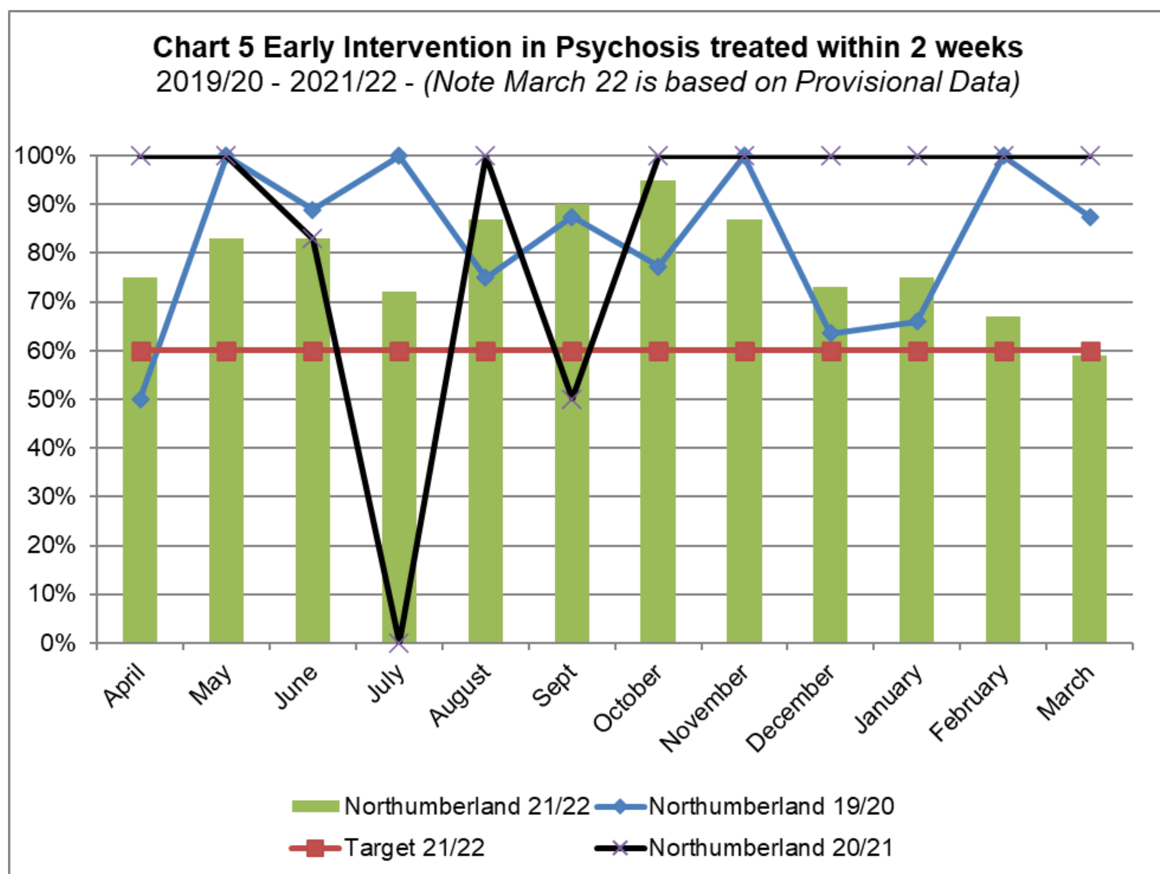
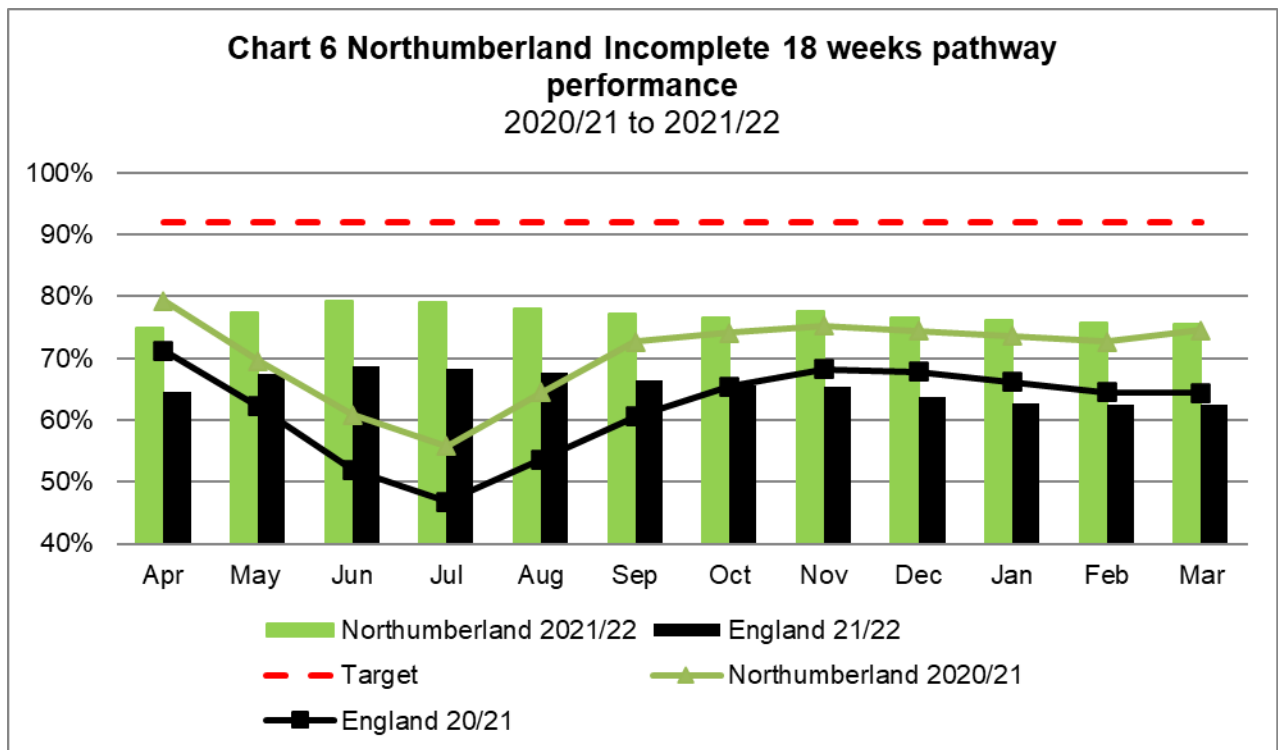


Chart 5 above shows our strong performance against the 60% NHS Constitution target. An ongoing challenge is offering an appointment for treatment within the 2 week period along with the low volume of clients being referred into the service.

Planned Care

Patient Access to Services

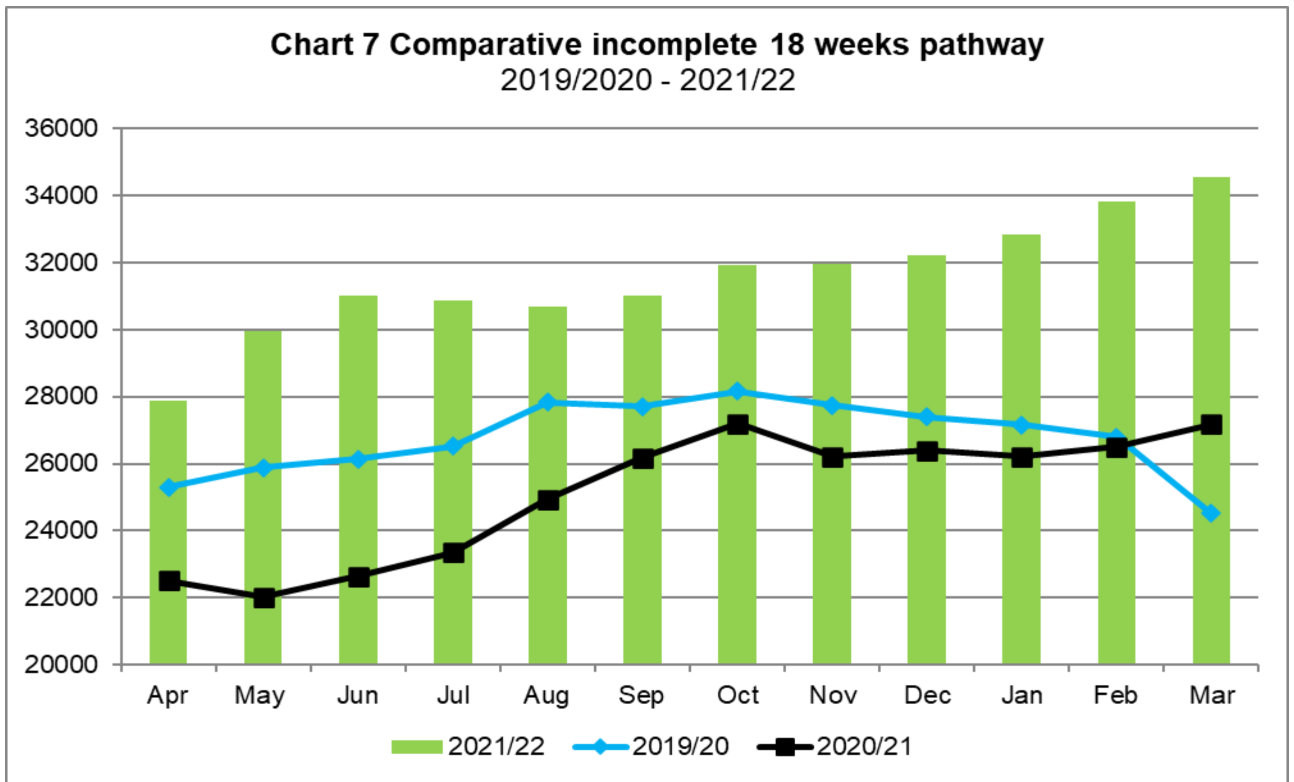
Chart 6 below shows that our performance along with the national position has deteriorated across the range of 18 weeks referral to treatment specialties and has failed to achieve the 92% constitutional target for the incomplete (waiting list) indicator throughout the year. Performance in Northumberland continues to be better than the national average however.



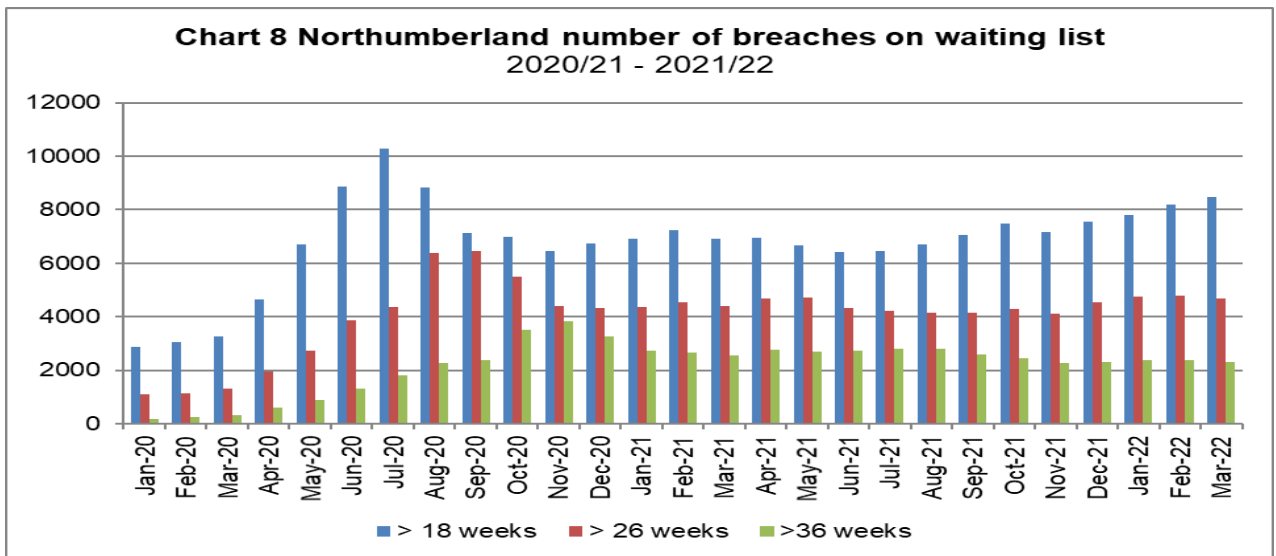
A significant proportion of the underperformance relates to the reduced capacity the providers have had to treat patients due to having to prioritise the treatment and care of patients with COVID-19 at different points in the year.

The social distancing requirements along with the additional time to administer more complex cleaning regimes and the use of personal protective equipment has also reduced both bed capacity and the volume of patients seen in outpatient appointments. Growing demand as COVID-19 restrictions lifted and patients began accessing services again, combined with continually high staff absence rates due to COVID-19, also created significant pressure on services.

The chart below shows the increase in waiting list as a consequence.

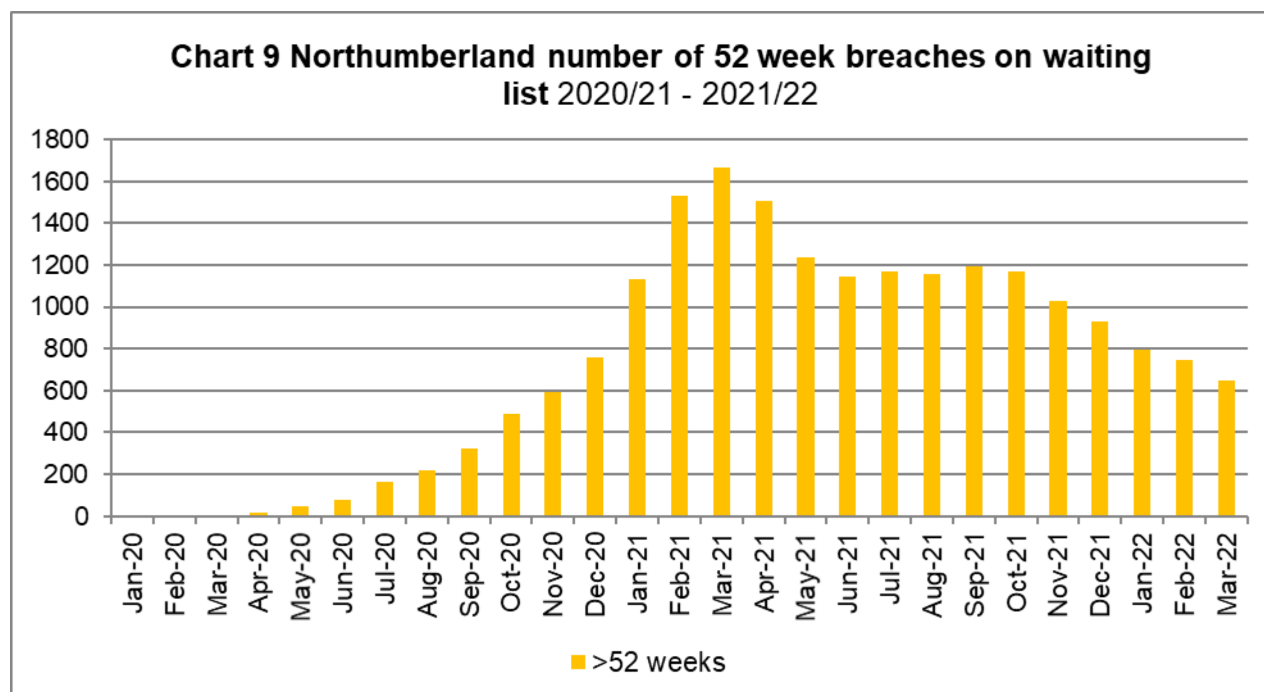


Not only did the volume of patients waiting for treatment increase, the length of time increased as well for many patients. A new range of metrics was introduced to review the breaches in excess of 18 weeks as shown below.



52 week waits

Because of the pandemic and the limited capacity of providers to treat patients, the volume of 52 weeks breaches grew significantly from the summer of 2020 onwards as shown on the chart below. The chart also demonstrates the improvement in performance during 2021/22 with the number of 52 week breaches reducing during the year.



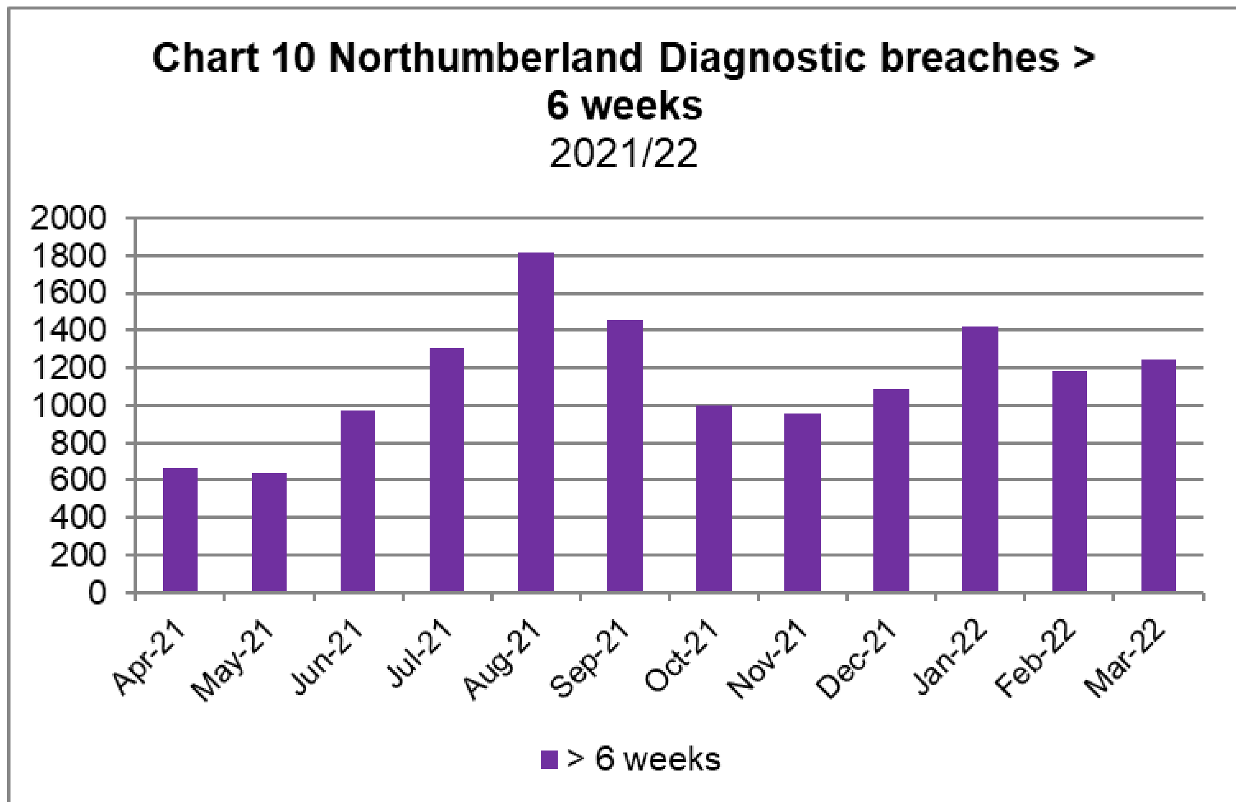
At the end of 2021/22 the specialties with the greatest waiting list pressures continue to be those requiring surgical procedures such as orthopaedics, dermatology, plastics and urology. The specialties with 52 weeks' breaches remaining are ophthalmology and neuro-surgery. Alongside hospital providers' continued use of waiting list initiatives to increase capacity, the CCG has continued to work with neighbouring CCGs and local providers to put actions in place to enable greater capacity. One example has been the increased use of the independent sector provider capacity and another was the approval of investment in greater cataract surgery provision at Newcastle upon Tyne Hospitals Foundation Trust (NuTH). Actions such as this have contributed to the reduction in 52 week breaches throughout the year.

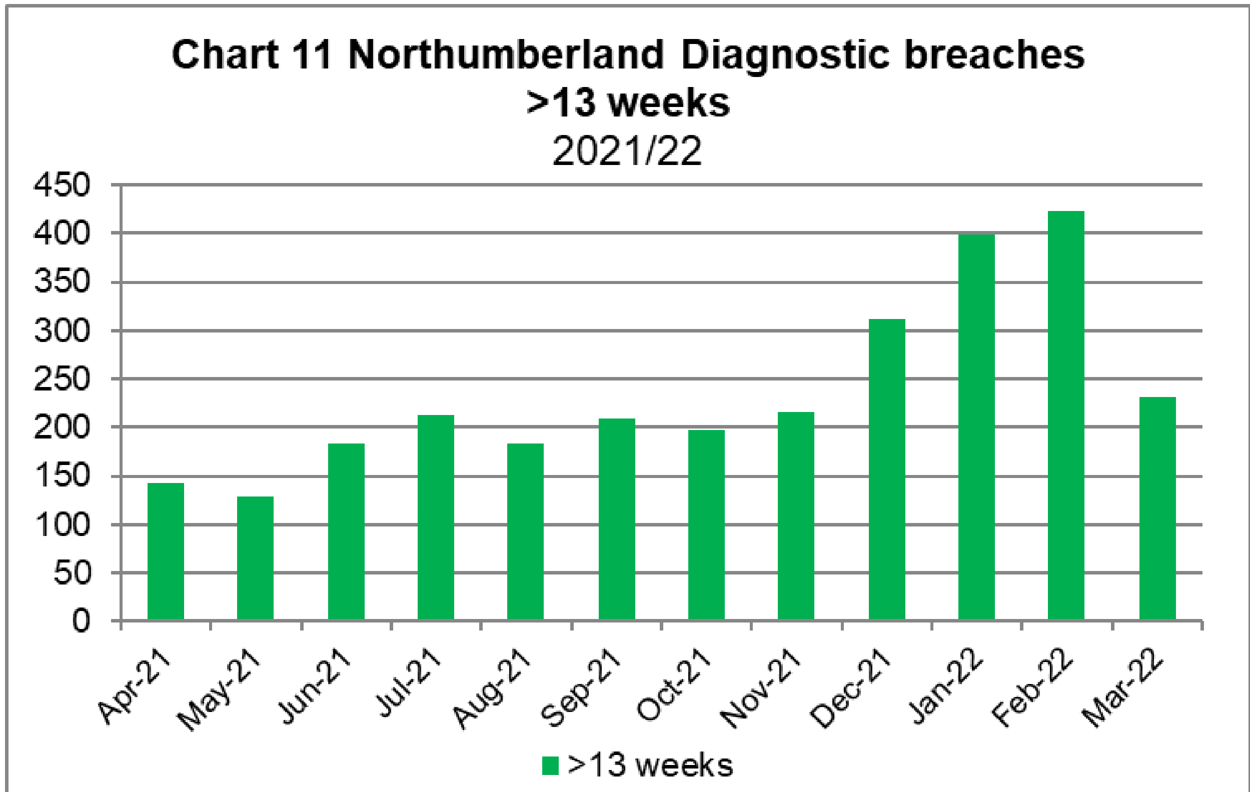
The CCG is continuing to monitor the waiting list profile and work with providers both at place level and across the wider health system to ensure that patients are not harmed because of waiting longer for treatment.

Diagnostic services

The NHS constitutional standard states that no more than 1% of patients should receive their diagnostic test later than six weeks after a GP referral. This standard was breached because of the on-going impact of the pandemic.

New metrics were introduced to monitor the recovery of the standard based upon monitoring the volume of patients waiting more than both 6 and 13 weeks as shown on the charts below and overleaf.





At the beginning of 2021/22 the tests generating the highest proportion of breaches continued to be non-obstetric ultrasound and cardiology procedures. The backlog for these diagnostics was addressed with the main growing pressures throughout the year being increased waiting times for computerised tomograpghy (C.T.), MRI and audiology. In the case of CT and MRI, the recovery of other services as referrals have increased as COVID-19 restrictions were lifted, led to a knock-on increased demand for diagnostic tests.

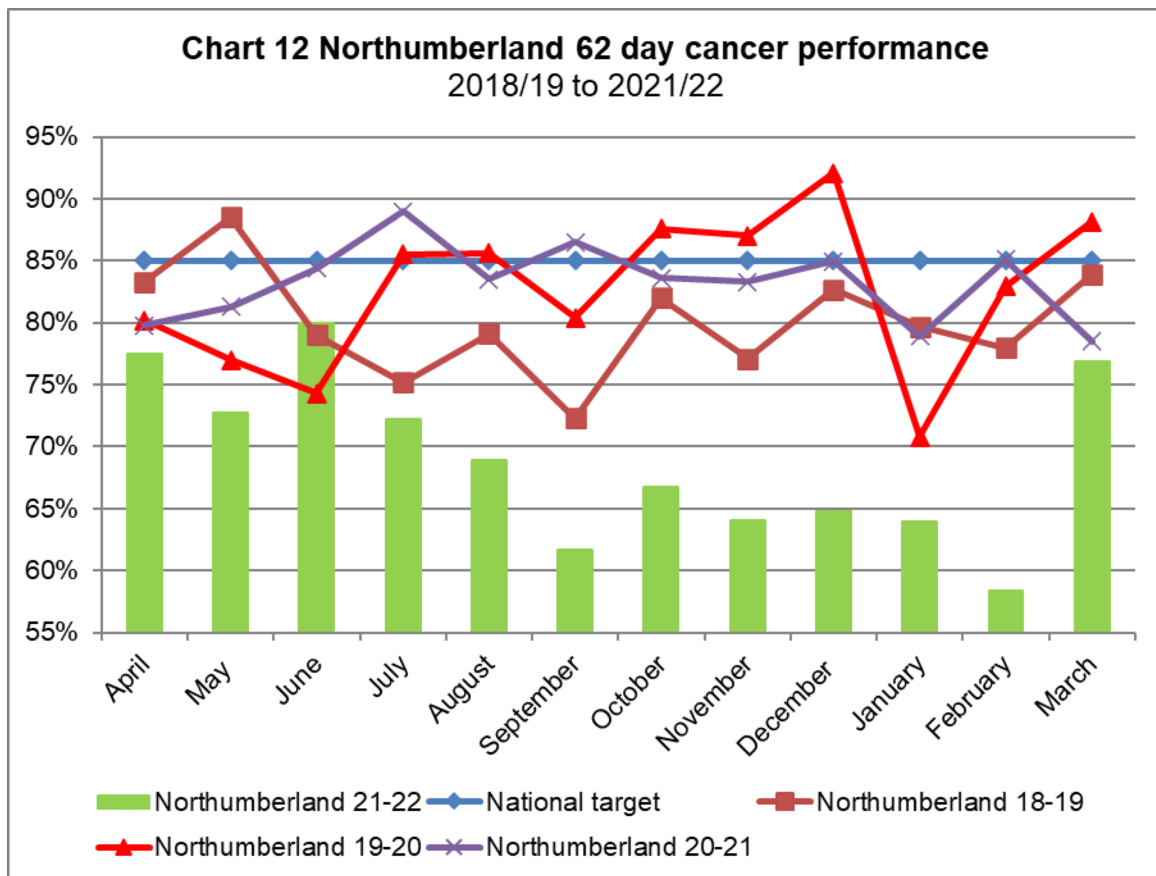
Cancer

Cancer Performance

The graph and tables below illustrate the continued difficulties to return to achieving the constitutional standards for cancer services. After initially facing difficulties during the earlier stages of the pandemic in terms of getting patients to access services given their perceived greater risk of contracting COVID-19, on a positive note during 2021/22 patients started accessing services again. The greater demands as patients came forward for treatment placed significant demands on the available capacity. The capacity available, as described earlier, continued to be constrained due to IPC measures and staff absences during to COVID-19.

Whilst cancer performance standards have been difficult to achieve across all pathways, particular pressure has been seen, in terms of the volume of breaches, in dermatology (skin), breast services, and gastrointestinal (GI) services. General actions across the board have been implemented to put waiting list initiatives in place and increase the use of the independent sector. Examples of pathway specific actions that have seen positive impact on 2021/22 are:

- Numerous initiatives to develop the lower and upper GI pathways including faecal immunochemical test (FIT) testing by GPs before referral and nurse led triage and endoscopy pathway improvements. FIT testing has showed a reduction in colonoscopy demand.
- Using patient navigators to pull diagnostics and treatments forward where possible.
- Chemotherapy capacity has expanded through the implementation of 7 day working
- Recruitment to specialist radiology posts, to create greater capacity



Patients seen within 2 weeks of referral from a GP in Northumberland

April 2021 to March 2022
Target 93%

Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	2755	3087	332	89.2%
Lung	249	257	8	96.9%
Gynaecological	1661	1793	132	92.6%
Upper Gastrointestinal	1462	1528	66	95.7%
Lower Gastrointestinal	3372	3553	181	94.9%
Urological (Excluding Testicular)	1543	1572	29	98.2%
Testicular	47	49	2	95.9%
Haematological (Excluding Acute Leukaemia)	157	162	5	96.9%
Acute leukaemia	1	1	0	100%
Head and Neck	838	899	61	93.2%
Skin	1990	3732	1742	53.3%
Sarcoma	10	10	0	100%
Brain/Central Nervous System	1	1	0	100%
Childrens	11	18	7	61.1%
Other	4	4	0	100%
Total	**14101**	**16666**	**2565**	**84.6%**

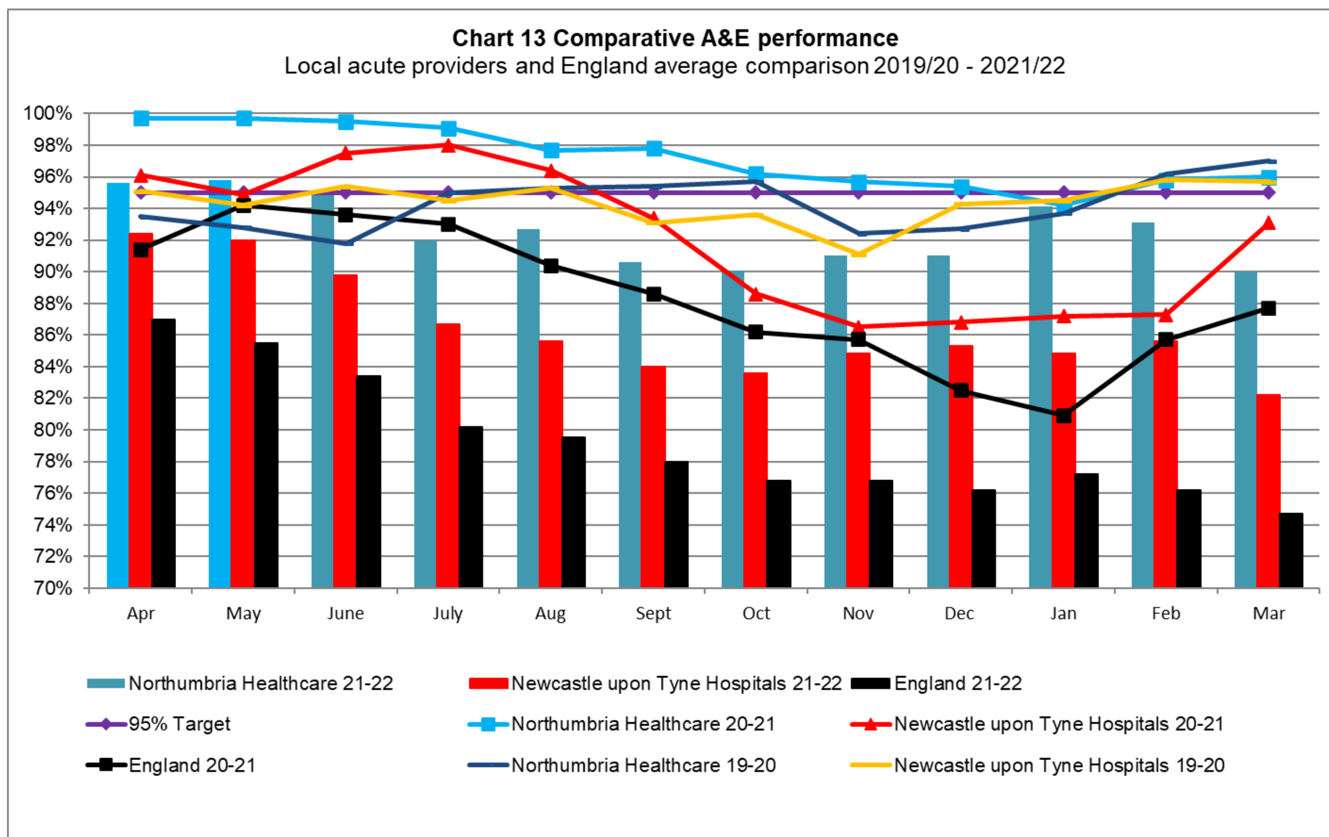
62 days cancer performance from referral to commencing treatment in Northumberland

April 2021 to March 2022
Target 85%

Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	175	202	27	86.6%
Lung	31	68	37	45.6%
Gynaecological	33	73	40	45.2%
Upper Gastrointestinal	38	70	32	54.3%
Lower Gastrointestinal	97	159	62	61.0%
Urological (Excluding Testicular)	209	320	111	65.3%
Testicular	4	4	0	100%
Haematological (Excluding Acute Leukaemia)	47	61	14	77.0%
Acute leukaemia	1	1	0	100%
Head and Neck	37	44	7	84.1%
Skin	237	317	80	74.8%
Sarcoma	4	7	3	57.1%
Brain/Central Nervous System	1	1	0	100%
Other	7	8	1	87.5%
Total	**921**	**1335**	**414**	**69.0%**

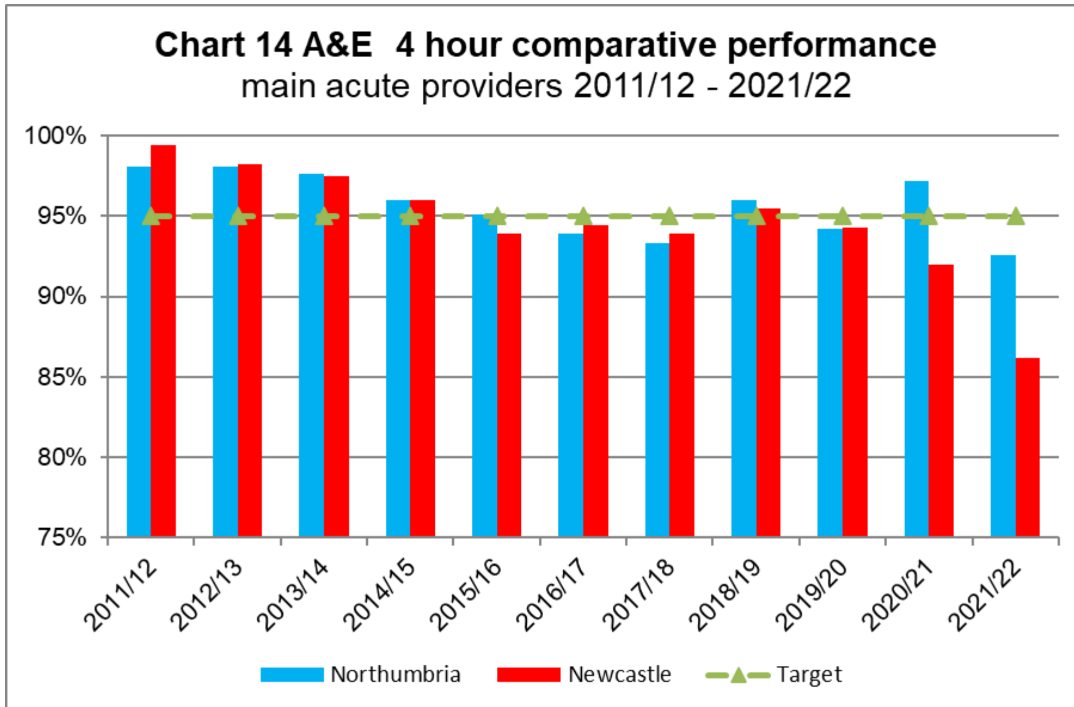
Urgent Care

Accident and Emergency Wait Times

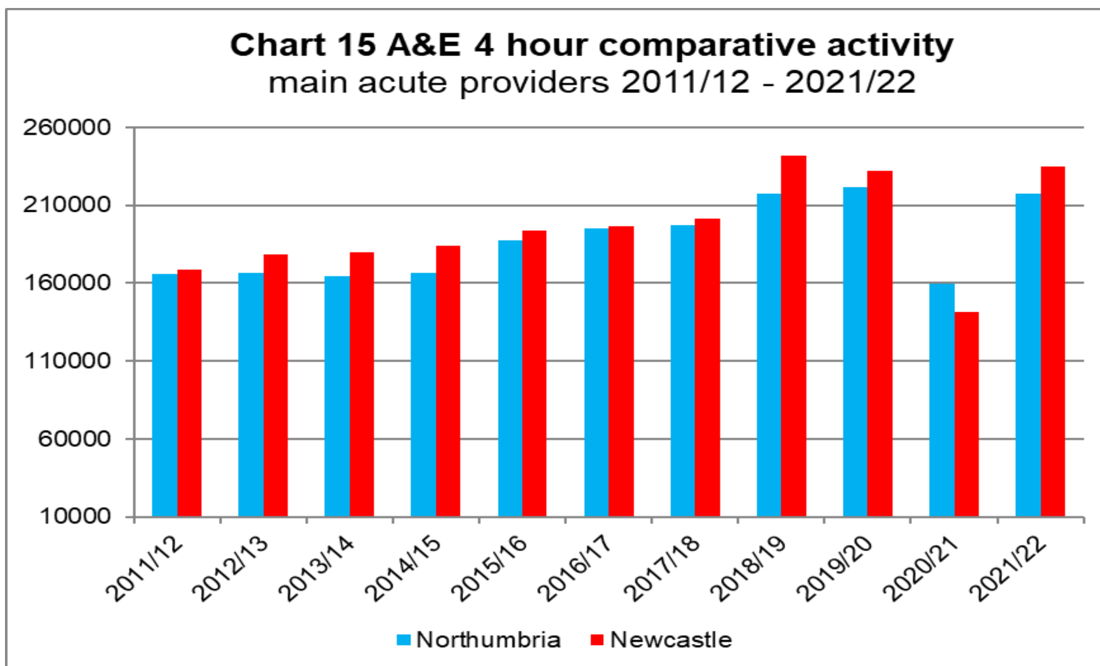


Local providers have traditionally shown some of the strongest performance nationally to ensure that patients were either treated or admitted to a ward within a maximum of four hours when they attended an accident and emergency department. This has continued although the constitutional standard has been difficult to meet at both of Northumberland's main providers due to impact of the pandemic.

Chart 13 above shows that Northumberland residents had access to a more responsive Accident and Emergency service when compared to the overall England average.



In recent years there has been a year on year increase in activity at each of the two main local acute providers as shown in chart 15 below, although during 2020/21 as a consequence of COVID-19 there was a reluctance from patients to attend the department resulting in a significant reduction in activity.



Ambulance Response Times

During 2021/22 Northumberland Clinical Commissioning Group accepted Host Commissioner responsibility for the Commissioning and Contracting arrangements with NEAS.

Throughout the last six months of 2021/22 the CCG has worked collaboratively with NEAS to develop a transformation improvement plan that will address service performance and meet Ambulance Response Standards and National Key performance indicators for 111 IUC. During 2021/22 the ambulance sector as a whole remained under significant pressure. Increasing demand and changes to the nature of the heath economy continued to adversely affect service performance.

In order to deliver improvements against all Ambulance Response Standards a three-year transformation programme to increase capacity and address the underlying resource gap, has been developed to respond to patients in a timely manner. The transformation programme includes significant recruitment across areas of the service including Paramedics, Clinical Care Assistants and Health Advisors to support improved 999 call answer times and response times. Alongside additional vehicles to increase capacity on the road

Increased clinical capacity within the clinical assessment service will support increased validation of ambulance dispositions from 111, with the aim of reducing ambulance demand, ensuring ambulances are only dispatched to those patients who need a face-to-face triage

Implementation of a sickness absence plan focused on mental health and wellbeing has also been established. In early 2018 Ambulance Services nationally introduced new metrics to report ambulance response times. This has involved the reclassification of incidents to give increasing priority to life threatening incidents. A summary of the revised classifications and metrics is below:

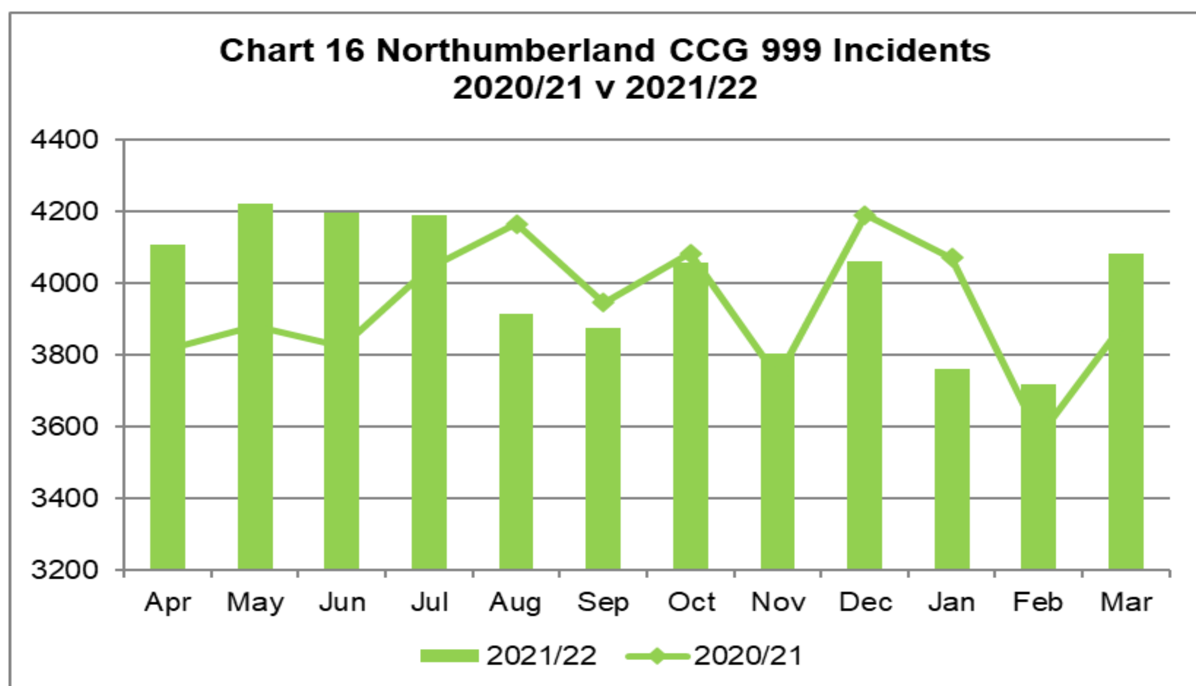
Category	Mean	90th % ile
Category 1 Life threatening	7 minutes	15 minutes
Category 2 Serious	18 minutes	40 minutes
Category 3 Urgent		2 hours
Category 4 Non urgent		3 hours

The metrics capture both the average and the 90th percentile performance to give a better profile of performance as it focuses on the variation in response waiting times. NEAS started to report on the new metrics in January 2018.

When considering the performance in the charts below the volume of patients in each category should be noted. An annual summary of the total number of incidents alongside the proportion is shown below.

2021/22	Category 1	Category 2	Category 3	Category 4
Incidents	3,688	28,597	10,137	770
Percentage	8.5%	66.2%	23.5%	1.8%

The volume of incidents across Northumberland varied throughout the year on a month-by-month basis as shown on the chart below during 2021/22. The variation followed a similar profile to 2020/21 aside from April to July 2021 where activity was higher likely due to differing pandemic impacts between years.

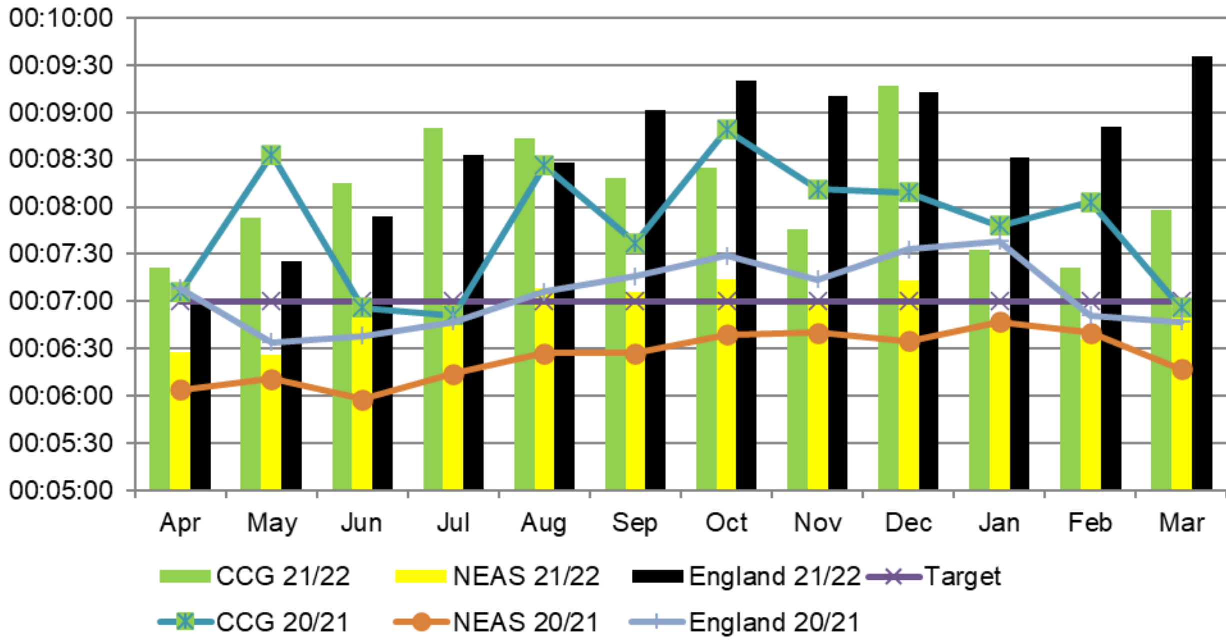


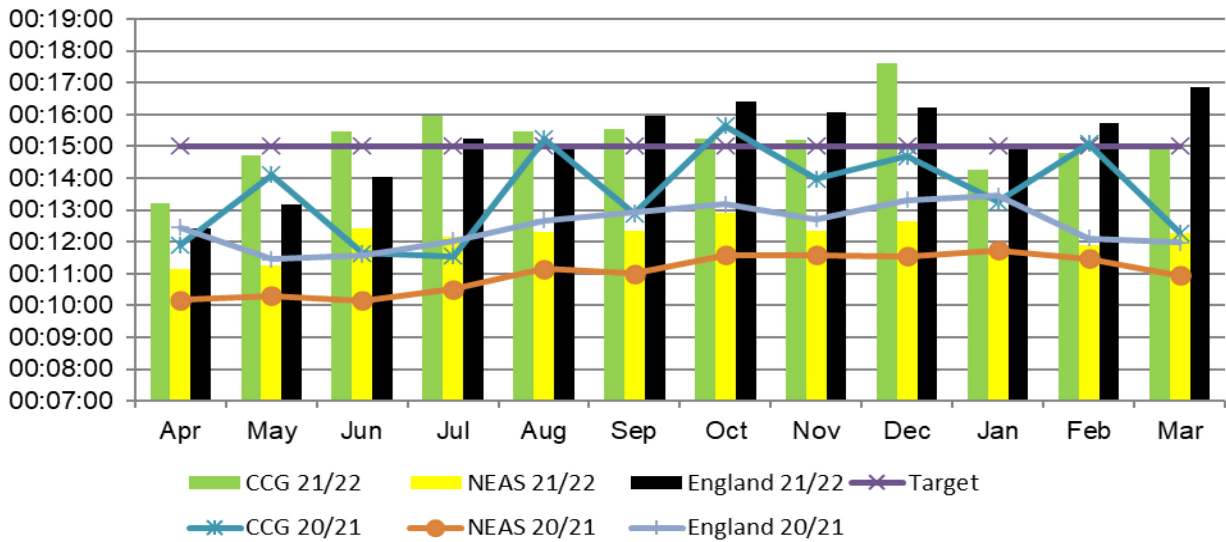
	Northumberland CCG - 2021/22 Performance											
Category	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1 Average												
1 90th												
2 Average												
2 90th												
3 90th												
4 90th												
Achieved (6)	3	2	0	1	1	0	0	1	1	3	3	1

	NEAS - 2021/22 Performance											
Category	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1 Average												
1 90th												
2 Average												
2 90th												
3 90th												
4 90th												
Achieved (6)	3	2	2	2	1	1	1	1	1	3	3	2

The overall summary of performance is shown on the above tables for both Northumberland and NEAS overall indicating the number of targets achieved each month out of a total of six. In general performance correlates with demand i.e. the number of 999 incidents. COVID-19 pressures, particularly around staff absences impacted performance considerably during 2021/22.

The charts outlined below show the comparative performance of Northumberland with both the overall performance of NEAS and England during 2020/21 and 2021/22 against each of the six national targets.





NEAS overall has performed well against Category 1 (life threatening thresholds) with the 90th centile response time being consistently below 15 minutes. The CCG performance, like the national average, has not performed so well, however.

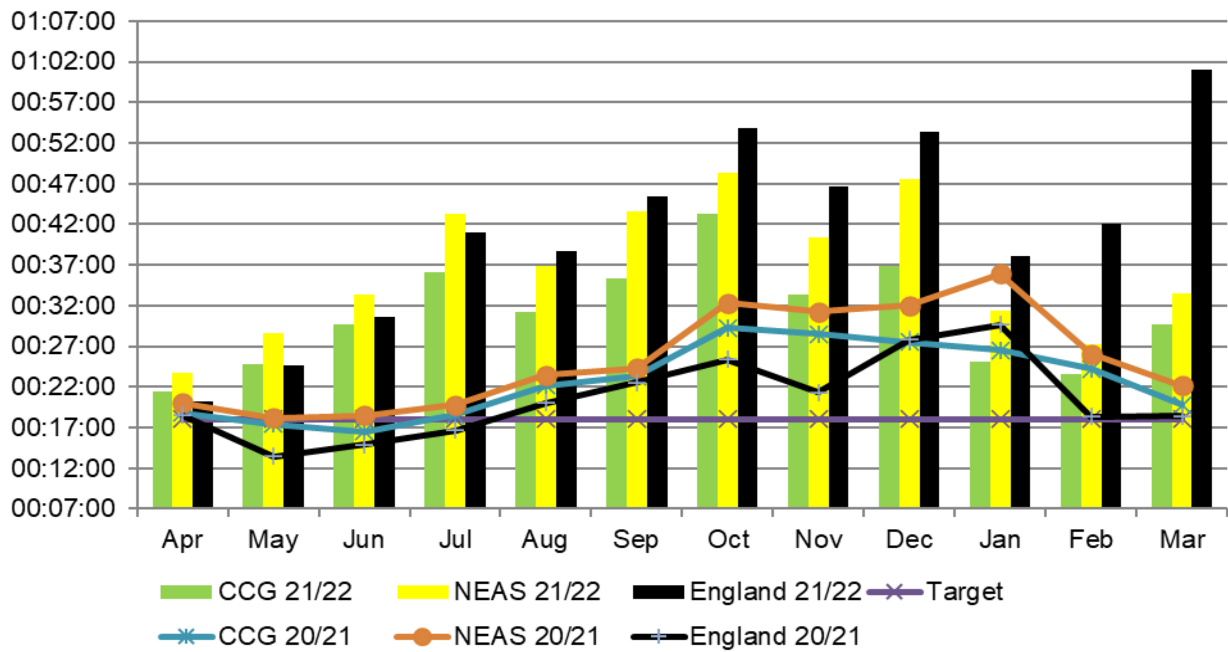


Chart 19 Category 2 - mean ambulance response times
April 2020 - March 2022
01:07:00
01:02:00
00:57:00
00:52:00
00:47:00
00:42:00
00:37:00
00:32:00
00:27:00
00:22:00
00:17:00
00:12:00
00:07:00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
CCG 21/22
NEAS 21/22
England 21/22
Target
CCG 20/21
NEAS 20/21
England 20/21

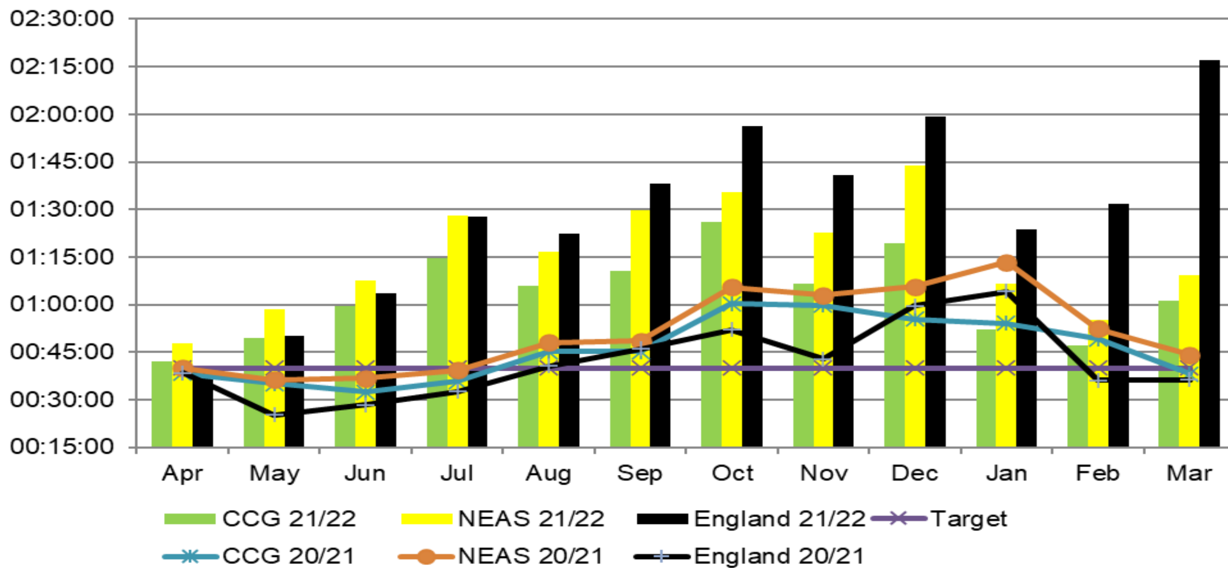


Chart 20 Category 2 - 90th%ile ambulance response times
April 2020 - March 2022
02:30:00
02:15:00
02:00:00
01:45:00
01:30:00
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01:00:00
00:45:00
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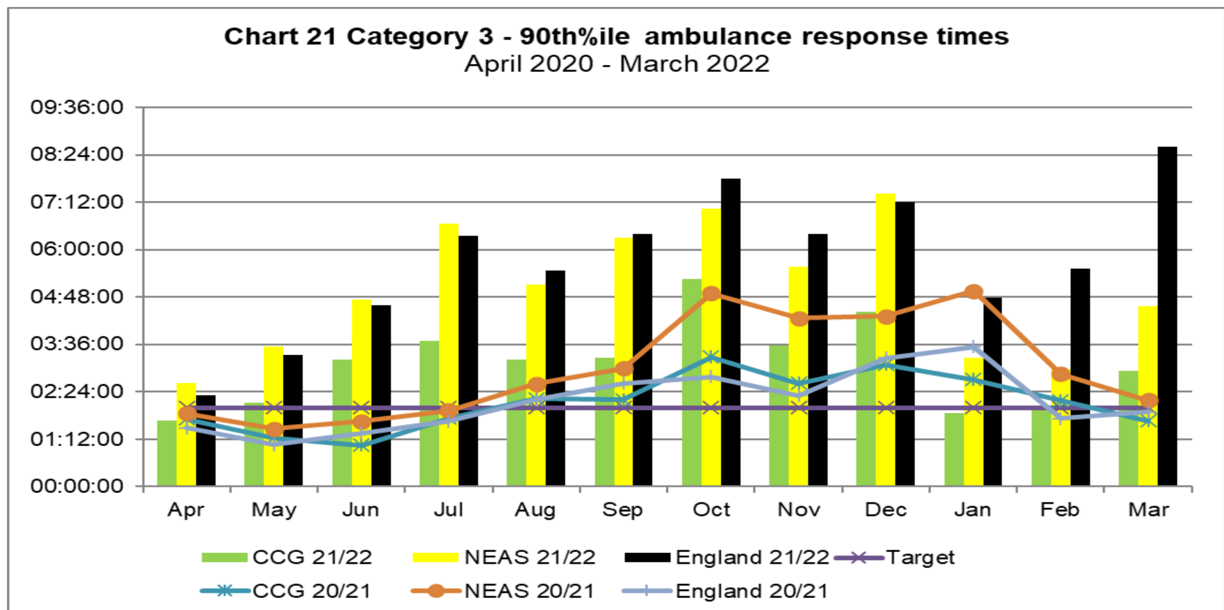
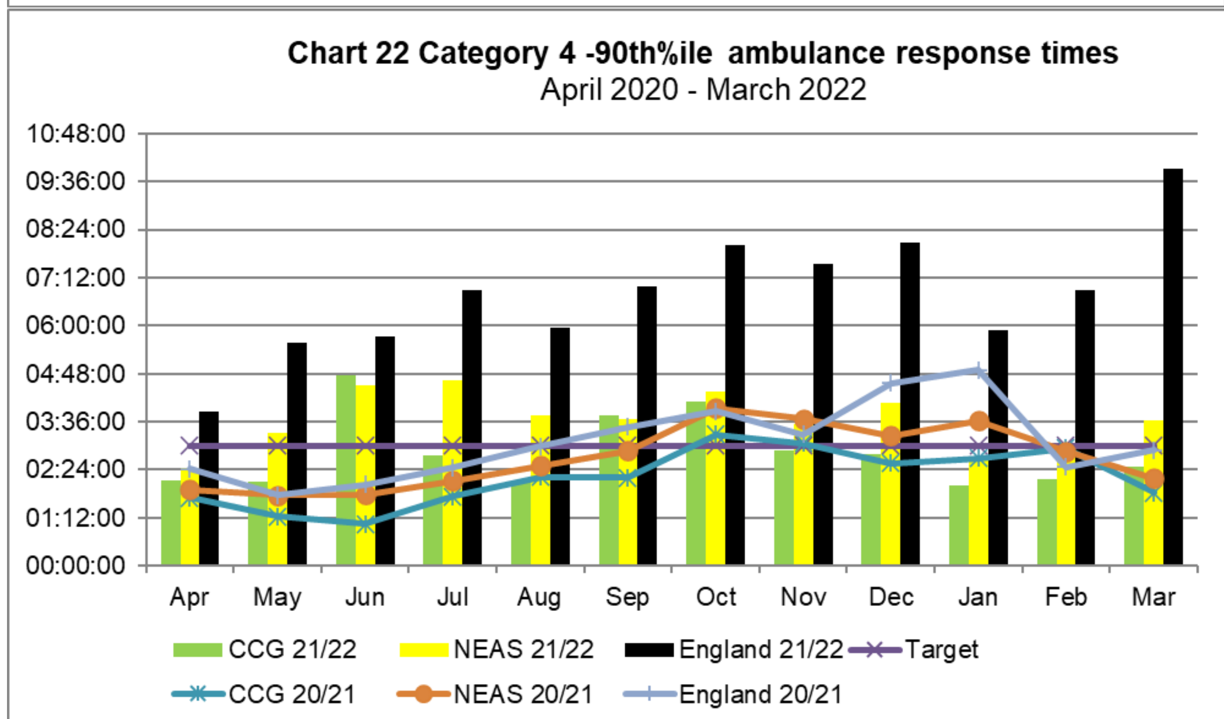
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
CCG 21/22
NEAS 21/22
England 21/22
Target
CCG 20/21
NEAS 20/21
England 20/21

In contrast however NEAS' Category 2 performance compares less favourably against the lower priority response time metrics. From July 2021 onwards and for the majority of the year Northumberland's and the overall NEAS performance was stronger than the overall England position.





Category 3 and 4 performance shows much stronger CCG level performance compared to NEAS and England wide and an improvement on the previous year.

Healthcare Acquired Infections

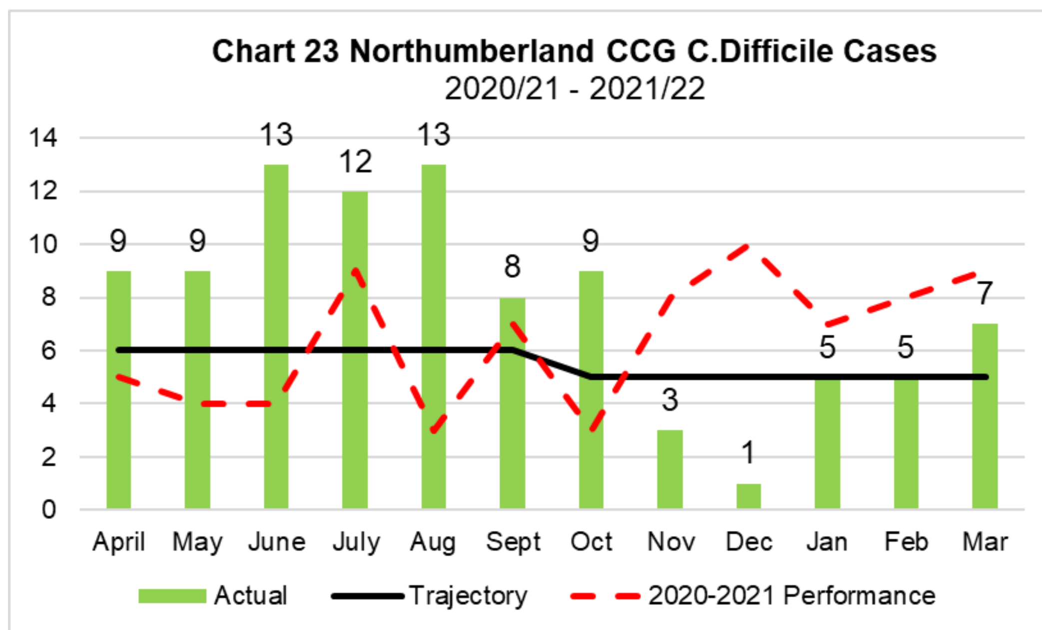
The CCG works collaboratively with its local providers in reviewing the learning from cases and reviewing working practices to reduce the risk of future infections. The local providers conduct root cause analysis and study the trends in the incidence of cases. Regular meetings take place both at place and on a wider footprint to discuss and review healthcare acquired infections.

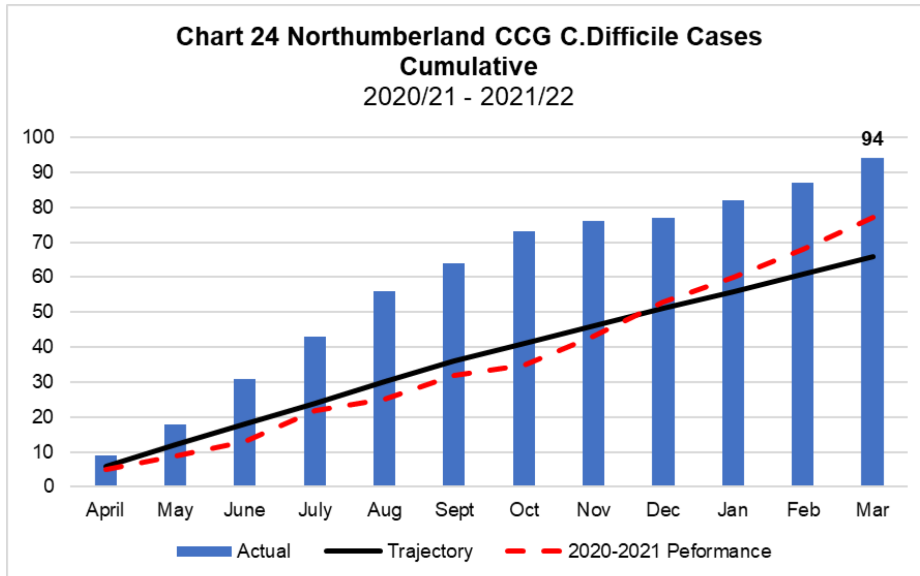
MRSA

One MRSA case was reported during 2021/22 which was attributed to Northumberland CCG. The CCG conducted a full post infection review with colleagues from the Trust and no gaps in care were identified.

Clostridium Difficile

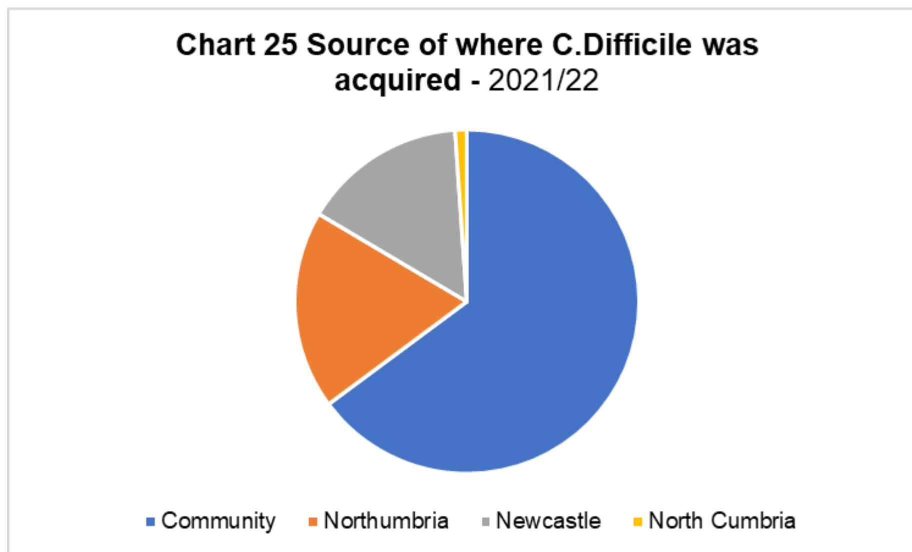
The charts below show the comparative number of cases on both a monthly basis compared with the trajectory and over the same periods of time in the previous year





Based upon the end of year position in 2021/22 there has been a total of 94 cases compared with 77 cases reported during the same periods of time in 2020/21 and against an annual trajectory of 66. The monthly trajectory has been breached on seven out of 12 occasions in 2021/22.

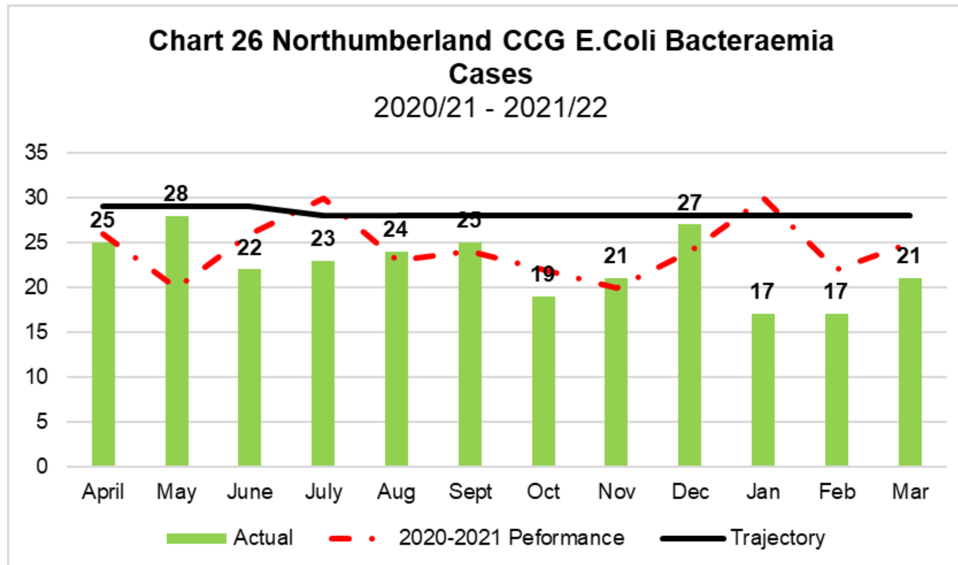
The chart below shows the split between community and hospital as to where the infection was acquired during 2021/22.

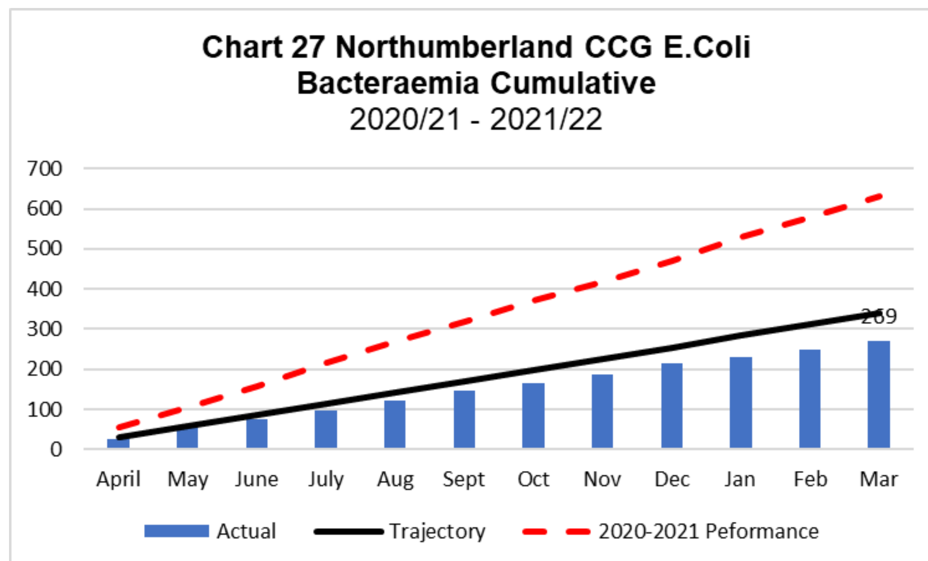


59 out of 77 cases (65%) were acquired in the community.

E.Coli

The charts below show the comparative number of cases on both a monthly and cumulative basis compared with the trajectory and over the same periods of time in the previous year.



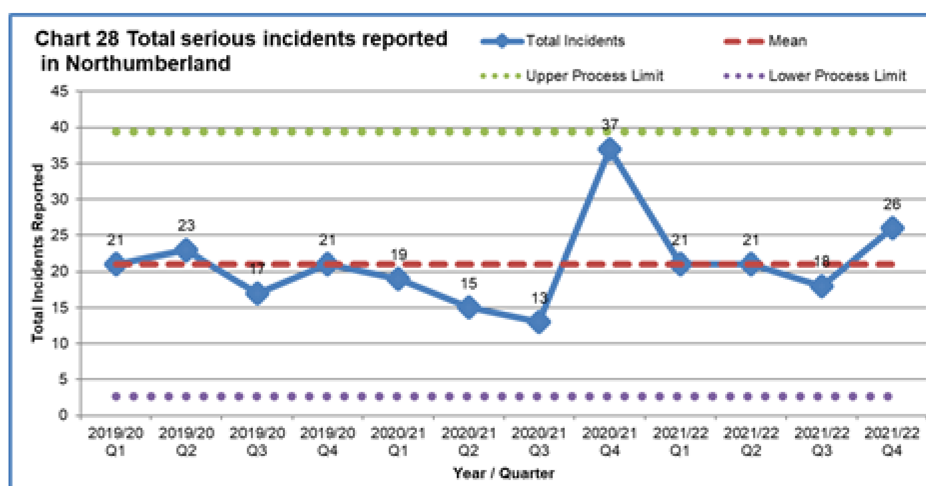


Based upon the end of year position in 2021/22 there has been a total of 269 cases compared with 292 cases reported during the same periods of time in 2020/21 and against an annual trajectory of 339. The CCG stayed within its trajectory for every month in 2021/22.

Never Events

There were five never events reported in 2021/22 compared to one that was reported in 2020/21. All of these never events were surgical/invasive procedures, three of which were reported by Northumbria and two were reported by Newcastle.

Serious Incidents

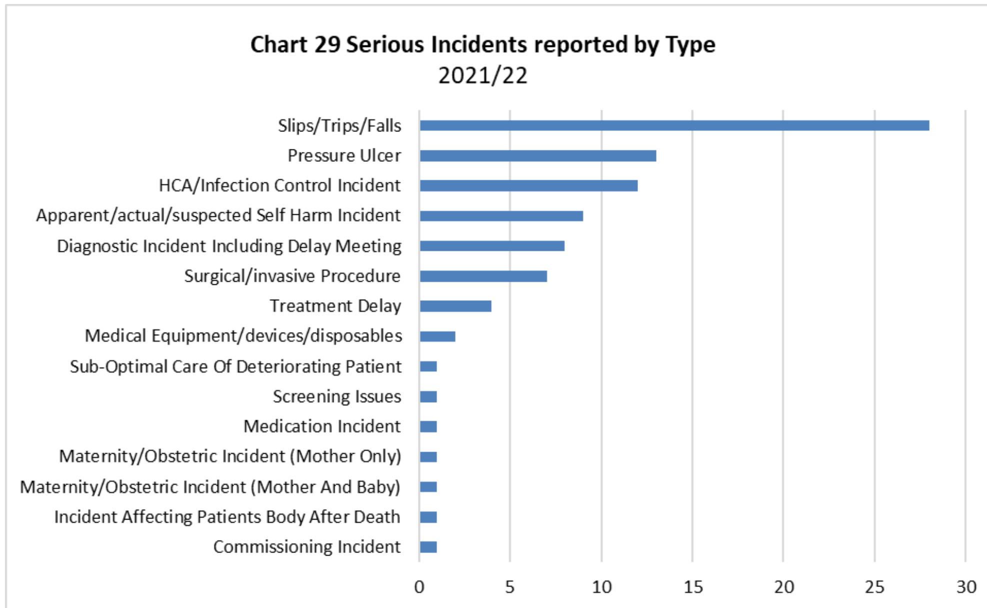


Total serious incidents reported

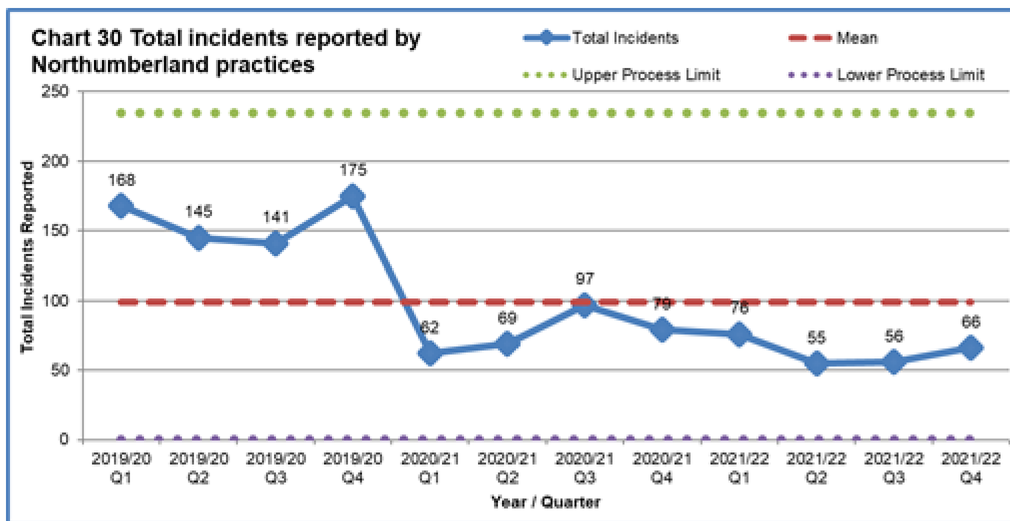
86 serious incidents were reported in 2021/22 relating to Northumberland patients the same as reported in 2020/21. The chart above provides a breakdown of the number of Serious Incidents reported per quarter.

All serious incident and never event reports received were taken to the CCG Serious Incident Panel for review and consideration for sign off.

Quarterly reports are presented to the Clinical Management Board and the Quality Review Group that analyses the trends, learning and areas for further improvement.



SIRMS



Northumberland GP practices reported 253 incidents onto the Safeguarding Incident Management System (SIRMS) during 2021/22 compared to 309 in 2020/21. As demonstrated in the chart above Northumberland practices have reported fewer than 2020/21, this is likely to be due to the continued COVID-19 pressures and has been observed across all CCG areas.

Care Homes

The COVID-19 Care Homes & Care Settings Outbreak Prevention and Control Team met weekly throughout the pandemic. The CCG along with colleagues from Northumberland County Council and Northumbria IPC and Community Nursing colleagues managed 231 outbreaks within nursing, residential and specialist residential settings and 108 outbreaks within Domiciliary and ISL settings.

In total, the CCG monitored 2340 positive staff cases and 1133 positive resident and service user cases, and collaboratively worked with local IPC nurses who conducted 46 visits to homes to provide further support and training.

Regular newsletters were sent out to all care homes and home care providers to ensure timely distribution of updated guidance.

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

By making the most of social, environmental, and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our footprint.

Improve Quality

Quality forms the foundation of each of our clinical and service areas and is reflected in our day-to-day business. As a result of the prolonged COVID-19 pandemic, with restrictions on normal service delivery across clinical and non-clinical settings, the focus of our assurance systems has been to continue to monitor potential harm to patients. The priority has been to safeguard vulnerable people and protect those at risk.

Overall, the services for Northumberland residents continue to be of good quality. We have continued to strengthen our partnerships with Northumberland County Council (including the Public Health Team) and NHCFT, and this has proved vital in protecting our residents and supporting the staff in the care homes operating across the county.

Other areas of focus in 2021/22 included:

- Work to continually refine early warning and monitoring systems to provide meaningful intelligence and allow prompt actions. This was achieved through continuous improvement in reporting and reviewing of incidents to the internal working groups and Boards of the CCG.

- Working closely with other CCGs to ensure the quality assurance system is aligned across the Integrated Care Partnership (ICP) to ensure consistency.

- Improvements in service quality and patient safety and the reduction of harmful never events and its impact of patients and service users, including keeping the following constantly under review:

    - Mortality rates
    - C.Diff and MRSA infection rates, and Gram Negative Blood Stream Infection particularly E.Coli
    - COVID-19 infection rates
    - Falls and pressure ulcers
    - Serious Incidents and Never Events
    - Waiting time associated with the reduced capacity of the providers to deliver planned care because of the pandemic
    - Providers plans for the recovery of all patient pathways to pre-pandemic levels
    - Reviewing patient experience reflected in national and local patient satisfaction surveys.

Engaging People and Communities

It is essential that the people of Northumberland and the communities we serve are involved in our commissioning activities, including the design and planning of health services, decision making and engaging on proposals for change that will have an impact on how services are provided to them. Meaningful participation and involvement with all of our stakeholders is vital to ensure that we can develop a health service that is specifically tailored to the needs of the county.

During 2021/22 we have ensured that the services we deliver to the people of Northumberland matches their needs. Throughout the year we have engaged on a regular basis with the public, community and voluntary community sector (VCS) organisations, local community groups and patient participation groups using a variety of methods including focus groups, surveys, and through digital channels such as the website and social media.

We continue to work closely with Healthwatch Northumberland to act on their independent engagement feedback to inform the CCG’s decision making processes.

All feedback received is always fully considered and, where possible, acted upon. Each quarter, our engagement feedback is presented to our Governing Body via the Communications and Engagement reports. Members of the public are also encouraged to submit questions to our Governing Body meetings which are held in public. However, due to the ongoing COVID-19 pandemic, members of the public have been unable to attend these meetings in person, but all meetings held in public are recorded and made available to watch on the CCG's website.

Despite the restrictions placed upon our engagement activities because of the pandemic, we have ensured that we involved our communities in our commissioning activities, using innovative and inclusive methods.

Our engagement activities in 2021/22 have given the people of Northumberland the opportunity to help shape and influence local health services on numerous occasions and our key highlights are below:

Integrated Care Boards – Communities and People

As we move into greater collaborative working arrangements, we have worked together with involvement leads across the new Integrated Care Board (ICB) footprint to develop stronger partnership arrangements. Through this partnership work, we have held conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how involvement will work once we become the North East and North Cumbria ICB. We have collectively shared this feedback to identify principles for engagement to take forward, and an aspiration for involvement which will be used to develop a framework for Involvement for the ICB. This framework has been built upon conversations with our stakeholders, and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission.

Improving Access to Psychological Therapies (IAPT) Service

Between May and June 2021, we embarked on a period of engagement work that sought views on the Improving Access to Psychological Therapies (IAPT) service through a series of surveys and focus groups. The purpose of the engagement was to understand local patient experience of the service to support people with common mental health problems and identify where improvements need to be made.

Based on the feedback from the engagement, action is needed to reduce waiting times, increase resources to recruit and train more staff and increase face-to-face contact. The information from the feedback report is being used as a 'thermometer gauge' around service provision and future delivery in terms of where and how sessions can be offered and how this links into greater integrated working. Furthermore, the concerns around waiting times have been noted and improvement in this area is being prioritised.

End of Life Strategy Development

Following the request in 2019 by the County Council's health and wellbeing overview and scrutiny committee, for the CCG to develop a countywide strategy for palliative and end-of-life care, a wide-ranging piece of work has taken place to assess the existing provision against the six agreed national ambitions and to develop priorities to meet gaps in what is on offer to residents in Northumberland.

The committee asked the end-of-life strategy development steering group to ensure the local population, including seldom heard groups, were involved in developing the strategy. On behalf of the steering group, the engagement team developed a range of approaches to gather feedback from the public, patients, carers and staff on the ambitions of the strategy as well as an end-of-life agreement. Engagement activity took place in two phases starting in May 2021, to coincide with Dying Matters Awareness Week, and continued until November 2021. Activity included focus groups, an online survey, plus an online Citizens Panel consisting of 16 participants.

At the end of 2021, all feedback was collated and an engagement report was submitted to the steering group and subsequently presented to the overview and scrutiny committee in early 2022. A draft communications plan and resources to raise awareness of the end-of-life agreement and strategy will now be produced.

Primary Care Network Engagement Working Group

During 2021/22 the CCG strengthened its links with Patient Participation Groups (PPGs) to ensure two-way communication with the CCG around primary care issues and the wider health economy takes place. As part of the work to develop a model of

engagement that will feed into a system wide approach and to enable the public to influence strategic decision making, the CCG established a PCN Engagement Working Group.

Membership of the group includes representatives from Primary Care Networks (PCNs), PPGs, the VCS, Healthwatch and Carers Northumberland. The aim of the group is to lay the foundations for the future by co-designing an engagement framework for PPGs and PCNs that can feed into the Integrated Care System. It also provides the CCG with an opportunity to hear local themes and issues. Three meetings have taken place since August 2021 and discussions have covered community champions training, a new patient and carer bulletin, which launched in December 2021, and work to co-design a PPG Toolkit with PPGs members and Healthwatch.

Community Engagement

In the autumn of 2021 COVID-19 restrictions had lifted and the engagement team were able to carry out proactive face-to-face engagement with VCS community hubs and groups across Northumberland.

The aim was to pick up intelligence themes from targeted protected characteristic groups, including people experiencing language barriers, young people, people with long term health conditions, carers, and people experiencing mental health problems, specifically in the areas of Bedlington, Ashington, Newbiggin, Blyth and rural locations in Northumberland.

The engagement activity was supported with the addition of an online survey, and in total over 250 people spoke to the team about health and healthcare services and where improvements need to be made, particularly as the NHS recovers from COVID-19.

Going forward, we will continue to work with organisations to target groups including drug and alcohol support, unemployment, young people and mental health and continue to build these relationships.

Your NHS Online Community

Due to COVID-19 restrictions in 2020/21, we were unable to carry out any face-to-face engagement. Therefore, the CCG in partnership with Northumbria Healthcare NHS Foundation Trust (Trust) invested in an online private community platform called 'Your NHS Online Community'. The Online Community has enabled us to carry on ‘testing the temperature’ in communities and picking up specific feedback to improve our services throughout the pandemic and it has gone from strength to strength in 2021/22.

In March 2021, membership stood at 184, and in one year it has grown to over 270 members that we are able to seek views from, test ideas and scenarios and actively involve. The Online Community enhances the way we engage with our local communities by enabling us to digitally communicate and engage in real time. It also helps us build up community insights by gathering questions and concerns about issues.

Topics for discussion on the Online Community have varied including how to access remote NHS services, young people's mental health services, Self-Care Week and general public confidence in the local NHS services. We continue to observe high engagement levels which are consistently above national levels.

Recruitment to the Online Community continues via social media, existing CCG, Trust and VCS communication channels and we are actively targeting diverse communities, in order to achieve a representative demographic profile of the Northumberland population.

GP Practice Relocations, Mergers and Branch Closures

Throughout the year the CCG has provided significant support to GP practices who have applied to the CCG to either relocate their practice, merge with another practice, close a branch surgery and/or dispensary to ensure they have appropriately engaged with their patients and stakeholders in their proposals. This has included supporting them with their communications and engagement plans, preparing the necessary communications materials and advising on engagement feedback reports. Practices have included: Felton and Widdrington Surgeries merger and new build, Alnwick Medical Group regarding their Longhoughton branch and Valens Medical Group about the proposed relocation of their Brockwell surgery to a new facility on the Northumbria Specialist Emergency Care Hospital site in Cramlington.

Improving Access

In January 2022, the CCG commenced an extensive piece of research and engagement to gather patient views on accessing healthcare in General Practices. During the pandemic there were changes made to the way GP services were accessed. Many of these changes were national requirements, with a purpose to manage increasing demand, such as greater use of telephone consultations, e-consultations, video calls and SMS texting.

This piece of engagement was designed to evaluate current experience of access to GP practices, including remote consultations, to ensure the views of patients can inform any future service changes in relation to accessing general practice.

Furthermore, it was necessary to address the current pressures in General Practice and public perceptions in Northumberland, and nationally, around the difficulty of securing face-to-face appointments with a GP.

The CCG commissioned an independent market research company to engage with the Northumberland population to better understand their views. The research company adopted a number of methods for the patient engagement including focus groups and an online survey. The survey sought to understand patients' views on issues such as which healthcare professional they would prefer to see, how quickly they want to be seen, whether weekend and evening appointments are useful, and how far they are willing to travel or would a telephone or video consultation be preferable.

Recognising that there are some people we do not hear from enough, the CCG also commissioned support from Healthwatch Northumberland and seven VCS organisations to specifically target inclusion health groups, such as carers, people experiencing language barriers or young people. These organisations either supported people to complete the survey or carried out focus groups to ensure as many people as possible had the opportunity to share their views.

The engagement activity ended at the end of March 2022 and work will continue in the next financial year to analyse the data and formulate a plan for the way forward. Feedback from the research will be shared with stakeholders and the public in the near future.

Rothbury Community Hospital

In January 2022, the Trust announced a new strategic partnership with a third-party care provider People First Care, which will allow the NHS to deliver a flexible number of beds to meet the needs of patients in Rothbury, while continuing to provide extra support for people's health and care needs in their own home. As part of the scheme, the Trust will commit to taking NHS beds within Rothbury Community Hospital, with numbers moving up and down flexibly to meet patient needs. Under the plans, People First Care will operate a 12-15 bed unit for people needing respite care, rehabilitation services, longer-term recuperation or end-of-life care. This facility will be supported by a wider team of district nurses, GPs and nurse practitioners.

The CCG's Governing Body approved the new model of care to utilise 12 beds within Rothbury Community Hospital at its meeting in March 2022. The CCG's Governing Body agreed the new model will ensure the best provision for patients in Rothbury and surrounding areas, as it provides a mix of important health and care services. Following five years of continuous engagement with the local community to find a solution for Rothbury Community Hospital, it is now hoped this new model will be up and running by summer 2022.

Reducing Health Inequality

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

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

Public Sector Equality Duty (PSED)

We understand that we are required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

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

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

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

Governance

Equality, Diversity, and Inclusion is governed and reports into the Governing Body. The board ensures we are compliant with legislative, mandatory, and regulatory requirements regarding equality and diversity and inclusion. It develops and delivers national and regional diversity related initiatives within the CCG, provides a forum for sharing issues and opportunities and monitors the achievement of key EDI objectives.

Equality Strategy

Our Equality Strategy for 2021-2024 has been developed. The revised strategy highlights the aims set out within the 'We are the NHS: People Plan 2020/21 – action for us all' and outlines our strategic direction in how we foster a culture of inclusion and belonging, take action to develop a diverse workforce that is representative of the communities it serves, train our people, and work together differently to deliver patient care.

The Equality Delivery System 2 (EDS2) – Our Equality Objectives

We have continued to utilise the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010. We have used the NHS Equality Delivery System 2 (EDS2) to continue monitoring our equality objectives outlined below:

> **Objective 1** – Continuously improve engagement, and ensure that services are commissioned and designed to meet the needs of patients
>
> **Objective 2** – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular the ageing population and those with a disability.
>
> **Objective 3** - Monitor and review staff satisfaction to ensure they are engaged, supported, and represent the population they serve.
>
> **Objective 4** – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff – Encouraging Diversity

We encourage a diverse range of people to apply to and work for us as we recognise the benefits such diversity brings to the quality of our work and the nature of our organisation. We continue to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; and reasonable adjustments under the Equality Act 2010 are considered and implemented during the recruitment process and during employment. By working closely with DWP, we have maintained our 'Level 2 Disability Employer' status for 2020 - 2022 by demonstrating our commitment to employing the right people for our business and continually developing our people.

Workforce Race Equality Standard

In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES). We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

Our Equality Impact Assessment (EIA) Toolkit was reviewed in 2020 to continue the process to be embedded into core business processes and to provide a comprehensive insight into our local population, patients and staff's diverse health needs. The tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers, as well as including prompts for engagement with protected groups the tool also aids compliance with the Accessible Information Standard. The EIA is embedded into our governance process and sign off from the Governing Body is required for monitoring and completion.

Accessible Information Standard

The Accessible Information Standard aims to make sure that people with a disability or sensory impairment have access to information that they can understand, and access to any communication support they might need. The CCG has due regard to the standard by obtaining feedback from Patient Reference Groups (PRG's) in relation to how we can improve our communication methods and make them more accessible for all. Further information can be found at:
https://www.england.nhs.uk/ourwork/accessibleinfo/

Health Inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population. We understand our local population and local health needs, using joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

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

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

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

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

We continue to monitor the health profiles and data available which detail the health challenges of our population including the Joint Strategic Needs Analysis (JSNA) and Public Health Profiles.

Further information can be found at:

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

Northumberland CCG JSNA: https://www.northumberland.gov.uk/Care/JSNA/Health-wellbeing-assessment.aspx

Health and Wellbeing Strategy

The Northumberland Health & Wellbeing Board brings together Local Government (including public health, adult social care, children's services and elected representatives), the NHS (including commissioners and providers of healthcare services), the Local Medical and Pharmaceutical Committees, Healthwatch Northumberland and the Voluntary, Community and Social Enterprise (VCSE) sector, to ensure that the needs of Northumberland's population are met and tackle local inequalities in health. The Chairman of the Board is an elected member from Northumberland County Council. Through the Health and Wellbeing Board, NHS Northumberland Clinical Commissioning Group (CCG) and Northumberland

County Council (NCC) have a duty to develop a Joint Health and Wellbeing Strategy (JHWS). The strategy is a long-term plan which is used to inform local commissioning decisions. Based on an assessment of the needs of service users and communities, its intention is to tackle factors that impact on their health and wellbeing. As a result, we have identified four key themes to guide us in the next ten years, with an additional three cross-cutting themes that will underpin our activities:

Key Themes:

- Giving children and young people the best start in life
- Empowering people and communities
- Tackling some of the wider determinants of health
- Adopting a whole system approach to health and care

Additional cross-cutting themes:

- Improving mental wellbeing and resilience
- Supporting people with long-term conditions
- Exploiting digital technology

https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Public%20Health/Northumberland-Joint-Health-and-Wellbeing-Strategy-2018-2028.pdf

https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Public%20Health/Northumberland-CC-Health-and-Wellbeing-17-12-19-2.pdf

Financial Review

Context of the reported financial outturn 2021/22

Due to the continuation of the COVID-19 pandemic, the Government extended the temporary financial framework arrangements for NHS organisations for another year to cover the period to 31 March 2022.

The temporary funding arrangements move CCGs away from the traditional annual published allocations that CCGs have a statutory requirement to deliver within to meet their key financial performance indicators.

The financial framework arrangements for 2021/22 built upon the system-based approach to resource allocation distribution and planning that had been introduced in the 2020/21 financial year.

Planning and allocations for 2021/22 consisted of two six monthly system resource envelopes allocated to area systems with the NENC ICS. Individual NHS provider and commissioner organisations within each system were required to agree plans within the system resource envelopes and work collaboratively together to ensure each NHS partner organisation within the system was able to plan a breakeven or better position.

The CCG was able to do this in each of the two six monthly plans, planning a £670K surplus in the first half of the year and a breakeven position for the second half of the year, therefore £670K for the year in total.

The financial performance the CCG is measured against for the financial year 2021/22 is the total resource it has received from these two six monthly allocations agreed through the system planning process, plus any other additional non-recurrent or centrally funded national allocations received throughout the year.

Key financial performance indicators 2021/22

For the financial year 2021/22, the CCG met the statutory requirement to ensure that expenditure in the financial year did not exceed its allocated resource. The CCG's in-year surplus was £2,052k with a cumulative historic debt of £55,353k as at 31 March 2022.

The CCG total revenue resource allocation for 2021/22 was £621,011k and total spend was £618,959k.

Table 1 – Key Financial Performance Indicators 2021/22

NHS Act Section	Duty	Target £'000	Performance £'000	Total £'000	Duty Achieved
223H(1)	Expenditure not to exceed income	621,011	618,959	2,052	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	620,911	618,859	2,052	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	6,315	5,236	1,079	Yes

CCG Commissioning Budget 2021/22

As mentioned earlier with the temporary financial arrangements in place this year the CCGs commissioning budget was received in two halves in the year.

The initial six-month allocation received by the CCG on the back of a half year system plan submitted on 6 May 2021 was approved through Governing Body on 27 May 2021. The second half of the year plan was submitted on 18 November 2021 to cover the remaining six months of the year, with each of the plans being reviewed in detail at the Corporate Finance Committee and key points reported to the Governing Body.

CCG Running Costs Budget 2021/22

Included in the commissioning allocations the CCG had an annual running cost allocation of £6,315k in 2021/22. This covered the CCG's pay budgets, other non-pay running costs and the Service Level Agreement with the CCG's commissioning support unit North of England Commissioning Support (NECS).

Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires all CCGs to aim to pay 95% of all valid invoices by the due date within 30 days of receipt of a valid invoice, whichever is later. The CCG has met the requirements of the code, as reported in the annual accounts, and indicated in Note 5 of the accounts.

ACCOUNTABILITY REPORT

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

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Mark Adams
Accountable Officer
20 June 2022

Corporate Governance Report

Members Report

Member practices

The CCG membership body consists of one clinical representative from each of the following 37 member practices:

Adderlane Surgery	Haydon and Allendale Medical Practice
Alnwick Medical Group	Humshaugh and Wark Medical Group
Bedlingtonshire Medical Group	Marine Medical Group
Belford Medical Group	Northumberland Health at Widdrington and Felton Surgeries
Bellingham Practice	Netherfield House Surgery
Branch End Surgery	Ponteland Medical Group
Burn Brae Medical Group	Prudhoe Medical Group
Cheviot Medical Group	Railway Medical Group
Coquet Medical Group	Riversdale Surgery
Corbridge Medical Group	Rothbury Practice
Cramlington Medical Group	Scots Gap Medical Group
Elsdon Avenue Surgery	Seaton Park Medical Group
Forum Family Practice	Sele Medical Practice
Gables Medical Group	Union Brae and Norham Practice
Gas House Lane Surgery	Village Surgery
Glendale Surgery	Valens Medical Partnership
Greystoke Surgery	Well Close Medical Group
Guide Post Medical Group	White Medical Group
Haltwhistle Medical Group	

CCG Membership Meetings

The membership met in July to consider the Annual Report and Accounts. Regular Locality Meetings and extensive briefings, including a weekly CCG bulletin to General Practice, have been used to update the membership on key policy changes, guidance, and events throughout the year.

Composition of Governing Body

The Governing Body membership consists of:

- Dr Graham Syers, Clinical Chair
- Mr Mark Adams, Accountable Officer
- Mrs Janet Guy, CCG Deputy Lay Chair – Strategy and Governance
- Mrs Karen Bower, Lay Governor Corporate Finance and Patient and Public Involvement
- Dr Paula Batsford, Locality Director (Blyth Valley) *1
- Mr Steve Brazier, Lay Governor with lead for audit and conflict of interest
- Prof Marios Adamou, Governing Body Secondary Care Doctor
- Dr Chris Waite / Mr Tony Brown, Locality Directors (North)
- Dr John Warrington, Medical Director and Locality Director (Central)
- Dr Ben Frankel, Locality Director (West)
- Dr Robin Hudson, Medical Director
- Mrs Siobhan Brown, Chief Operating Officer
- Mr Jon Connolly, Chief Finance Officer
- Mrs Annie Topping, Executive Director of Nursing, Quality and Patient Safety
- Mr Paul Turner, Executive Director of Commissioning, Contracting and Corporate Governance

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021

Committee(s) including Audit Committee

The Audit Committee membership consists of:

- Mr Steve Brazier, Lay Governor with lead for Audit and Conflict of Interest (Chair)
- Mrs Janet Guy, CCG Deputy Lay Chair – Strategy and Governance

The governance statement provides full details of the members and the work of the other CCG committees and groups.

Register of Interests

Details of any declarations of interest for Governing Body members and member practices can be found on the CCG's website at http://www.northumberlandccg.nhs.uk/about-us/register-of-interest/.

Personal data related incidents

The CCG reported no data incidents to the Information Commissioners Office during 2021/22.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG, at the time of the Members' Report is approved, confirms that:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

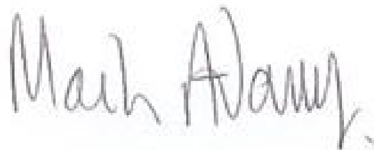
The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year. In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.



Mark Adams
Accountable Officer
20 June 2022

Governance Statement

Introduction and context

NHS Northumberland Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter. I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

The Clinical Commissioning Group Governance Framework

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. The CCG has a constitution which sets out clearly the governing structure of the organisation and the decision making that takes place at the Governing Body. This is supported by a scheme of delegation which sets out further detail of decisions delegated to Committees and individuals.

Membership of the Clinical Commissioning Group

A total of 37 practices comprise the members of NHS Northumberland Clinical Commissioning Group (CCG) and details of these are included in the CCG's constitution. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract are eligible to apply for membership of the CCG. No other providers of primary medical services have applied for membership of the CCG during 2021/22.

The membership of the CCG, through its practice representatives is responsible for:

- Making recommendations to NHS England for any amendments to the CCG's constitution
- Approving arrangements for appointments within the CCG
- Making recommendations to NHS England for the appointment by NHS England of the Accountable Officer
- Approving the appointment of, and terms and conditions for, members of the CCG's Governing Body

Each member has a practice representative who represents their practice's views and acts on behalf of the practice in matters relating to the CCG.

In addition to the practice representatives the CCG has identified a number of roles to either support the work of the CCG and/or represent the CCG. The roles may be filled by GPs, primary care health professionals, or other practice employees/ partners who are not health professionals. These representatives undertake the following roles on behalf of the CCG:

One Locality Director each, for:

- Blyth Valley
- Central Northumberland
- North Northumberland
- West Northumberland

One Business Director for:

- Finance and Commissioning

Committee(s), including Audit Committee:

The Governing Body

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

The Governing Body is established as a committee of the CCG in accordance with the constitution, standing orders and scheme of delegation. In accordance with the terms of reference, the Governing Body will normally be held bi-monthly. A minimum of five Governing Body meetings are held in each financial year.

A minimum of two meetings each year would normally be held in public. Due to the ongoing COVID-19 pandemic and associated restrictions it was not possible to hold meetings in public, but members of the public were invited to submit questions to be answered during meetings and papers were published on the CCG website.

A total of seven meetings of the Governing Body were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Clinical Chair (Chair)	Graham Syers	6/7
Deputy Lay Chair (Deputy Chair)	Janet Guy	7/7
Two Lay Governors:		
Lead on audit and conflict of interest	Steve Brazier	6/7
Lead on corporate finance and patient and public involvement	Karen Bower	7/7
The Accountable Officer	Mark Adams	7/7
One registered nurse	Annie Topping	7/7
One secondary care specialist doctor	Prof Marios Adamou	6/7
The Locality Director Blyth Valley *1	Dr Paula Batsford	7/7
The Locality Director North	Dr Chris Waite/Tony Brown	7/7
The Medical Director and Locality Director Central *2	Dr John Warrington	4/7
The Locality Director West	Dr Ben Frankel	4/7
The Medical Director	Dr Robin Hudson	6/7

The Chief Operating Officer	Siobhan Brown	6/7
The Chief Finance Officer	Jon Connolly	7/7
The Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	5/7

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021
*2 Dr John Warrington assumed temporary duties as Locality Director for Blyth Valley from 22 September 2021

The principal function of the Governing Body is to provide the CCG with an independent and objective view of the CCG's arrangements to exercise its functions effectively, efficiently, and economically and in accordance with the CCG's principles of good governance.

Apart from those functions reserved to the CCG's membership the primary roles of the Governing Body are:

- Approving the CCG's vision, strategy and annual commissioning plan
- Leading on all governance, assurance openness and transparency matters
- Securing continuous improvements in the standards and outcomes of care
- Oversight of financial and risk management
- Where specified in the Terms of Reference of the Governing Body committees and boards, receiving the minutes of meetings of joint or collaborative arrangements between the CCG and other statutory bodies

Specifically, the Governing Body:

- Ensures the efficient and effective use of CCG resources
- Ensures that the CCG does not exceed its delegated budget while delivering its agreed strategic objectives and performance target achievement
- Ensures that services for the population of Northumberland are commissioned in a way which delivers improved health, better outcomes and patient experience, efficiency and reduced health
- Continually reviews and improves performance in relation to health outcomes, nationally and locally agreed performance targets
- Gains assurance from the Clinical Management Board that services are safe, high quality and sustainable
- Ensures continuous and meaningful engagement with the public and patients in the planning, delivery and prioritisation of services
- Ensures that planning, prioritisation and decision making is transparent, equitable and auditable

Regular items on the agenda of the Governing Body meetings include:

- Updates on the work of the Audit Committee, the Northumberland Primary Care Commissioning Committee and the Clinical Management Board
- Financial performance updates
- A report highlighting key issues is presented by the Chief Operating Officer
- Updates on the development of the CCG assurance framework and corporate risk register
- Updates on the communications and engagement strategy
- Commissioning plan progress
- Reviewing and providing comment on the proposed arrangements for the Integrated Care System

Minutes of Governing Body meetings are available here:
https://www.northumberlandccg.nhs.uk/about-us/governing-body/

Committees of the Governing Body

The Governing Body undertakes a proportion of its work through committees. Each committee has a set of terms of reference, which have been formally approved by the Governing Body. Committee Chairs present their chair approved minutes to the Governing Body meeting following their meeting.

Audit Committee

The principal function of the Audit Committee is to provide the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities (both clinical and non-clinical) that supports the achievement of the CCG's objectives.

The remit and responsibilities of the Committee are to critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained. The duties of the Committee are driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, and is flexible to new and emerging priorities and risks. The membership of the Audit Committee is drawn from Lay members of the Governing Body. In accordance with the terms of reference the Audit Committee meets bi-monthly, with a minimum of five meetings per financial year. A total of six meetings of the Audit Committee have been held during the year with attendance by members as follows:

Title	Member	Attendance
Lay Governor for Audit and Conflicts of Interest	Steve Brazier (Chair)	6/6
Lay Chair	Janet Guy	6/6

The Committee's main activities during 2021/22 have been:

- Receiving and critically reviewing reports from both internal audit, external audit and service audit reports
- Approving the internal audit work plan for current and future years
- Assuring the accuracy of the CCG's 2021/22 annual reports and accounts
- Reviewing risks to ensure they are complete, appropriately scored and mitigations are managed and appropriate
- Reviewing the processes in place to identify conflicts of interest in decision making, and how any identified conflicts were handled
- Reviewing and providing comment on the proposed arrangements for the Integrated Care System

Appointments and Remuneration Committee

The principal function of the Appointments and Remuneration Committee (ARC) is to advise the Governing Body on senior appointments, about appropriate remuneration and terms of service, and determine the remuneration and terms of service of members of the Governing Body and other staff directly accountable to the Accountable Officer or Chief Operating Officer.

The membership of the ARC is drawn from Lay members of the Governing Body. In accordance with the terms of reference the ARC meets as and when required, no less than once per financial year and no more than 15 months between meetings.

One meeting of the ARC was held during the year 2021/22. Attendance by members was as follows:

Title	Member	Attendance
Lay Chair	Janet Guy (Chair)	1/1
Lay Governor for Audit and Conflicts of Interest	Steve Brazier	1/1
Lay Governor for Corporate Finance and PPI	Karen Bower	1/1

The Committee discussed remuneration levels for 2021/22 for appropriate CCG staff not covered by NHS Agenda for Change terms and conditions.

Northumberland Primary Care Commissioning Committee

The principal role of the Northumberland Primary Care Commissioning Committee (NPCCC) is to commission primary medical services for the people of Northumberland.

The remit and responsibilities of the NPCCC shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

NHS England has delegated to the CCG authority to exercise primary care commissioning functions that include but are not limited to the following activities:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Providers of Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services (‘Local Enhanced Services’ and ‘Directed Enhanced Services’)
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Approving practice mergers
- Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes)

The membership of this Committee is drawn from Lay members of the Governing Body, the CCG Chief Operating Officer or nominated Director, the CCG Chief Finance Officer and CCG Directors. In accordance with the terms of reference the NPCCC meets at regular intervals and not less than five times per financial year. A total of six meetings of the NPCCC have been held during the year with attendance by members as follows:

	Member	Attendance
Lay Chair	Janet Guy (Chair)	6/6
Lay Governor for Corporate Finance and PPI	Karen Bower	6/6
Chief Operating Officer	Siobhan Brown	4/6
Chief Finance Officer	Jon Connolly	6/6
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	6/6

Service Director for Integration and Transformation	Rachel Mitcheson	6/6
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	4/6

The Corporate Finance Committee

The Corporate Finance Committee's (CFC) principal function is to assist the Governing Body in its duty to act efficiently, effectively and economically. The committee oversees the current and projected financial position of the CCG. It also assures the Governing Body that the CCG has sufficient capacity and capability to deliver its strategic objectives. The CFC is not a decision-making committee.

The CFC is responsible for:

- **Strategy –** overseeing the development and implementation of sustainable system plans that will achieve financial targets including detailed QIPP plans
- **Financial Performance –** providing challenge on the CCG's current and projected financial position, reviewing the ongoing overall financial position of the CCG and providing assurance to the Governing Body that the projected outturn is deliverable
- **Procurement –** overseeing the development and implementation of CCG procurements
- **Assurance –** providing overall assurance to the Governing Body that the CCG's projected financial position is deliverable and that the CCG is adequately resourced in terms of workforce

In accordance with the terms of reference the CFC will normally meet bi-monthly, not less than five times per financial year.

A total of 6 meetings of the CFC have been held during the year with attendance by members as follows:

Title	Member	Attendance
Lay Governor for Corporate Finance and Patient and Public Involvement (Chair)	Karen Bower	6/6
Lay Governor for Audit and Conflict of Interest	Steve Brazier	4/6
Clinical Chair	Dr Graham Syers	6/6
Business Director (Finance and Commissioning)/Locality Director and Medical Director	Dr John Warrington	4/6
Chief Operating Officer	Siobhan Brown	6/6
Chief Finance Officer	Jon Connolly	6/6
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	3/6
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	6/6

The Clinical Management Board

The principle function of the Clinical Management Board (CMB) is to assist the Governing Body in its duties to promote a comprehensive health service, reduce inequalities, promote innovation and assure themselves of the quality of services that the CCG has commissioned.

The Clinical Management Board will be responsible for clinical direction and engagement and providing day to day operational management overarching direction for the successful delivery of the objectives of the CCG:

Clinical Direction and Engagement:

- Preparing and recommending the strategy and annual commissioning plan for the Governing Body to consider and approve.
- Formulating and recommending service change and development arising out of the strategy.
- Developing and maintaining effective working arrangements with the Northumberland CCG localities to support the commissioning and delivery of high quality, safe, value for money and effective services.
- Establishing working arrangements with other CCGs, Provider Trusts, the Local Authority, other health care partners, the NHS England/NHS Improvement Area and Regional Team and the clinical senate that would

support the integration of both health services with other health services and health services with health-related and social care services where the CCG considers that this would improve the quality of services or reduce inequalities.
- Ensuring that the views of patients and the public are properly reflected in the development of clinical recommendations to Governing Body.

Operational Management:

- Delivering target outcomes and outputs set by the Secretary of State, NHS England/NHS Improvement, NICE, CQC and other national/regional authorised bodies and providing assurance to the Governing Body in this respect.
- Ensuring the co-ordination and monitoring of the CCG's clinical work programme, in delivery of the CCG's annual commissioning plan.
- Approval of budgets, business cases, procurements, and contract variations up to £1m.
- Approving the CCG's operational procedures.
- Overseeing and managing the contract and annual work plan with the CCG's commissioning support services provider; and
- Review risks, assurance and controls relevant to the Clinical Management Board (and as aligned to corporate objectives).
- Receives assurance in relation to the quality of CCG commissioned services including primary care, and ensures appropriate arrangements are in place to ensure that services commissioned by the CCG (including those commissioned jointly with other organisations) are being delivered in a quality and safe manner.

In accordance with the terms of reference the CMB meets monthly. A total of 12 meetings of the CMB were held during the period April 2021 to March 2022, membership and attendance was as follows:

Title	Member	Attendance
Medical Director (Chair)	Dr Robin Hudson	9/12
Medical Director and Locality Director (Central) (Deputy Chair) *2	Dr John Warrington	12/12
Clinical Chair	Graham Syers	9/12
Locality Director (Blyth Valley) *1	Dr Paula Batsford	4/12
Locality Director (North)	Dr Chris Waite	9/12
Locality Director (North)	Tony Brown	7/12
Locality Director (West)	Dr Ben Frankel	10/12

Executive Director of Nursing, Quality and Patient Safety	Annie Topping	12/12
Service Director of Transformation and Integrated Care	Rachel Mitcheson	11/12
Chief Operating Officer	Siobhan Brown	11/12
Chief Finance Officer	Jon Connolly	11/12
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	11/12
Public Health Consultant	Dr James Brown	6/12

*1 Dr Paula Batsford stood down from her role as locality Director for Blyth Valley and Governing Body Members on 21 September 2021
*2 Dr John Warrington assumed temporary duties as Locality Director for Blyth Valley from 22 September 2021

Regular items on the agenda of the CMB meetings include:

- Updates on the issues discussed at the Safeguarding Group, Quality Safety Group and the Medicines Optimisation Group
- Review and approval of policies and strategies of the CCG
- Updates on the financial position, performance report and commissioning plan
- Updates on quality and safety issues

Subgroups of the Clinical Management Board

Quality and Safety Group

The principal function of the group is to assure the quality of commissioned services by:

- Monitoring and examining the soft and hard intelligence relating to the quality of services provided
- Identifying areas of concern and good practice
- Acting where appropriate
- Ensuring effective processes and systems are in place to manage clinical risks
- Ensuring mechanisms are in place to enable systematic quality outcome improvement including lessons have been learnt and embedded in relevant services
- Making recommendations for further action to CMB
- Providing assurance to CMB that quality sits at the heart of everything the CCG does and that its business is focussed on improving quality outcomes

In accordance with the terms of reference the Quality and Safety Group (QSG) meets on a bi-monthly basis. Six meetings were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Executive Director of Nursing, Quality and Patient Safety (Chair)	Annie Topping	6/6
Deputy Director of Quality and Patient Safety	Claire Coyne	6/6
Governing Body Secondary Care Doctor	Dr Marios Adamou	1/6
Integrated Care Lead	Fiona Kane	4/6
Acting Head of Quality and Patient Safety for Adults	Leesa Stephenson	6/6
Senior Clinical Quality Officer (NECS)	Sara Anderson/Kim Ewen	6/6
Locality Manager representative	Diane Gonsalez	4/6
Communications and Engagement Manager	Emma Robertson	4/6
Head of Performance and Assurance	David Lea	5/6
Medicines Optimisation Team Representative	Susan Turner	5/6
Public Health Commissioner	Dr James Brown	2/6

The group provides CMB with assurance in relation to the quality of CCG commissioned services including primary care. To achieve this, the Group will seek to promote a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience.

The group has no executive powers other than those specifically delegated by CMB.

Medicines Optimisation Group

The Medicines Optimisation Group (MOG) has been established as a sub-group of the CMB. The group is responsible for ensuring that the CCG:

- Is informed about prescribing performance and intervenes where appropriate to ensure high quality and cost effectiveness is maintained
- Has sufficient competence to achieve and maintain authorisation
- Maintains a presence on the relevant local medicines management groups
- Has a robust medicines management vision and strategy

The remit and responsibilities of the group are:

- Providing CCG representation to enable the CCG to influence and contribute to the Area Prescribing Committee and its sub-committees
- Reviewing data on prescribing performance relating to the CCG
- Informing the CMB of matters arising regarding cost, safety or quality relating to prescribing issues
- Providing close liaison with the commissioning medicines manager to ensure that competencies have been assured for authorisation
- Considering the commissioning priorities of the CCG and providing advice to the CCG on the implications of their commissioning priorities
- Providing oversight of the commissioning support function and providing the 'CCG contract management' of the arrangements for medicines management

In accordance with the terms of reference the MOG meets quarterly, with a minimum of three meetings per financial year. A total of four meetings of the MOG were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
CCG Locality Director/GP Prescribing Lead (Chair)	Dr Chris Waite	3/4
CCG Prescribing Management Lead	Alan Bell	4 /4
NECS - Senior Medicines Optimisation Pharmacist	Helen Seymour	4/ 4
NECS - Medicines Optimisation Pharmacist	Susan Turner	4 /4
Finance Lead	Subject to availability	4/ 4

Over the past year the Medicines Optimisation Group has been involved in several work areas. The group regularly monitors prescribing budgets, implements strategies to ensure cost effective prescribing and agrees the budget setting formula for practices. The main mechanism for delivery in primary care is the Practice Medicines Management scheme and this has continued to be developed in 2021/22. A prescribing decision support tool is used by all 37 practices to support high quality, cost effective prescribing. This allows best practice messages to be displayed to clinicians at the point of prescribing.

The group reviews the agenda and minutes of the Regional Prescribing Forum, Area Prescribing Committee (APC), Formulary Sub-committee and the Medicines Guidelines Group for consideration of matters requiring approval of the Clinical Management Board. The group receives a regular activity report from the North of England Commissioning Support Unit (NECS) on prescribing and ensures appropriate action is taken to mitigate prescribing quality, safety, and cost risk.

Safeguarding Group

The Safeguarding Group (SG) has been established as a sub-group of the CMB.

CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place, and that a robust framework is in place. CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. The group is responsible for providing assurance to the CMB that Northumberland CCG is discharging its responsibilities appropriately and effectively.

The remit and responsibilities of the group are:

- To oversee the implementation of the updated ‘Working Together to Safeguard Children’ statutory guidance and the new safeguarding arrangements to be in place at CCG level.
- To ensure compliance with the legal and regulatory requirements for safeguarding such as the Children and Social Work Act 2017, Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards.
- To ensure the CCG is fully engaged and contributed to national and local legislative safeguarding consultations and arrangements.
- To support the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk averse.

- To oversee the development and delivery of a CCG strategy, annual plan and local policies for safeguarding vulnerable adults and children.
- To ensure Designated Safeguarding Professionals play an active role in all parts of the commissioning cycle, from procurement to quality assurance.
- To gain assurance from all commissioned services (both NHS and independent healthcare providers) to ensure compliance with national safeguarding standards, and that effective systems are in place to safeguard and protect vulnerable adults and children and continuous improvement.
- To ensure lessons are shared and learned from Child Death Overview Process (CDOP), Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHR), local and national enquiries particularly in primary care.
- To oversee and facilitate the development of improvement activities in primary care on safeguarding.
- To ensure a programme of work is in place to assure the quality of safeguarding practices across adults and children such as audits, visits, reviews, training, attendance at provider committees, and feedback mechanisms etc.

In accordance with the terms of reference the group will meet bi-monthly. A total of six meetings of the SG were held during the period April 2021 to March 2022; membership and attendance was as follows:

Title	Member	Attendance
Executive Director of Nursing, Quality and Patient Safety (Chair)	Annie Topping	4/6
Deputy Director of Quality and Patient Safety	Claire Coyne	6/6
Clinical Chair	Graham Syers	4/6
Designated Nurse Safeguarding Children	Margaret Tench *1	3/6
Deputy Designated Nurse for Vulnerable People	Leesa Stephenson	6/6
Designated Doctor for Safeguarding Children	Naomi Jones	4/6
Designated Doctor for Looked After Children	Anna Redfern	2/6

*1 Margaret Tench left the CCG on 31 December 2021

UK Corporate Governance Code

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

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

As Accountable Officer I have overall responsibility for:

- Ensuring the implementation of an effective risk management strategy, including effective risk management systems and internal controls.
- The development of the corporate governance and assurance framework.
- Meeting all the statutory requirements and ensuring positive performance towards our strategic objectives.

Each of the directors of the CCG is responsible for:

- Coordinating operational risk in their specific areas in accordance with the risk management strategy.
- Ensuring that all areas of risk are assessed appropriately and action taken to implement improvements.
- Ensuring that staff under their management are aware of their risk management responsibilities in relation to the risk management strategy.
- Incorporating risk management as a management technique within the performance management arrangements for the organisation.

All members of staff are aware of their responsibilities in relation to the risk management strategy and policy. This ensures that risk is seen as the responsibility of all members of staff and not just senior managers.

Risk Management is embedded in the activity of the CCG through:

- The Risk Management Policy and supporting policies and procedures
- The Committee structures as described earlier
- Management processes
- The assurance framework
- Risk management skills training including both clinical risk assessments of various types and the mandatory and statutory training programme
- Governing Body development sessions
- The building of a counter fraud culture

The CCG considers that it had an effective risk management approach in place as demonstrated by the risk management arrangements set out below.

The risk management framework sets out how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives. This includes the processes and procedures adopted by the CCG to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

The CCG employs a standardised methodology in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources. As a result, risk management is an important element of the CCG's business planning processes.

The risk management policy outlines:

- The roles and responsibilities of the Governing Body, committees and CMB in respect of risk management
- The roles and responsibilities of officers for elements of risk management
- Access to specialist advice
- The risk management process in place within the CCG including the systematic identification, assessment, evaluation, and control of risks via mechanisms such as the assurance framework and the corporate risk register
- A description of risk management terms to ensure common understanding and full guidance on the risk analysis matrix for the grading of risk for priority

Risk (and change in risk) identification is achieved primarily through the following processes:

- Clinical and non-clinical risk assessment
- Complaints management
- Claims management
- Performance and finance and contracting monitoring and reports
- Incident reporting including serious and untoward incidents
- Audits (both internal and those carried out by external bodies)

The Governing Body sets boundaries to guide staff on the limits of risk they are able to accept in the pursuit of achieving its organisational objectives.

The Governing Body set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable.
- An opportunity: what the Governing Body is prepared to put 'at risk' in order to encourage innovation in creating changes.

The two main features of the risk management process are the assurance framework and risk registers. The CCG has adopted a bottom up approach to the generation of its risk registers. The purpose is to ensure that risks are identified and managed at the appropriate level and to provide a mechanism of escalation through the tiers that alerts the Audit Committee and the Governing Body to extreme and high risks.

During 2021/22 strategic and operational risks have been monitored by the relevant governance committees. The strategic and the corporate risk register for 2021/22 have been reviewed by the Audit Committee, Governing Body and the Clinical Management Board. The strategic risk register covers all the CCG's main activities including financial, clinical and organisational activities and identifies the principal objectives and targets that the organisation is striving to achieve and the risks to the achievement of these targets. It identifies actions that need to be taken to address gaps in control and assurance and a small number have been identified. Each action has an identified lead and is monitored throughout the year by the Governing Body.

The CCG recognises that for any risk management strategy to work, potential and actual risks and incidents must be reported, and action taken to prevent a recurrence. The Incident Reporting and Management Policy - CCG CO08 covers the reporting of all types of incidents, including near misses. Reporting of near misses where there has been no actual injury or loss may enable appropriate action to be taken to prevent future incidents.

The CCG has a responsibility for managing risks identified in the commissioning process to ensure the quality of the services it commissions is safe and of a high

standard. The CCG has a responsibility to ensure their contractors have effective systems in place to identify and manage risks and incidents and support them in the development of these where necessary. The CCG acts as a conduit for information about such risks and incidents, to ensure that the learning (and the opportunities for risk reduction) from them is not lost within the CCG or the wider NHS.

The CCG has an open and non-judgmental approach to the reporting of adverse incidents and encourages everyone within the organisation to contribute to the reporting and learning process. The processes and procedures in the incident reporting and management policy are not designed to apportion blame but focus on understanding the root cause of errors and learning from them to avoid a further reoccurrence.

Risk Assessment

The CCG has adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in the Risk Management Policy. Throughout the year the CCG identified and managed a range of risks, both strategic and operational.

Reports to the committees/groups of the CCG also included information on new and emerging risks. The strategic and operational risks will continue to be reviewed on a quarterly basis by the Governing Body, Clinical Management Board as well as Audit Committee meetings.

The high-level strategic risks managed throughout 2021/22 and considered by Governing Body and Audit Committee are summarised as follows:

System Resilience

As a result of a lack of robust planning for surges in demand for frontline services throughout the year, there is a risk that urgent and emergency care pressures increase and accident and emergency activity levels rise, which may result in multiple demands on ambulance, community, acute and primary care services. This may lead to impact on organisational performance at provider level, reputational impact on the CCG and a threat to the delivery of safe, high quality services.

The risks is mitigated by the work of the North ICP strategic Accident and Emergency Board, Winter Plans agreed by the North ICP Operations Board and the Post COVID-19 Recovery Plan and Commissioning Plan.

Allocation of Resources – Value for Money

As a result of not allocating resources effectively to achieve the best patient outcomes, there is a risk that the CCG does not allocate resources effectively to achieve the best patient outcomes.

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk is mitigated by the work of the Corporate Finance Committee, the Population Health Management Programme and the work of the System Transformation Board.

Ensure Services are High Quality and Safe

As a result of increased patient demand and limited resources (workforce and funding/finance) in the local health and care system and early stage development of Primary Care Networks (PCNs), there is a risk that the CCG is not able to commission the right services at the right time across different settings (acute, community, primary care, mental health and out of hospital) to meet the needs and improve the health of the population. This could result in poor patient outcomes, potentially unsafe services, failure of statutory obligations and reputational damage to the CCG.

This risk is mitigated by the work of the Northumberland Primary Care Commissioning Committee which reports and makes decisions on the primary care workforce programme, sustainability programme and quality assurance and improvement programme.

Robust processes are in place to monitor Mental Health commissioning including the ICS/ICP MH Workstream and performance matrix against deliverables of Long Term Plans, the Mental Health strategic meeting chaired by the North of England Commissioning Support Service (NECS) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) monthly contracting meetings and Quality Review Groups.

There are also robust processes in place in partnership with the Local Authority to monitor the quality of Continuing Healthcare (CHC) commissioning, including visits to providers, reviews of complaints and quality indicators at Joint Management Group meetings, and review of care packages.

Integrated Working

As a result of the NHS entering the transition phase of CCG closedown and the move into statutory Integrated Care Systems (ICSs) there is a risk of lack of communication and/or cooperation across and between system partners, lack of clarity on roles and responsibilities and a lack of shared vision and commitment. This could result in delayed decision making, derogation of patient care, increased financial costs and poor value for money, reputational damage to the CCG or failure to meet statutory duties.

This risk is mitigated by the work of the System Transformation Board and its quarterly reporting to the Health and Wellbeing Board. The North ICP are also working together across a range of professions and clinical portfolios. Place Based Working Developments and Workshops are ongoing as part of future ICS arrangements.

Safeguarding

As a result of failure to comply with good clinical practice, policies and procedures, there is a risk that the CCG is not able to manage safeguarding duties appropriately, including deprivation of liberty safeguards, liberty protection safeguards and delivery of the learning disabilities transformation programme.

This could result in vulnerable people's safety being compromised, a derogation of patient care, and legal challenge resulting in both reputational and financial damage to the CCG.

This risk is mitigated by the work of the CCG's Quality Safeguarding Group which is established as a sub-committee of the Clinical Management Board. There are also robust safeguarding children and adult policies in place, and robust processes in place for the identification of potential cases of deprivation of liberty that require investigation.

Financial Management

There is a risk that the CCG does not manage its finances effectively, resulting in a breach in the CCG's statutory responsibilities, reputational damage, non-achievement of Value for Money (VFM) and/or inappropriate allocation of resources across services. This risk is mitigated by the oversight of the Corporate Finance Committee, the robust processes embedded across the CCG including monthly financial reviews, regular meetings with budget managers and comprehensive monthly board reports. Robust financial governance is in place across the CCG and its member practices.

Mental Health Investment Standard (MHIS)

There is a risk that the CCG has insufficient funding and is unable to meet the MHIS. This could result in under resourced mental health services, increased scrutiny from NHS England and Reputational Damage.

This risk is mitigated by workforce planning meetings with NHS England and Providers. Investment decisions have been made and are being implemented.

CCG Operating Resilience

As a result of major external or internal events occurring there is a risk that they could lead to the CCG's ability to conduct routine business (e.g. loss of property or IT infrastructure, global pandemic, NHS organisational restructure) being compromised which may result in capacity or operational delivery gaps. This could lead to reduced operational output, a failure to deliver against statutory duties and damage to the CCG's reputation.

This risk is mitigated by robust business continuity arrangements.

Capacity and Capability

The CCG may have insufficient human resource or allocate human resource ineffectively across the CCG teams to deliver its functions.

This may result in the CCG not delivering its functions effectively; regulatory action from NHS England; increased cost and poor Value For Money; and reputational damage.

This risk is mitigated by the organisational development and human resources processes in place, with regular updates being provided to CFC and Audit Committee.

Communications and Engagement

As a result of a lack of effective engagement with CCG members, stakeholders and members of the public there is a risk of reduced input and buy-in for key service changes and population health management initiatives from across the system. This may result in sub-optimal service design and delivery and poor patient experience. This risk is mitigated by the robust communications and engagement strategies embedded within the CCG's ways of working.

Population Health and Inequalities

As a result of the complex and fragmented nature of health and social care data there is a risk that the CCG will not be able to access the insight and intelligence necessary to make informed decisions on population health needs based on evidence.

This may result in a widening of existing health inequalities and unmet need within our patient and population communities.
This risk is mitigated by the work of the population health management programme, quarterly reporting to CMB and System Transformation Board, and a robust governance system.

Effectiveness of Commissioning

As a result of the CCG failing in its duties to commission services which improve the health and wellbeing of the local population, there is a risk of subsequent failure to improve patient experience, deliver value for money and efficiencies, address healthcare inequalities and increase the engagement and wellbeing of patients and the workforce

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk is mitigated the Joint Strategic Needs Assessment being embedded in all planning processes, close working with public health colleagues and reporting to the Governing Body and the Health and Wellbeing Board.

Effectiveness of Corporate Governance

As a result of the CCG failing in its duties to commission services which improve the health and wellbeing of the local population, there is a risk of subsequent failure to improve patient experience, deliver value for money and efficiencies, address healthcare inequalities and increase the engagement and wellbeing of patients and the workforce.

This may result in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk is mitigated by the approved constitution, the information governance framework, and robust governance arrangements in place across the CCG and its member practices including standards of business conduct, conflict of interest management and anti-fraud arrangements.

High Level Operational Risks include:

Performance access targets for diagnosis and treatment

Failure to deliver key performance targets for diagnosis and treatment including 18 week Referral to treatment, six weeks for diagnostics and wide range of cancer targets Patients health suffers or they have poor experience, the CCG breaches its Outcomes Framework, or suffers reputational damage.

The CCG is releasing non- recurrent funding to support the clearance of backlogs enabling the providers to either outsource work or take on additional agency / locum staff.

Prescribing

There is a risk that inconsistent adherence to guidelines or formulary may lead to poor quality prescribing or drug shortages which could lead to patient safety and experience issues and unnecessary prescribing costs. This could ultimately result in reputational damage, legal challenge and unsustainable prescribing cost growth to the CCG.

This risk is mitigated by the work of the Medicines Optimisation Group which reports to the CCG's Clinical Management Board.

Coronavirus (COVID-19)

There is potential for the coronavirus outbreak to interrupt the business of the CCG or its providers, either due to increased staff sickness or potential disruption to supply chain. This could result in large work backlogs, impacts to staff welfare, impacts to patient welfare, increased costs.

This risk is mitigated by ICP level co-ordinated responses, command and control centre within the CCG, Business Continuity Plans and Governance procedures in place to continue due diligence around decision making and financial governance.

COVID-19 medium to long-term financial uncertainty for the CCG (ongoing provider costs or recurrent allocation funding changes)

Financial uncertainty for the CCG after the current COVID-19 financial provisions end, caused by increased surges in activity (e.g. providers clear backlogs on a return to Payment by Results (PbR) basis, costs are materially different from historic forecasts (e.g. transformation of services results in the underlying baseline activity and future capacity of hospitals and primary care changing), uncertainty over future CHC costs following the CHC Hospital Discharge Programme, and uncertainty as to

whether non-recurring allocations are included in current block contract arrangements. There is a potential that COVID-19 expenditure is not reimbursed or of the CCG returning to in year deficit as a result of COVID-19 impact and system wide management of positions.

This risk is mitigated by system planning at ICS and ICP level investigating potential gaps in financial requirements as part of the ICS planning process.

Provider Delivery

There is a risk that providers fail to meet key performance outcomes and cease operations leading to compromised patient care and the CCG having to introduce potentially expensive short term measures in response. NHS England could revoke the CCG's commissioning authority if found negligent. This could lead to increased financial pressure and reputational damage to the CCG.

This risk is being actioned by robust action plans in place in areas of concern such as spinal, cancer and other specialties. The CCG is working with the foundation trusts for triggers, early warning and solutions to the issues including cross foundation trust to foundation trust pathways.

Other sources of assurance

Internal Control Framework

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

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

The system of internal control is underpinned by the existence of a number of individual controls that are in place:

- Senior management/executive review
- Policies and procedures covering important activities
- Standing Financial Instructions and Scheme of Delegation
- The checks and balances inherent in internal and external audit reviews
- Governing Body oversight

In addition to management processes the CCG participates in the assurance process undertaken by NHS England; the outcome reports from these are presented to the Governing Body.

The CCG has an internal audit function which has been in place throughout 2021/22. An internal audit plan was drawn up and approved by the Audit Committee prior to the start of the financial year in March 2021.

Robust anti-fraud arrangements are in place within the CCG. The Counter Fraud, Bribery and Corruption Policy was approved by the Joint Locality Executive Board in August 2013. The policy provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation.

An anti-fraud plan for 2021/22, which is aligned to fraud, bribery, and corruption standards, was approved by the Audit Committee in July 2021. Progress against the plan has been reported during the year to the Audit Committee. Anti-fraud awareness training has been delivered to staff and members of the Governing Body and publicity material has been made available in practices. No proven issues of fraud have been identified during the period April 2021 to the date of signing of this statement.

The CCG has a Standards of Business Conduct Policy which was approved by JLEB in March 2015 and is revised annually. In January 2021 the policy was extended for 12 months in light of COVID-9. The policy forms part of the CCG's corporate governance framework, which requires it to issue guidance to members, officers, and employees on the acceptance of gifts/hospitality and the declaration of interests. The CCG is committed to ensuring the highest standards of professional and ethical conduct and this policy is intended to enable these standards to be met. This policy enables the CCG to comply with the Standards of business conduct for NHS staff, Health service guidelines HSG (93)5, 1993, the Prevention of Corruption Acts 1906 and 1916, the Bribery Act 2010 and the Seven Principles of Public Life (The Nolan Principles).

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

An annual internal audit of the CCG's conflicts of interest systems and management is undertaken. The outcome in 2021/22 was an assurance rating of 'significant assurance'. The area identified as requiring improvement was:
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- The CCG considers conflicts of interest when appointing governing body members, members of committees and sub committees and senior employees.

This action has been undertaken.

Data Quality

The CCG has a Data Quality Policy - CCG IG02, which was initially approved by the JLEB in January 2013 and has been reviewed regularly. The most recent version was approved by the Clinical Management Board in October 2020. The CCG recognises that all their decisions, whether healthcare, managerial or financial, need to be based on information which is of the highest quality. Data quality is crucial, and the availability of complete, accurate, relevant, and timely data is important in supporting patient/service user care, governance, management and service agreements for healthcare planning and accountability. The Governing Body and member practices are satisfied with the quality of data used to inform decision making and planning to deliver the commissioning agenda and to ensure the CCG meets its statutory requirements.

Information Governance

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

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

We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

The Information Governance agenda is considered at the Clinical Management Board. The CCG has also appointed a Caldicott Guardian and Senior Information Risk Owner.

The Data Security and Protection Toolkit will be completed by 30 June 2022.

NECS, as the provider of IT services to the CCG, has a range of controls in place. Control objectives include: physical access, logical access, segregation of duties, data transmissions, data centre environmental controls, IT processing, data integrity and backups, change management procedures, network security measures, data migration, problem and incident resolution, system recovery and disaster recovery. Assurance on the effectiveness of these controls is provided to the CCG through the ISAE 3204 report from NECS' internal auditors Deloitte LLP.

There are processes in place for incident reporting and this is reported to the Audit Committee as part of the governance assurance report provided by NECS. The Quality Safety Group has a specific remit to investigate serious incidents and monitor completion of the subsequent action plans. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Business Critical Model

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

I can confirm that all business-critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health and Social Care.

The CCG has a Business Continuity Management Plan, approved by the JLEB in December 2013 and reviewed annually. The most recent version was approved by Governing Body in October 2019. It has been regularly reviewed throughout the COVID-19 response.

Third party assurances

Delegation of functions

The CCG currently contracts with several external organisations for the provision of back office services and functions. These include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services (SBS). The use of SBS is mandated by NHS England for all CCGs and is fundamental in producing NHS England group financial accounts using an integrated financial ledger system
- The provision of core business services from the North of England Commissioning Support Unit (NECS)
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the Electronic Staff Record (ESR) payroll systems provided by IBM
- The provision of services from NHS Business Services Authority (BSA - prescribing)
- The provision of services from Capita Business Services Limited (Primary Care Co-commissioning)
- The provision of NHS Digital, (Primary Care Co-commissioning)

Assurances on the effectiveness of the controls in place for the above are received in part from an annual Service Audit Report from the relevant service providers as well as additional testing of controls that has been undertaken by the CCG's internal auditors.

Assurances received for these services are as follows:

NHS Shared Business Services (SBS)

The Independent service auditor's assurance report (ISAE 3402) on controls at NHS Shared Business Services Limited for the period 1st April 2021 to 31st March 2022 provided a qualified opinion. This is because the following control objective was not achieved:

- Controls exist to provide reasonable assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate.

North of England Commissioning Support Service (NECS)

The Report on Internal Controls (Type II) Finance and Payroll 1 April 2021 to 31 March 2022, provides a qualified opinion. This is because the following control objectives were not achieved:

- Credit notes raised are valid, accurate and processed in a timely manner.

- Amendments to user access rights are subject to the appropriate level of approval.

- Leavers access rights are removed from the system in a timely manner.

- Changes processed by the CSU to staff standing data are valid and are processed accurately, completely and in a timely manner.

Payroll

The auditors report provides the following assurances for the year ended 31 March 2022:

Payroll – Temporary Amendments, Exception Reporting and Payroll Processing – Substantial assurance

Payroll – Starters, Leavers and Amendments to Pay - Substantial assurance

Conclusion - the auditors report did not identify, as part of the internal audit work for 2021/22, any fundamental weaknesses in the systems reviewed that would put the achievement of the systems' objectives at risk and / or major and consistent non-compliance with the control framework that require management action as a matter of urgency.

Electronic Staff Record Programme (ESR)

The ISAE 3000 Type II Controls Report for the Electronic Staff Record Programme (ESR), for the period 1 April 2021 to 31 March 2022 provided a qualified opinion.

This is because the controls necessary to ensure that access to the development and production areas of the NHS hub was controlled and appropriately restricted, were not in place from 1 April 2021 to 6 June 2021 but were implemented on 7 June 2021. As a result, there were insufficient logical access controls in place to appropriately restrict access to the development and production area of the NHS hub for part of the reporting period and therefore controls were not suitably designed to achieve Control Objective 2 “Controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access” during the period 1 April 2021 to 6 June 2021.

NHS Business Services Authority (BSA)

The Type II ISAE 3402 Report for the period 1 April 2021 to 31 March 2022 relating to the NHS Business Services Authority: Prescription Payments Process provides a qualified opinion because controls were not suitably designed and did not operate effectively during the period 1 April 2021 to 31 March 2022 to achieve the following control objective:

- Controls are in place to provide reasonable assurance that access to systems is appropriately restricted.

NHS Digital

The Independent service auditor’s assurance report (Type II ISAE 3000 Report) for General Practitioners for the period 1 April 2021 to 31 March 2022 provided a qualified opinion. This is because the following control objectives were not achieved:

- Controls are in place to provide reasonable assurance that system change cannot be undertaken unless valid, authorised and tested.

- Controls are in place to provide reasonable assurance that access to systems is controlled.

Primary Care Support England, Capita Services Limited

The ISAE3402 Service Auditor Report in respect of primary care support England (PCSE) services from 1 April 2021 to 31 March 2022 provides a qualified opinion. This is because the auditors identified a qualification relating to the following control objectives:

- Controls provide reasonable assurance that GPs and Other Medical Practitioners (OMPs) pensions are calculated and deducted / paid completely and accurately based on a signed request form / authorised request.

- Controls provide reasonable assurance that the upload process of the payment files generated from PCSE Online to ISFE is performed completely and accurately.

- Controls provide reasonable assurance that logical access by internal Capita staff to NHAIS, Ophthalmic System (OPS) and PCSE Online is restricted to authorised individuals.

- Controls provide reasonable assurance that logical access by internal Capita staff to ISFE, Local Pharmacy Application (LPA), PCSE Online and Pensions Online (POL) are restricted to authorised individuals.

The service auditor reports received provided qualified opinions with some identified exceptions for some control objectives. A review has been carried out by the CCG on these control exceptions and it has been confirmed that the CCG has in place internal controls to mitigate the control exceptions identified.

Control Issues

Issues Reported at Month 9:

Quality and Performance – 52 week wait

Due to the local system responding and diverting resources in order to respond to the pressures of COVID-19, the volume of patients on the planned care waiting lists have increased along with unprecedented numbers of patients waiting in excess of both 52 weeks and 104 weeks.

Recovery is being addressed on an ICP footprint with local commissioners and providers working in collaboration. Initiatives used include the use of the independent sector, revising pathways, however the impact of staff absence and challenges in recruiting to vacancies is still impacting upon recovery along with the social distancing requirements and enhanced cleaning procedures limiting the capacity of clinics and operating theatres.

Whilst the breaches are across most specialties, the specialities with the highest volumes of breaches include ophthalmology, dermatology, plastics and orthopaedics. Within ophthalmology a significant volume of patients are awaiting cataract procedures. Newcastle-upon-Tyne Hospitals NHS Foundation Trust has created a new cataract operating facility off-site which has enhanced capacity and combined with the use of the independent sector is leading to significant reductions in the volume of excess waits.

Within dermatology, a new tele-dermatology pathway has been introduced enabling a high proportion of patients to be diagnosed online through the use of a digital app enhancing the volume of patients to be triaged. In managing the backlog particularly the patients diagnosed with cancer, staff from the plastics specialty have been assisting which in turn has impacted upon the patient awaiting routine plastic procedures.

Within trauma and orthopaedics, the COVID-19 restrictions have had a major impact upon complex spinal patients due to the higher infection risk. Many of the patients waiting in excess of 104 weeks are within this specialty. Whilst capacity is being addressed on a mutual aid basis, a business case to address the excess waits is being prepared by the Specialist Commissioning team.

Cancer

Although patients suspected or diagnosed with cancer have been prioritised for treatment throughout the pandemic, significant breaches are ongoing against the NHS Constitution metrics. Published performance against the 92% 2 week wait target within Northumberland at the end of November 2021 was 77.6% and against the 85% 62 day threshold 64.0%.

As well as workforce and clinical issues limiting treatment capacity, the reluctance of patients to come into hospital for diagnosis and treatment along with either themselves or family members testing positive for COVID-19 has had an impact on treatment times. Work is being coordinated across the providers to identify if these issues have had an impact on the later staging of cancer. A significant volume of the breaches have occurred within dermatology, the use of the revised tele-dermatology pathways continues to improve performance. In addition, excess breaches have been evident within the lower GI although the expanded use of the FiT test continues to make an improvement on the diagnosis of cancer and managing the volumes of patients that need to be seen. Revisions to the breast pathway along with the recruitment of additional radiology capacity continues to improve performance within this speciality.

Diagnostics

Northumberland performance in November 2021 was 10.8% excess waits above six weeks against a 1% threshold with local acute performance at 2.3% at NHCFT and 23.0% at NUTH. Performance is significantly improving due to the use of the independent sector and waiting list initiatives are underway within the main acute providers. There were excess breaches within the cardiology related specialties however these are now clearing. The increased use of the FiT test is also supporting the recovery of the Lower GI pathway.

Ambulance Services

The range of ambulance response time metrics are consistently underperformed against both at place and at organisation level. A wide range of measures are in place to improve future performance with focussed work on reducing handover delays, reducing conveyance to hospital, increased use of Hear and Treat. The projects have been enhanced by additional winter funding to increase Call Handlers for both NHS 111 and 999, increase the resources for clinical triage and the establishment of a performance and quality desk to troubleshoot/remove blockages in the system. Early indicators suggest these initiatives are having an impact although it will take some time before the higher level metrics are achieved.

Mental Health and Dementia

Serious Mental Illness Mental Health Checks – Q3 performance was 36.9% against a 60% target. Work is ongoing with GP practices to improve performance however pressure on the primary care services to delivery COVID-19 resilience has delayed the rollout of these health checks. The shortage of blood bottles also made an impact. Whilst the CCG has further incentivised the practices to focus on this area of work, it may not be possible to achieve the end of year target.

Improving Access to Psychological Therapies (IAPT) – whilst at place Northumberland performs well against the 50% recovery target, the major challenge continues to relate to the access target. Combined with low referral rates and pressures within the higher level steps, Northumberland is not achieving this particular target. The provider has reviewed clinical coding and is using a wider range of assessment tools to improve recovery rates. Outsourcing along with recruitment of locums is improving uptake, however it will be challenging to achieve the access target for the end of the year.

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

The CCG has delegated approval of a comprehensive system of internal control, including budgetary control that underpins the effective, efficient, and economic operation of the CCG, to the Governing Body. The Accountable Officer is held to account for ensuring that the CCG discharges this duty and provides assurance to the Governing Body. The Governing Body in providing assurance that the CCG is acting consistently with this duty is supported by the following committees:

Audit Committee – provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and

compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The internal audit service further supports the audit committee by evaluating and reporting on the effectiveness and adherence to the systems of internal controls that the CCG has in place.

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

Delivery of the financial plan has been delegated by the Governing Body to the Chief Finance Officer, who is the Governing Body's professional expert on finance and ensures, through robust systems and processes, the regularity and propriety of expenditure is fully discharged.

The Chief Finance Officer is also responsible for:

- Making arrangements to support, monitor and report on the CCG's finances
- Overseeing robust audit and governance arrangements leading to propriety in the use of CCG resources
- Advising the Governing Body on the effective, efficient, and economic use of its allocation to remain within that allocation and deliver required financial targets and duties
- Producing the financial statements for audit and publication in accordance with statutory requirements to demonstrate effective stewardship of public money and accountability to taxpayers
- Overseeing all financial systems and internal controls, including the development and modification of accounting systems
- Maintaining relationships with external professional advisors
- Managing relationships with internal and external audit functions and playing a leading role in liaison with any regulatory bodies

The CCG has a responsibility to ensure its expenditure does not exceed the aggregate of its allotments for the financial year. This responsibility has been delegated to the Governing Body which approves the rolling three-year financial plan, setting out the deployment of resources within allocations and the approach to delivery and risk mitigation. The Governing Body also approves and reviews the CCG's Scheme of Delegation and Standing Financial Instructions (SFIs). The Governing Body is held to account for the monitoring and overall delivery of financial performance and compliance with SFIs.

Counter fraud arrangements

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

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

- An Accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks
- The CCG Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.
- A member of the Governing Body is proactively and demonstrably responsible for tackling fraud, bribery, and corruption
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations

There were no reported incidents of fraud during 2021/22.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

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

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;
2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
3. Brought forward Internal Audit assurances;
4. An assessment of the organisation's response to Internal Audit recommendations, and
5. Consideration of significant factors outside the work of Internal Audit.

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

Area of Audit	**Level of Assurance Given**
Governance, Risk and Performance	Substantial
Conflicts of Interest	Substantial
Contract and Performance Management	Substantial
Key Financial Controls	Substantial
Continuing Health Care Payments	Substantial

Definitions of Assurance Levels

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

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

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

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

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

- The Governing Body
- The Audit Committee
- The Clinical Management Board
- Internal audit
- Other explicit review/assurance mechanisms.

The following arrangements highlight how the Governing Body assures itself that the system of internal control is effective.

The Governing Body

Governing Body agendas during the year were structured around the key risks and issues.

The Audit Committee

The Annual Internal Audit Plan, as approved by the Audit Committee, enables the Governing Body to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the assurance framework.

The Chief Operating Officer

The Chief Operating Officer (COO) is the Senior Information Responsible Officer (SIRO). The COO is a member of the Clinical Management Board (CMB) and the Governing Body and attends the Appointments and Remuneration Committee.

The Executive Director of Commissioning, Contracting and Corporate Governance

The Executive Director of Commissioning, Contracting and Corporate Governance is the executive lead for risk management and governance and is a member of the Governing Body and CMB.

The Executive Director of Nursing, Quality and Patient Safety

The Executive Director of Nursing, Quality and Patient Safety is the executive lead director for clinical governance and quality and is a member of the Governing Body, CMB and Chairs the Quality and Safety Group.

Internal Audit

During the year the CCG used Audit One as providers of internal audit services. The contract and associated internal audit plan specify that the delivery of the internal audit function will continue to follow the Public Sector Internal Audit Standards.

Some of the key areas included in the internal audit plan were around risk management arrangements, governance structures, commissioning arrangements and performance management. All planned audits were completed to time.

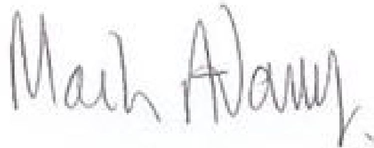
Conclusion

The system of control described in this report has been in place in the CCG for the year ended 31 March 2022 and up to the date of the approval of the annual report and accounts.

The work undertaken in 2021/22 across the range of assurance providers to the CCG has shown that:

- The CCG recorded an in-year surplus of £2.052m.
- The CCG remains with a cumulative deficit of £53.353m.
- While the CCG has been able to deliver its statutory requirements this year during the temporary financial arrangements imposed by government on the back of the COVID-19 pandemic, the CCG still has further work to do to maintain financial stability in future years on a possible return to Published Allocations. Its continued response to the COVID-19 situation working with its partner organisations will be an important part of this work.
- The Head of Internal Audit concluded an overall opinion of ‘substantial assurance’

I have concluded that the CCG had a sound system of internal control in place continuously throughout the year, designed to meet the organisation's objectives and the ongoing requirements of the COVID-19 response. Whilst financial controls are sound, the CCG will need to retain its focus on financial sustainability. In response to the COVID-19 pandemic, the priority recovery of services, and the impending statutory establishment of Integrated Care Boards, the CCG will need to look at innovative and cost-effective solutions whilst maintaining financial control into 2022/23.



Mark Adams
Accountable Officer
20 June 2022

Remuneration and Staff Report

Remuneration Report

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

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

It is considered that the Governing Body and Clinical Management Board members represent the senior managers of the CCG.

The members of the Governing Body and Clinical Management Board were all appointed through a robust recruitment interview process which was in line with the CCG's Constitution. All posts may be terminated by mutual agreement, resignation or dismissal in line with the CCG's Constitution.

Remuneration Policy

The appointment of the lay governors (including Deputy Lay Chair) and Governing Body Secondary Care Doctor is discussed and voted for by CCG members.

Remuneration for the posts of lay governors (including Deputy Lay Chair)and Governing Body Secondary Care Doctor, very senior managers and clinical leads are considered by the members of the CCG's Appointments and Remuneration Committee who make formal recommendations thereafter to Governing Body.

The Governing Body has an established Appointments and Remuneration Committee; its membership comprises the CCG Deputy Lay Chair (who chairs the Committee) and all other Lay Governors. The principal function of the Appointments and Remuneration Committee is to advise the Governing Body on senior appointments, about appropriate remuneration and terms of service, and determine the remuneration and terms of service of members of the Clinical Management Board and other staff directly accountable to the Accountable Officer or Chief Operating Officer.

The Chief Operating Officer is the lead officer for the committee and is invited to attend all meetings but withdraws from discussions relating to their own

remuneration. Other officers, employees, and practice representatives of the group are invited to attend all or part of meetings of the committee to provide advice or support as deemed necessary. They are not in attendance for discussions about their own remuneration or terms of service. Declarations of interest are made at the start of every meeting.

An annual salary review is undertaken to determine whether an annual uplift should be awarded and if so the level of the uplift. In making this decision, the Appointments and Remuneration Committee takes into consideration a number of factors including the level of pay awards made nationally to other staff groups within the NHS as well as NHS England guidance and the affordability to the organisation.

Performance evaluation of the Accountable Officer is undertaken by the Clinical Chair. The CCG Deputy Lay Chair also undertakes performance evaluation of other Lay governors including the Governing Body Secondary Care Doctor.

Performance evaluation of the Chief Operating Officer is undertaken by the Accountable Officer and CCG Clinical Chair. The CCG Clinical Chair and Chief Operating Officer undertake performance evaluation of the Locality Directors and Medical Directors. The Chief Operating Officer undertakes performance evaluation of the Chief Finance Officer, the Executive Director of Nursing, Quality and Patient Safety and the Director of Commissioning and Contracting.

The CCG currently has no provision for compensation for early termination or early retirement. Comparative information for the prior year is disclosed in the tables on the following pages.

All Pensions related benefit figures are received from NHS Pensions.

Remuneration of Very Senior Managers

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

Northumberland CCG has two senior managers that are paid more than £150,000 per annum on a pro-rata basis.

The Appointments and Remuneration Committee, as the Senior Salaries Review Body, critically reviews the salary of very senior managers when making recommendations to Governing Body regarding the remuneration.

The CCG had 18 senior managers in post at 31 March 2022.

Table 2: Northumberland CCG senior manager remuneration report 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Graham Syers	Clinical Chair	60-65	-	0-5	-	15-17.5	80-85
Janet Guy	Deputy Lay Chair	20-25	-	0-5	-	-	20-25
Karen Bower	Lay Governor	5-10	-	0-5	-	-	5-10
Steve Brazier	Lay Governor	5-10	-	0-5	-	-	5-10
Professor Marios Adamou	Secondary Care Doctor	5-10	-	0-5	-	-	5-10
Mark Adams	Accountable Officer	40-45	-	0-5	-	-	40-45
Jon Connolly	Chief Finance Officer	65-70	-	-	-	-	65-70
Siobhan Brown	Chief Operating Officer	120-125	-	0-5	-	32.5-35	160-165
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	55-55	-	0-5	-	7.5-10	65-70
Dr John Warrington	Medical Director/Locality Director/Business Director	65-70	-	0-5	-	27.5-30	90-95
Dr Paula Batsford	Locality Director	20-25	-	0-5	-	12.5-15	35-40
Dr Ben Frankel	Locality Director	35-40	-	0-5	-	10-12.5	45-50
Dr Chris Waite	Locality Director	25-30	-	0-5	-	5-7.5	30-35
Tony Brown	Locality Director	25-30	-	0-5	-	-	25-30
Dr Robin Hudson	Medical Director	80-85	-	0-5	-	152.5-155	230-235

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Paul Turner	Executive Director of Commissioning, Contracting and Corporate Governance	100-105	6	-	-	45-47.5	150-155
Rachel Mitcheson	Service Director – Transformation and Integrated Care	50-55	-	-	-	60-62.5	110-115
Dr James Brown	Consultant in Public Health	80-85	-	-	-	45-47.5	125-130
Pamela Lee	Consultant in Public Health	30-35	1	-	-	-	30-35

Notes to senior manager remuneration report 2021/22

Expenses payments (taxable) are shown in £00 and include lease car allowances and mileage claims.

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

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

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

Dr Paula Batsford left the Locality Director role on 22 September 2021. Remuneration relates to the Locality Director role.

40% of Executive Director of Nursing, Quality & Patient Safety role is recharged to NHS England.
50% of Service Director Transforming Integrated Care role is recharged to Northumberland County Council.

Dr James Brown and Pamela Lee are employed by Northumberland CCG in Consultant in Public Health roles. This is recharged in full to Northumberland County Council.

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

Staff sharing arrangement for senior manager remuneration 2021/22

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

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

Rachel Mitcheson is employed by Northumberland CCG and works for Northumberland County Council as part of a staff sharing arrangement.

Annie Topping is employed by Northumberland CCG and works for NHS England as part of a staff sharing arrangement.

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

Table 3: Northumberland CCG staff sharing arrangement 2021/22 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) to nearest £100 £00	**TOTAL** (bands of £5,000) £ 000
Mark Adams	Accountable Officer	170-175	-	170-175
Jon Connolly	Chief Finance Officer	140-145	-	140-145
Rachel Mitcheson	Service Director – Transformation and Integrated Care	100-105	-	100-105
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	90-95	-	90-95

Table 4:Northumberland CCG senior manager remuneration report 2020/21 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Graham Syers	Clinical Chair	60-65	-	-	-	40-42.5	100-105
Janet Guy	Deputy Chair	20-25	-	-	-	-	20-25
Karen Bower	Lay Governor	5-10	-	-	-	-	5-10
Steve Brazier	Lay Governor	5-10	-	-	-	-	5-10
Professor Marios Adamou	Secondary Care Doctor	5-10	-	-	-	-	5-10
Mark Adams	Accountable Officer	40-45	-	-	-	-	40-45
Jon Connolly	Chief Finance Officer	65-70	-	-	-	-	65-70
Siobhan Brown	Chief Operating Officer	120-125	-	-	-	30-32.5	155-160
Annie Topping	Director of Nursing, Quality & Patient Safety	90-95	10	-	-	22.5-25	115-120
Dr John Warrington	Business Director	65-70	-	-	-	47.5-50	115-120
Dr Paula Batsford	Locality Director	50-55	-	-	-	10-12.5	60-65
Dr Ben Frankel	Locality Director	35-40	-	-	-	7.5-10	45-50
Dr Chris Waite	Locality Director	25-30	-	-	-	20-22.5	45-50
Tony Brown	Locality Director	25-30	-	-	-	27.5-30	50-55
Dr Robin Hudson	Clinical Lead – Quality, Cancer and End of Life	75-80	-	-	-	25-27.5	100-105
Paul Turner	Director of Commissioning and Contracting	95-100	8	-	-	52.5-55	150-155

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Rachel Mitcheson	Service Director – Transformation and Integrated Care	45-50	-	-	-	190-192.5	235-240
Karen Rodman	Health Pathways Lead	10-15	-	-	-	-	10-15
Debra Elliott	Deputy Head of Governance	See note below					
Dr James Brown	Consultant in Public Health	80-85	-	-	-	27.5-30	110-115
Pamela Lee	Consultant in Public Health	15-20	-	-	-	0-2.5	15-20

Notes to senior manager remuneration report 2020/21

Expenses payments (taxable) are shown in £00 and include lease car allowances and mileage claims.

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

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

Debra Elliot left the Deputy Head of Governance role on 31 July 2020. Debra Elliott is employed by North of England Commissioning Support Unit and recharged to the CCG as part of a Commissioning Delivery Support Service Level Agreement. Salary and pension related benefits information is not reported because Debra Elliot is not a senior manager of that organisation.

50% of Service Director Transforming Integrated Care role is recharged to Northumberland County Council.

Dr James Brown and Pamela Lee are employed by Northumberland CCG in Consultant in Public Health roles. This is recharged in full to Northumberland County Council.
Karen Rodman left the Health Pathways Lead role on 31 August 2020.

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

Staff sharing arrangement for senior manager remuneration 2020/21

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

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

Rachel Mitcheson is employed by Northumberland CCG and works for Northumberland County Council as part of a staff sharing arrangement.

The total remuneration earned for all work across all organisations in 2020/21 is shown below:

Table 5: Northumberland CCG staff sharing arrangement 2020/21 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) to nearest £100 £00	**TOTAL** (bands of £5,000) £ 000
Mark Adams	Accountable Officer	170-175	-	170-175
Jon Connolly	Chief Finance Officer	135-140	5	135-140
Rachel Mitcheson	Service Director – Transformation and Integrated Care	95-100	-	95-100

Table 6. Northumberland CCG senior officers pension benefits 2021/22 (this has been subject to audit)

		Real increase in pension at pension age	**Real increase in pension lump sum at pension age**	**Total accrued pension at pension age at 31 March 2022**	**Lump sum at pension age related to accrued pension at 31 March 2022**	**Cash Equivalent Transfer Value at 1 April 2021**	**Real Increase in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value at 31 March 2022**	**Employer's contribution to stakeholder pension**
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Graham Syers	Clinical Chair	0-2.5	0-2.5	15-20	35-40	288	14	311	-
Siobhan Brown	Chief Operating Officer	2.5-5	-	20-25	10-15	306	20	344	-
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	0-2.5	-	35-40	105-110	852	25	890	-
Dr John Warrington	Medical Director/Locality Director/Business Director	0-2.5	0-2.5	20-25	40-45	332	23	365	-
Dr Paula Batsford	Locality Director	0-2.5	0-2.5	10-15	25-30	213	11	232	-
Dr Ben Frankel	Locality Director	0-2.5	0-2.5	10-15	25-30	169	8	180	-
Dr Chris Waite	Locality Director	0-2.5	0-2.5	5-10	25-30	179	7	190	-
Tony Brown	Locality Director	-	-	15-20	-	238	-	227	-
Dr Robin Hudson	Medical Director	5-7.5	12.5-15	25-30	45-50	324	132	466	-

Paul Turner	Executive Director of Commissioning, Contracting and Corporate Governance	2.5-5	2.5-5	20-25	30-35	235	24	272	-
Rachel Mitcheson	Service Director – Transformation and Integrated Care	2.5-5	2.5-5	30-35	70-75	530	52	596	-
Dr James Brown	Consultant in Public Health	2.5-5	0-2.5	20-25	40-45	348	32	390	-
Pamela Lee	Consultant in Public Health	-	-	25-30	80-85	-	-	-	-

Pension information provided by NHS Pensions

Cash equivalent transfer values at 1 April 2021 have been inflated by 0.5% in accordance with NHS Business Services Authority instruction.

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

Table 7. Northumberland CCG senior officers pension benefits 2020/21 (this has been subject to audit)

		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
		(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Dr Graham Syers	Clinical Chair	0-2.5	2.5-5	15-20	35-40	242	35	286	-
Siobhan Brown	Chief Operating Officer	0-2.5	-	20-25	10-15	269	18	305	-
Annie Topping	Director of Nursing, Quality & Patient Safety	0-2.5	2.5-5	35-40	105-110	792	44	848	-
Dr John Warrington	Business Director	2.5-5	2.5-5	20-25	40-45	283	38	331	-
Dr Paula Batsford	Locality Director	0-2.5	-	10-15	25-30	196	8	212	-
Dr Ben Frankel	Locality Director	0-2.5	0-2.5	5-10	20-25	156	8	168	-
Dr Chris Waite	Locality Director	0-2.5	0-2.5	5-10	25-30	156	19	178	-
Tony Brown	Locality Director	0-2.5	-	15-20	-	211	22	237	-
Dr Robin Hudson	Clinical Lead – Quality, Cancer and End of Life	0-2.5	0-2.5	15-20	30-35	292	20	323	-

Paul Turner	Director of Commissioning and Contracting	2.5-5	2.5-5	15-20	30-35	193	29	234	-
Rachel Mitcheson	Service Director – Transformation and Integrated Care	7.5-10	20-22.5	30-35	65-70	359	155	527	-
Dr James Brown	Consultant in Public Health	0-2.5	0-2.5	20-25	40-45	314	21	346	-
Pamela Lee	Consultant in Public Health	0-2.5	0-2.5	35-40	105-110	-	-	-	-

Pension information provided by NHS Pensions

Cash equivalent transfer values at 1 April 2020 have been inflated by 1.7% in accordance with NHS Business Services Authority instruction.

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

Cash equivalent transfer values

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

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

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

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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

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

There was no compensation on early retirement for loss of office paid during 2021/22.

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

There were no payments to past members paid during 2021/22.

Fair pay disclosure (This has been subject to audit)

Percentage change in remuneration of highest paid director

	Salary and allowances %	Performance pay and bonuses %
The percentage change from the previous financial year in respect of the highest paid director	0.0	100%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	(2.9)	100%

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

Average percentage change from previous financial year for employees as a whole is calculated on an annualised salary basis and is impacted by the movement in the full time equivalent number of employees in 2021/22. In 2021/22 CCG Agenda for Change employees received a 3 per cent pay award uplift in line with NHS Pay Review Bodies' recommendations.

The percentage change from the previous financial year for performance pay and bonuses is 100% as a non-consolidated payment was paid to senior managers that were not on a national pay framework in 2021/22. These managers did not receive a consolidated pay rise. No performance pay or bonuses were paid to employees in 2020/21.

Pay ratio information

Remuneration of Northumberland CCG staff is shown in the table below:

2021/22	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,057	£54,764	£108,639
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,057	£54,764	£108,075
2020/21			
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£40,307	£51,668	£100,481
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£38,890	£51,668	£100,481

Total annualised remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The range includes staff in part time roles.

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

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

The banded remuneration of the highest paid director in Northumberland CCG in the financial year 2021/22 was £125-130k (2020/21: £120-125k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021/22	3.2:1	2.3:1	1.2:1
2020/21	3.0:1	2.4:1	1.2:1

In 2021/22, no employee (2020/21, no employee) received remuneration in excess of the highest paid director excluding shared staff posts; where shared staff posts are senior managers of the CCGs, these are disclosed separately in the 'Shared Arrangements' disclosure.

Remuneration ranged from £22,000 to £170,000 (2020/21: £20,000 to £168,000). The range does not reflect actual values paid as this includes the annualised remuneration for part time employees and employees from other organisations employed in shared staff posts.

The 2021/22 remuneration ratios remain at a consistent level to 2020/21 remuneration ratios due to marginal changes to the overall number, composition and remuneration of the workforce.

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

Staff numbers and costs are analysed by permanent employees and 'other.' Permanently employed refers to members of staff with a permanent (UK) employment contract directly with the CCG.

Other refers to any staff engaged that do not have a permanent (UK) employment contract with the CCG. This includes employees on short term contracts of employment and agency/temporary staff.

The figures exclude lay members of the Governing Body.

Table 8: Northumberland CCG average number of people employed

	Permanent Employees	Other	Total
Average number of people employed	53.10	0.16	53.26

Average number based upon full time equivalent.

Table 9: Northumberland CCG staff costs

	Permanent Employees	Other	Total
Staff costs	£'000	£'000	£'000
Salaries and wages	3,066	7	3,073
Social security costs	327	-	327
Employer Contributions to NHS Pension scheme	525	-	525
Apprentice Levy	1	-	1
Staff costs	3,919	7	3,926

Staff costs exclude lay members of the Governing Body

Staff composition

The CCG has a staff headcount of 69 employees (including non-executives and chair) as at the 31 March 2022. This includes 4 very senior managers and 65 other CCG Employees.

Below is the gender split for the headcount:

Table 10: Northumberland CCG staff gender profile at 31 March 2022

	Total	Male	%	Female	%
Very Senior managers	4	2	50.0%	2	50.0%
Other CCG employees	65	22	33.8%	43	66.2%
Total CCG employees	**69**	**24**	**34.8%**	**45**	**65.2%**
Governing Body members	15	11	73.3%	4	26.7%

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

Staff sickness absence

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

Table 11: Northumberland CCG staff sickness absence data

	2021/22 Number	2020/21 Number
Total days lost	777	293
Average working days lost	**14.5**	**6**

Staff Turnover

Staff turnover of permanent employees is reported as a percentage of the average number of people employed. The staff turnover percentage in 2021/22 was 11% (2020/21: 12%).

Staff policies

The CCG has a suite of staff policies in place. The CCG has taken steps throughout 2021/22 to maintain and develop the provision of information to, and consultation with employees, including:

- Providing employees with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the CCG's performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the CCG
- Membership of the North East Partnership Forum, where staff representatives and CCG managers from across the region meet together
- Health and Safety

The CCG has a positive attitude to recruitment, employment, training and development of disabled persons. The CCG has successfully renewed its accreditation as a Two Tick Disability employer. The symbol, awarded by Jobcentre Plus, demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

Trade union representation

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

During 2021/22 there were no employees of Northumberland CCG who were trade union representatives.

Expenditure on consultancy

There was no consultancy expenditure incurred in 2021/22 (2020/21, nil).

Off-payroll engagements

New off-payroll engagements longer than 6 months

There were no new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months.

Table 12: Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	19

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

No exit packages including special (non-contractual) payments were made in 2021/22.

Parliamentary Accountability and Audit Report

NHS Northumberland CCG is not required to produce a Parliamentary Accountability and Audit Report. The CCG has no disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges. An audit certificate and report is also included in this Annual Report from page 149.

Independent auditor's report to the Governing Body of NHS Northumberland Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Northumberland Clinical Commissioning Group ('the CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in

accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Emphasis of Matter – transfer of the CCG's functions to the Integrated Care Board

We draw attention to notes 1.1 (going concern) and 14 (events after the reporting period) of the financial statements, which highlight that the Health and Care Act 2022 gained Royal Assent on 28 April 2022. As disclosed in notes 1.1 and 14 of the financial statements, it is the intention that the CCG's functions will transfer to a new Integrated Care Board from 1 July 2022. Given services will continue to be provided by another public sector entity, the financial statements are prepared on a going concern basis. Our opinion is not modified in respect of this matter.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is

materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2021/22 and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted

in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice and as required by the Local Audit and Accountability Act 2014.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the CCG, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates including year-end expenditure accruals, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management, the Audit Committee and the Governing Body the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the CCG which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management, the Audit Committee and the Governing Body on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing and testing year-end expenditure accruals.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management, the Audit Committee and the Governing Body. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the members of the Governing Body of NHS Northumberland CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

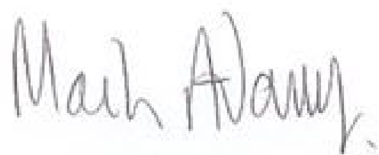
Certificate

We certify that we have completed the audit of NHS Northumberland CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell (Key Audit Partner)
For and on behalf of Mazars LLP

The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Date: 21 June 2022



Mark Adams
Accountable Officer
20 June 2022

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Other operating revenue	2	(100)	(145)
Total operating revenue		**(100)**	**(145)**
Staff costs	3	3,926	3,604
Purchase of goods and services	4	614,346	598,499
Depreciation charges	4	551	250
Other operating expenditure	4	136	132
Total operating expenditure		**618,959**	**602,485**
Comprehensive Net Expenditure for the year ended 31 March 2022		**618,859**	**602,340**

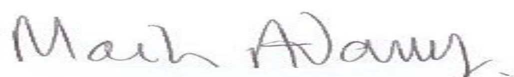
The notes on pages 5 to 16 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £'000	31 March 2021 £'000
Non-current assets:			
Property, plant and equipment	7	-	551
Total non-current assets		-	551
Current assets:			
Trade and other receivables	8	1,432	677
Cash and cash equivalents	9	213	376
Total current assets		**1,645**	**1,053**
Total assets		**1,645**	**1,604**
Current liabilities:			
Trade and other payables	10	(35,559)	(35,365)
Total current liabilities		**(35,559)**	**(35,365)**
Assets less liabilities		**(33,914)**	**(33,761)**
Financed by Taxpayers' Equity			
General fund		(33,914)	(33,761)
Total Taxpayers' Equity		**(33,914)**	**(33,761)**

The notes on pages 5 to 16 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit Committee on 10th June 2022 and signed on its behalf by:



Accountable Officer
Mark Adams

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000
Changes in Taxpayers' Equity for 2021-22	
Balance at 01 April 2021	(33,761)
Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2021-22	
Net operating expenditure for the financial year	(618,859)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(618,859)**
Net funding	618,706
Balance at 31 March 2022	**(33,914)**

	General fund £'000
Changes in Taxpayers' Equity for 2020-21	
Balance at 01 April 2020	(33,431)
Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2020-21	
Net operating costs for the financial year	(602,340)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(602,340)**
Net funding	602,010
Balance at 31 March 2021	**(33,761)**

The notes on pages 5 to 16 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(618,859)	(602,340)
Depreciation and amortisation	4	551	250
Decrease in trade & other receivables	8	(755)	754
(Decrease)/Increase in trade & other payables	10	194	(313)
Net Cash Outflow from Operating Activities		**(618,869)**	(601,649)
Net Cash Outflow before Financing		**(618,869)**	(601,649)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		618,706	602,010
Net Cash Inflow from Financing Activities		**618,706**	602,010
Net Increase/(Decrease) in Cash & Cash Equivalents	9	**(163)**	361
Cash & Cash Equivalents at the Beginning of the Financial Year		**376**	15
Cash & Cash Equivalents at the End of the Financial Year		**213**	376

The notes on pages 5 to 16 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual (GAM) 2021-22 issued by the DHSC. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 Accounting Convention

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

1.3 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement with Northumberland County Council, under Section 75 of the National Health Service Act 2006. Under the arrangement, each commissioner is responsible for decisions on the use of the resources held by them under the Section 75. The CCG is accounting for its own transactions without recognising a share of the assets, liabilities, revenue and expenditure of the pooled budget. See Note 12 for further details.

1.4 Revenue

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

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

1.5 Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 Retirement Benefit Costs

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

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

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

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, Plant & Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost, irrespective of their individual or collective cost.

1.7.2 Measurement

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

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

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

1.7.3 Subsequent Expenditure

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

Notes to the financial statements

1.8 Depreciation

Depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

1.9 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. The Clinical Commissioning Group does not hold any Finance leases.

1.9.1 The Clinical Commissioning Group as Lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 Cash & Cash Equivalents

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

1.11 Clinical Negligence Costs

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

1.12 Non-clinical Risk Pooling

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.13 Financial Assets

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the Clinical Commissioning Group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial assets for the Clinical Commissioning Group are classified at amoritised cost.

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

1.13.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.13.2 Impairment

For all financial assets measured at amortised cost or at fair value the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

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

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

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

Notes to the financial statements

1.14 **Financial Liabilities**

Financial liabilities are recognised when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

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

1.15 **Value Added Tax**

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

1.16 **Losses & Special Payments**

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

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

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

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

1.17.1 **Critical accounting judgements in applying accounting policies**

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

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

1.17.2 **Sources of estimation uncertainty**

The following assumption about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.The main estimate in 2021-22 related to prescribing expenditure which is one month in arrears and is based on BSA profiling. The accrual within the accounts is for the month of March only and is £5.4m (£5.5m in 20-21).

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23. However, the CCG does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

2 Other Operating Revenue

	2021-22 Total	2021-22 Admin	2021-22 Programme	2020-21 Total	2020-21 Admin	2020-21 Programme
	£'000	£'000	£'000	£'000	£'000	£'000
Other non contract revenue	100	24	**76**	145	20	125
Total other operating revenue	**100**	**24**	**76**	**145**	**20**	**125**

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

3 Employee benefits and staff numbers

3.1 Employee Benefits

	2021-22 Total	2021-22 Permanent Employees	2021-22 Other	2020-21 Total	2020-21 Permanent Employees	2020-21 Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,073	3,066	7	2,812	2,799	13
Social security costs	327	327	0	292	292	0
Employer Contributions to NHS Pension scheme	525	525	0	500	500	0
Apprentice Levy	1	1	0	0	0	0
	3,926	**3,919**	**7**	**3,604**	**3,591**	**13**

3.2 Average number of people employed

	2021-22 Total	2021-22 Permanently employed	2021-22 Other	2020-21 Total	2020-21 Permanently employed	2020-21 Other
	Number	Number	Number	Number	Number	Number
Total	**53.26**	**53.10**	**0.16**	**48.72**	**48.59**	**0.13**

3.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit Schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

3.3.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

3.3.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

For 2021-22, employers’ contributions of £524,720 were payable to the NHS Pensions Scheme (2020-21: £499,668) at the rate of 20.68% of pensionable pay. The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts as per Note 3.1

4 Operating expenses

	2021-22			2020-21		
	Total	**Admin**	**Programme**	**Total**	**Admin**	**Programme**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Services from other CCGs and NHS England	2,537	1,418	1,119	2,704	1,404	1,300
Services from foundation trusts	397,438	-	397,438	378,716	9	378,707
Services from other NHS trusts	0	-	0	19	-	19
Purchase of healthcare from non-NHS bodies	83,239	-	83,239	91,005	-	91,005
Purchase of social care	13,796	-	13,796	12,996	-	12,996
Prescribing costs	56,394	-	56,394	56,475	-	56,475
GPMS/APMS and PCTMS	57,458	-	57,458	53,143	-	53,143
Supplies and services – clinical	2,351	-	2,351	2,243	-	2,243
Supplies and services – general	191	158	33	134	132	2
Establishment	276	184	92	267	127	140
Premises	471	146	325	569	160	409
Audit fees	58	58	-	58	58	-
Non-audit services	3	3	-	8	8	-
Other professional fees	92	92	-	61	61	-
Legal fees	22	22	-	94	94	-
Education, training and conferences	20	20	-	7	7	-
Depreciation	551	-	551	250	-	250
Chair and Non Executive Members	132	132	-	128	128	-
Clinical negligence	4	4	-	4	4	-
Total operating expenditure	**615,033**	**2,237**	**612,796**	**598,881**	**2,192**	**596,689**

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

GPMS/APMS and PCTMS relates to Primary Care Commissioning.

The external auditor of the Clinical Commissioning Group is Mazars LLP. The audit fee for 2021-22 including VAT, was £58k (£58k in 2020-21).

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

The expenditure within Other Professional fees includes £51k for internal audit services provided by AuditOne (£50k in 2020-21).

Expenses related to Rentals under Operating Leases are within the Establishment and Premises lines. These costs can be seen in Note 6 - Operating Leases.

5 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,792	153,402	7,869	155,716
Total Non-NHS Trade Invoices paid within target	7,762	152,590	7,849	155,622
Percentage of Non-NHS Trade invoices paid within target	**99.61%**	**99.47%**	**99.75%**	**99.94%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	265	400,378	916	385,242
Total NHS Trade Invoices Paid within target	263	400,376	911	385,191
Percentage of NHS Trade Invoices paid within target	**99.25%**	**100.00%**	**99.45%**	**99.99%**

6 Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Minimum lease payments	144	1	145	159	1	160
Total	**144**	**1**	**145**	**159**	**1**	**160**

6.1.2 Future minimum lease payments	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	142	1	143	130	1	131
Between one and five years	273	1	274	-	4	4
After five years	-	-	-	-	-	-
Total	**415**	**2**	**417**	**130**	**5**	**135**

7 Property, plant and equipment

2021-22	**Plant & machinery £'000**	**Transport equipment £'000**	**Information technology £'000**	**Total £'000**
Cost or valuation at 01 April 2021	1,999	22	31	2,052
Cost/Valuation at 31 March 2022	**1,999**	**22**	**31**	**2,052**
Depreciation 01 April 2021	1,448	22	31	1,501
Charged during the year	551	-	-	551
Depreciation at 31 March 2022	**1,999**	**22**	**31**	**2,052**
Net Book Value at 31 March 2022	**-**	**-**	**-**	**(0)**
Purchased	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**
Asset financing:				
Owned	-	-	-	-
Total at 31 March 2022	**-**	**-**	**-**	**-**

2020-21	**Plant & machinery £'000**	**Transport equipment £'000**	**Information technology £'000**	**Total £'000**
Cost or valuation at 01 April 2020	1,999	22	31	2,052
Cost/Valuation at 31 March 2021	**1,999**	**22**	**31**	**2,052**
Depreciation 01 April 2020	1,198	22	31	1,251
Charged during the year	250	-	-	250
Depreciation at 31 March 2021	**1,448**	**22**	**31**	**1,501**
Net Book Value at 31 March 2021	**551**	**-**	**-**	**551**
Purchased	551	-	-	551
Total at 31 March 2021	**551**	**-**	**-**	**551**
Asset financing:				
Owned	551	-	-	551
Total at 31 March 2021	**551**	**-**	**-**	**551**

	Asset lives (years)
Plant & machinery	8
Transport equipment	4
Information technology	4

Within the 2021/22 financial year it was determined that the assets within Plant & Machinery were no longer in use.
As such the net book value remaining on the asset has been taken to operating expenditure in year.

8 Trade and other receivables

	31-Mar-22 £'000	31-Mar-21 £'000
NHS receivables: Revenue	1,018	294
NHS accrued income	80	-
Non-NHS and Other WGA receivables: Revenue	107	233
Non-NHS and Other WGA prepayments	141	147
Non-NHS and Other WGA accrued income	65	-
VAT	21	3
Total trade & other receivables	**1,432**	**677**

8.1 Receivables past their due date but not impaired

	31-Mar-22 £'000	31-Mar-21 £'000
By up to three months	7	24
By three to six months	-	31
By more than six months	-	6
Total	**7**	**61**

£7k of the amount above has subsequently been recovered post the statement of financial position date.

9 Cash and cash equivalents

	31-Mar-22 £'000	31-Mar-21 £'000
Balance at 01 April 2021	376	15
Net change in year	(163)	361
Balance at 31 March 2022	**213**	**376**
Made up of:		
Cash with the Government Banking Service	213	376
Balance at 31 March 2022	**213**	**376**

10 Trade and other payables

	31-Mar-22 £'000	31-Mar-21 £'000
NHS payables: Revenue	484	1,004
NHS accruals	1,897	227
Non-NHS and Other WGA payables: Revenue	7,391	6,286
Non-NHS and Other WGA accruals	24,175	25,638
Social security costs	51	49
Tax	57	48
Other payables and accruals	1,504	2,113
Total trade & other payables	**35,559**	**35,365**

Other payables include £596k outstanding pension contributions as at 31 March 2022 (£588k in 2020-21) - £59k for Clinical Commissioning Group employees (£58k in 2020-21) and £537k for Primary Care through Delegated Co-Commissioning (£530k in 2020-21).

11 Financial instruments

11.1 Financial assets	Financial Assets measured at amortised cost 31-Mar-22 £'000	Financial Assets measured at amortised cost 31-Mar-21 £'000
Trade and other receivables with NHSE bodies	1,039	186
Trade and other receivables with other DHSC group bodies	59	203
Trade and other receivables with external bodies	172	138
Cash and cash equivalents	213	376
Total at 31 March 2022	**1,483**	**903**

11.2 Financial liabilities	Financial Liabilities measured at amortised cost 31-Mar-22 £'000	Financial Liabilities measured at amortised cost 31-Mar-21 £'000
Trade and other payables with NHSE bodies	481	667
Trade and other payables with other DHSC group bodies	1,963	758
Trade and other payables with external bodies	33,007	33,843
Total at 31 March 2022	**35,451**	**35,268**

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

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

12 Pooled Budgets

Under s75 of the 2006 NHS Act, the Clinical Commissioning Group has entered into a pooled budget agreement with Northumberland County Council in relation to the Better Care Fund, which the Council hosts.

The actual contractual arrangements do not result in joint control being established, thus the CCG accounts for transactions on a gross accounting basis. The Clinical Commissioning Group's expenditure, as determined by the pooled budget agreement is shown below:-

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22 Expenditure £'000	Amounts recognised in Entities books ONLY 2020-21 Expenditure £'000
Better Care Fund	NHS Northumberland CCG / Northumberland County Council	To integrate health and social care services, reduce hospital based care and promote community based services	26,708	25,418

13 Related party transactions

Details of related party transactions are as follows:

		2021-22				2020-21			
		Expenditure with Related Party £'000	Income from Related Party £'000	Creditors owed to Related Party £'000	Debtors due from Related Party £'000	Expenditure with Related Party £'000	Income from Related Party £'000	Creditors owed to Related Party £'000	Debtors due from Related Party £'000
Director Related Organisations	**Director**								
ALNWICK MEDICAL GROUP	Dr Graham Syers	3,805	0	1,058	0	3,577	0	592	0
BROCKWELL MEDICAL GROUP	Dr John Warrington	0	0	0	0	1,571	0	0	0
VALENS MEDICAL PARTNERSHIP	Dr John Warrington	8,709	0	562	0	2,167	0	535	0
PONTELAND MEDICAL GROUP	Dr Robin Hudson	1,606	0	94	0	1,732	0	79	0
SELE MEDICAL PRACTICE	Dr Ben Frankel	2,574	0	293	0	1,971	0	69	0
WIDDRINGTON SURGERY	Dr Chris Waite	469	0	0	0	596	0	34	0
NORTHUMBERLAND HEALTH AT WIDDRINGTON & FELTON SURGERIES	Dr Chris Waite	310	0	49	0	0	0	0	0
NORTHUMBERLAND LMC	Dr John Warrington	76	0	7	0	75	0	8	0
NHS NORTH OF ENGLAND CSU	Mark Adams	2,478	0	52	0	2,695	-73	76	0
Non Director Related Organisations									
ADDERLANE SURGERY		269	0	14	0	275	0	11	0
BEDLINGTONSHIRE MEDICAL GROUP		1,633	0	130	0	1,614	0	69	0
BELFORD MEDICAL GROUP		1,130	0	59	0	1,138	0	37	0
BELLINGHAM PRACTICE		608	0	26	0	610	0	28	0
BRANCH END SURGERY		900	0	68	0	834	0	39	0
BURN BRAE MEDICAL GROUP		1,867	0	70	0	1,816	0	66	0
CHEVIOT MEDICAL GROUP		634	0	48	0	636	0	64	0
COQUET MEDICAL GROUP		2,000	0	102	0	1,815	0	81	0
CORBRIDGE MEDICAL GROUP		1,520	0	82	0	1,484	0	72	0
CRAMLINGTON MEDICAL GROUP		696	0	35	0	685	0	28	0
ELSDON AVENUE SURGERY		551	0	19	0	527	0	16	0
FELTON SURGERY		315	0	0	0	421	0	18	0
FORUM FAMILY PRACTICE		957	0	52	0	908	0	46	0
GABLES MEDICAL GROUP		1,024	0	63	0	990	0	46	0
GAS HOUSE LANE SURGERY		1,111	0	125	0	1,055	0	33	0
GLENDALE SURGERY		593	0	37	0	595	0	22	0
GREYSTOKE SURGERY		1,665	0	82	0	1,607	0	57	0
GUIDE POST MEDICAL GROUP		2,229	0	179	0	1,793	0	138	0
HALTWHISTLE MEDICAL GROUP		909	0	40	0	901	0	39	0
HAYDON AND ALLEN VALLEYS MEDICAL PRACTICE		757	0	89	0	905	0	67	0
HUMSHAUGH AND WARK MEDICAL GROUP		1,069	0	31	0	1,013	0	-21	0
LABURNUM MEDICAL GROUP		0	0	0	0	107	0	0	0
LINTONVILLE MEDICAL GROUP		0	0	0	0	1,626	0	0	0
MARINE MEDICAL GROUP		1,901	0	86	0	1,867	0	87	0
NETHERFIELD HOUSE SURGERY		900	0	33	0	877	0	37	0
PRUDHOE MEDICAL GROUP		923	0	42	0	873	0	31	0
RAILWAY MEDICAL GROUP		4,593	0	327	0	4,201	0	178	0
RIVERSDALE SURGERY		708	0	53	0	777	0	104	0
ROTHBURY PRACTICE		944	0	261	0	912	0	118	0
SCOTS GAP MEDICAL GROUP		570	0	64	0	634	0	64	0
SEATON PARK MEDICAL GROUP		2,971	0	133	0	2,829	0	156	0
UNION BRAE AND NORHAM PRACTICE		1,312	0	68	0	1,267	0	56	0
VILLAGE SURGERY		2,329	0	218	0	2,044	0	78	0
WELL CLOSE MEDICAL GROUP		3,147	0	221	0	2,251	0	116	0
WELLWAY MEDICAL GROUP		0	0	0	0	2,597	0	0	0
WHITE MEDICAL GROUP		1,390	0	73	0	1,342	0	72	0
HADRIAN PRIMARY CARE ALLIANCE LTD		421	0	19	0	412	0	0	0
NORTHUMBRIA PRIMARY CARE		51	0	0	0	15	0	0	0

Comparators for 2020-21 have been restated to show transactions and balances on an accruals rather than cash basis above.

The CCG membership body consists of one clinical representative from each of the 37 member practices. They ordinarily meet twice a year and are responsible for making recommendations for amendments to the CCG's constitution and approving appointments to the CCG's Governing Body. As such the GP Practices have been included within the Related Parties note above.

The list of Laburnum Medical Group was dispersed on 31st July 2020. A number of patients subsequently reigstered with either Seaton Park Medical Group and Lintonville Medical Group.

On 1st January 2021 Brockwell Medical Group, Lintonville Medical Group and Wellway Medical Group merged and are now Valens Medical Partnership. The figures shown in the Note above are reflective of this change.

On 1st January 2022 Felton Surgery and Widdrington Surgery merged to become Northumberland Health at Widdrington and Felton Surgeries. The figures shown in the Note above are reflective of this change.

In the main GPs within Northumberland are split into 6 Primary Care Networks (PCNs) based on locality. Within each PCN there is a nominated Practice who co-ordinates the receipt and distribution of funding on behalf of the PCN. The nominated GP Practices are as follows – Valens Medical Practice (Central), Village Surgery (Cramlington & Seaton Valley), Guide Post Medical Group (Wansbeck), Well Close Medical Group (Well Up North), Railway Medical Group (Blyth), and Sele Medical Practice (West).

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

The CCG commissions several services through Partnership Agreements from Northumberland County Council including Continuning Healthcare, Section 117 claims, Social Care, and contribution to Better Care Fund pooled budgets.

14 Events after the end of the reporting period

There is one non-adjusting post balance sheet event that relates to the Health and Social Care Bill which was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England. ICBs will take on the commissioning functions of CCGs. The Bill passed on 28th April 2022 and it is the intention that the CCG functions, assets and liabilities will therefore transfer to an ICB. (2020-21: None)

15 Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
The NHS Clinical Commissioning Group performance against those duties was as follows:

National Health Service Act Section Duty	Duty	2021-22 Target	2021-22 Performance	2020-21 Target	2020-21 Performance	Duty Achieved
223H(1)	Expenditure not to exceed income	621,011	618,959	603,385	602,485	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	-	-	-	-	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	620,911	618,859	603,240	602,340	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	6,315	5,236	6,306	4,962	Yes