NHS
Northumberland
Clinical Commissioning Group

ANNUAL REPORT

1 April to 30 June 2022

Improving healthcare for the people of Northumberland

Contents

PERFORMANCE REPORT[1]

Samantha Allen

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

Accountable Officer

30th June 2023

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

Performance Overview

Statement from Accountable Officer and Clinical Chair

Welcome to NHS Northumberland Clinical Commissioning Group's (hereafter referred to as the CCG) Annual Report for the first quarter of 2022/23 covering the period to 30 June, after which the CCG transferred their statutory duties to the newly formed North East and North Cumbria Integrated Care Board (hereafter referred to as the (ICB).

The early part of 2022/23 saw a continuation of the most challenging period in the history of the National Health Service, as our health and care service, and the country at large, adjusted to the Government's strategy of 'living with COVID-19'. The NHS has also been focused on addressing the backlog in elective care, improving access to services, responding to increased demand, and reducing health inequalities in the context of a wider cost-of-living crisis across England.

It is only right that this 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 and the resultant pressures it has caused for services 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 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. This approach will continue to be enhanced as we move forward collectively as part of an Integrated Care System within the North East and North Cumbria.

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 the early phases of the programme, 2022/23 has seen the delivery of a spring booster phase. This additional dose has increased the protection against the virus and its impact for our most vulnerable residents and increasing vaccine uptake and reducing inequality will continue to be a central pillar of our work going forward.

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 impacts on 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 throughout 2022/23.

Throughout the first quarter of 2022/23 the CCG took on an active role in supporting the establishment of the ICB as a statutory organisation as from 1 July 2022.

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.

COVID-19 has exposed health inequalities across our country that require urgent attention as we all continue to recover from the impact of pandemic. The ICB 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 carried forward into the early part of 2022/23 and will continue to be developed and delivered by the ICB going forward. The challenge to adapt health and care services to respond to, and meet the needs of, our population will remain our primary focus.

This report also addresses how the CCG has performed during the first quarter of 2022/23 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.

This annual report covers the final period of CCG operations 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 9½ years and who have made such an important contribution to the health and wellbeing of Northumberland's residents.

About NHS Northumberland Clinical Commissioning Group

As a statutory body, the CCG was 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 were mostly made up of doctors, nurses and other health professionals – with support from experienced health service managers.

We worked closely with all 37 family GP practices in Northumberland which are all members of the 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 2022/23 operational delivery plan is described in more detail later in the report.

Financial Context

The CCG had planned for the 2022/23 financial year again as part of the North East and North Cumbria Integrated Care System. However, with CCGs transitioning into the NENC ICB on 1 July 2022 the CCG was only 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 still had a requirement to meet its statutory duties / financial duties for the Quarter One period of the 2022/23 financial year, as a separate entity with statutory duties up to the transfer point. Therefore, the CCG completed an external audit accounts process as it would do within any other period.

CCG 2022/23 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 2022/23 operational delivery plan was refreshed to take account of the next phases of the NHS Long Term Plan https://www.longtermplan.nhs.uk/; 2022/23 priorities and operational planning guidance; and also new and emerging local priorities, to form the 2022/23 operational delivery plan.

In 2022/23 we continued to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we needed to continue to increase our capacity and resilience to deliver safe, high-quality services that meet the full range of people's health and care needs. Within this context, the 2022/23 priorities and operational guidance set out the following objectives for the NHS:

A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting.
E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
G. Continue to develop our approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

The following section outlines in more detail what the CCG has done in relation to the above priorities in the first part of 2022/23.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

CCG Staff Health & Wellbeing

The health and wellbeing of staff was 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 available to staff to access. 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.

The CCG's Staff Health & Wellbeing Group was formed to discuss health and wellbeing ideas including coordinating social activities and fundraising.

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

Embed new ways of working and delivering care

The introduction and evolution of the Practice Link Nurse 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 have informed the development of the continuing professional development plan 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.

The work being undertaken to address workforce gaps and challenges across acute, community, and mental health services are addressed in subsequent sections of the report, as is the wide-ranging work being done with primary care providers to create additional roles and extra capacity within our local neighbourhood teams.

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.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

Throughout 2022/23 so far 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.

The COVID-19 vaccination programme has continued to provide vital doses of protection to our most vulnerable residents, most recently through the delivery spring booster programme, the 4th major phase since the start of the vaccination programme. This has been provided alongside a continued 'evergreen offer' for any eligible individuals to come forward and receive their primary course of vaccinations.

The vaccination programme in Northumberland has delivered some of the highest uptake seen in the country, with eligible residents responding to their invitations to be vaccinated in phenomenal numbers and accessing the service through a wide network of sites. Over 740,000 doses of COVID-19 vaccinations have been administered to Northumberland resident, with 90% of eligible people having received a first dose, 87% a second dose, and 74% a third or booster dose. This fantastic response from both providers and the public means that our residents are amongst the best protected in England.

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 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; Healthwatch; the Voluntary and Community sector; and local, regional, and national NHS partners.
A COVID-19 Vaccine Equity Board, ran jointly between the CCG and Local Authority Public Health team, has 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 2022/23 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.

The CCG has 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.

In 2022 the CCG co-ordinated and continued rollout of the Spring Booster vaccination programme to its conclusion. The CCG also worked 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), which moving forward will be delivered by the ICB, building on the fantastic foundations the CCG has established.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

Elective Recovery

The CCG 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.

Recovery of cancer services

The impact of pandemic lockdowns in 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 2022/23 are 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.

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 continued to support several national cancer campaigns 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, which 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 continued 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

and the Fresh *'Quit Smoking'* campaign.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting.

Community Transformation

Supporting people to age well was a key priority in 2022 and beyond. 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 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.

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 will be published during 2022/23.

Supporting care homes continued 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.

NHS 111

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.

Access to NHS 111 for patients has 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 2022 were the

continuation of:

- **Improved access to medication schemes –** 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.

- **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.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

The work of the CCG was 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 was 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.

Restoring and increasing access to primary care services

2022 has been another challenging period for general practice so far, 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 and into 2022 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. 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 2022 the CCG continued to undertake 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.

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 had 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.

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 worked 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 a year 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 continued 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.

Ford Next Generation Learning (NGL) Programme

The CCG worked with the North East Local Enterprise Partnership at Northumberland College as part of their 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.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

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

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 further 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 was 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 have continued 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 continued 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 continued 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 was 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 developed 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

The CCG has 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 covered 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 offered 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 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 who 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 of co-producing plans to develop a sensory pathway for children whose primary need is sensory processing. This offer will be expanded to adults over time.

G. Continue to develop our approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
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.

North England Commissioning Support Unit (NECS) is in the process of developing a cloud based digital platform called AXIOM, which 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.

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 would include developing a Memorandum of Understanding with our stakeholders.

Within 2021/22 we developed and successfully held an *'Understanding Our Communities'* education workshop for our stakeholders 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.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

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.

Digital transformation in General Practice

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 were 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.

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 future Digital Strategy.

The digitisation of medical records programme was paused due to COVID-19 but resumed during 2021/22 and will be on-going into 2022/23. 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 allowed 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 re-utilised. 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.

Implementation of NHS Pathways Streaming Tool in Urgent Care settings

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.

I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Northumberland CCG has, since its inception in 2013, 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.

Effective collaboration and partnership working across systems is particularly evident within the CCG's quality and safeguarding functions, with several nationally recognized examples of partnership working and integration between stakeholder organisations:

- **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. Neighbouring CCGs have shown interest in sharing the CCNs with Primary Care and are looking at implementing this in their area as we move towards ICB working.

- **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 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.

Partnership arrangements in Northumberland

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 had a pivotal role in the design and delivery of the Northumberland 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.

The CCG played 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 Northumberland in a strong position for the future as it transitions to the ICB 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.

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.

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 and into the early part of 2022, the CCG has continued to play an active part in the development of the ICS, contributing to the development of strong local leadership and supporting the transition towards statutory status for the ICB 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 in Northumberland since 2013.

PERFORMANCE ANALYSIS

The CCG had 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 considered 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 provided 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 the early part of 2022 was 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.

Information has been included in charts showing performance over the last 12 months up to and including the end of June 2022.

Table 1 - NHS Northumberland CCG Performance indicators 2021/22

Indicators	Indicator Description	Latest Data Period	ICB			Monthly trend
			NHS Northumberland			
			Threshold	Actual	YTD	
Referral to treatment access times	% of patients initial treatment within 18 weeks for incomplete pathways	Jun-22	92.0%	76.1%	76.2%	
	Number of patients waiting more than 52 weeks for treatment		0	756	2,043	
Diagnostic waits	% patients waiting more than 6 weeks for the 15 diagnostics tests (including audiology)	Jun-22	1.0%	12.6%	14.1%	
A&E waits	% patients spending 4 hrs or less in A&E or minor injury unit	Jun-22	95.0%	90.5%	90.7%	
	Over 12 hour trolley waits		0	0	0	
Cancer Waits	% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	Jun-22	93.0%	89.6%	89.8%	
	% of patients seen within 2 weeks of an urgent referral for breast symptoms		93.0%	84.2%	86.2%	
	% of patients treated within 62 days of an urgent GP referral for suspected cancer		85.0%	71.1%	67.9%	
	% of patients treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service		90.0%	50.0%	58.1%	
	% of patients treated for cancer within 62 days of consultant decision to upgrade status		N/A	33.3%	60.0%	
	% of patients treated within 31 days of a cancer diagnosis		96.0%	84.0%	86.8%	
	% of patients receiving subsequent treatment for cancer within 31 days - surgery		94.0%	77.4%	77.5%	
	% of patients receiving subsequent treatment for cancer within 31 days - drugs		98.0%	97.7%	98.4%	
	% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy		94.0%	94.1%	96.5%	
	% 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)*	*75.8%*	*76.8%*	
Mental Health	6 Week wait IAPT treatment (People Entering Therapy)	Jun-22	75.0%	98.0%		
	6 Week wait IAPT treatment (People Completing Therapy)	Jun-22	75.0%	53.4%		
	18 Week wait IAPT treatment (People Entering Therapy)	Jun-22	95.0%	100.0%		
	18 Week wait IAPT treatment (People Completing Therapy)	Jun-22	95.0%	100.0%		
	Early intervention in psychosis - % with 1st episode treated within 2 weeks	Jun-22	60.0%	100.0%	46.7%	
	% people with anxiety disorders and depression who access psychological therapies (IAPT)	Jun-22	20.2%	1.71%	3.89%	
	% complete treatment who are moving to recovery	Jun-22	50.0%	53.2%	52.5%	
	Improve diagnosis rate for people with dementia	Jun-22	68.5%	58.6%		
	Waiting times for routine referral to CYP Eating Disorder Services - Within 4 weeks	Rolling 12 months to Q1 2022-23	95.0%	81.3%	81.3%	
	Waiting times for Urgent referrals to CYP Eating Disorder Services - within 1 week		95.0%	87.5%	87.5%	
HCAIs	Incidence of MRSA	Jun-22	0	0	0	
	Incidence of C Diff	Jun-22	71	10	6	
	Incidence of e-coli	Jun-22	262	20	20	
Ambulance (CCG)	Category 1 Response times (7 Minutes average)	Jun-22	7 minutes	00:08:41	00:08:41	
	Category 2 Response times (18 minutes average)		18 minutes	00:32:31	00:32:31	
	Category 1 Response times (90th centile)		15 minutes	00:15:04	00:16:03	
	Category 2 Response times (90th centile)		40 minutes	01:05:47	01:06:34	
	Category 3 Response times (90th centile)		2 hours	03:15:43	03:22:17	
	Category 4 Response times (90th centile)		3 hours	03:40:08	03:13:02	

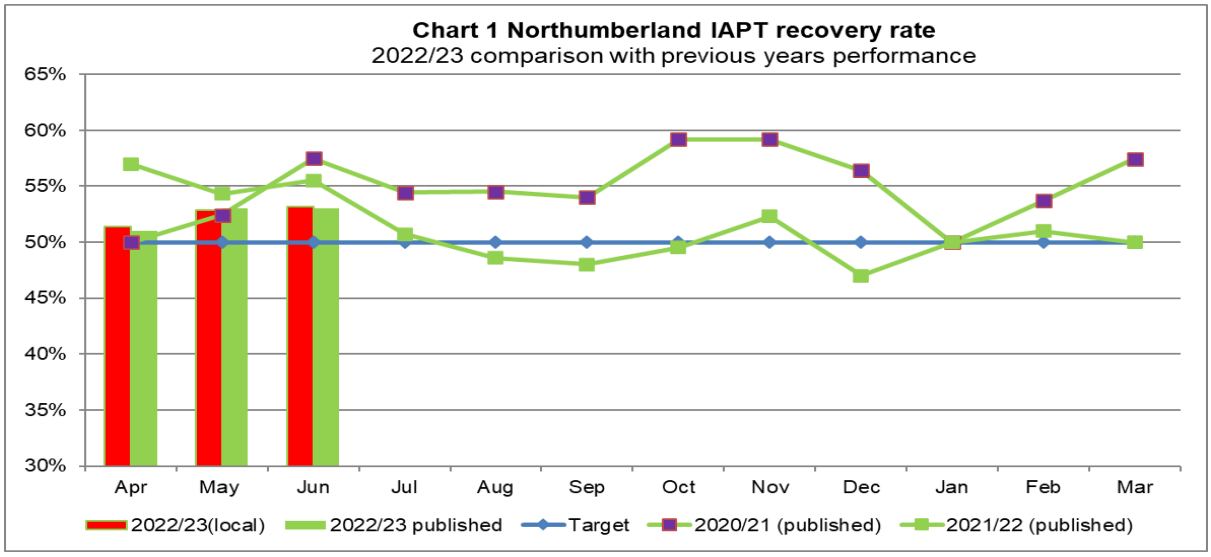
The previous section on the CCG's operational plan delivery illustrates the work undertaken to maximise achievement of the constitutional standards. The following section provides further detail about the CCG's performance against the NHS Constitutional standards and therefore how successful the CCG's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

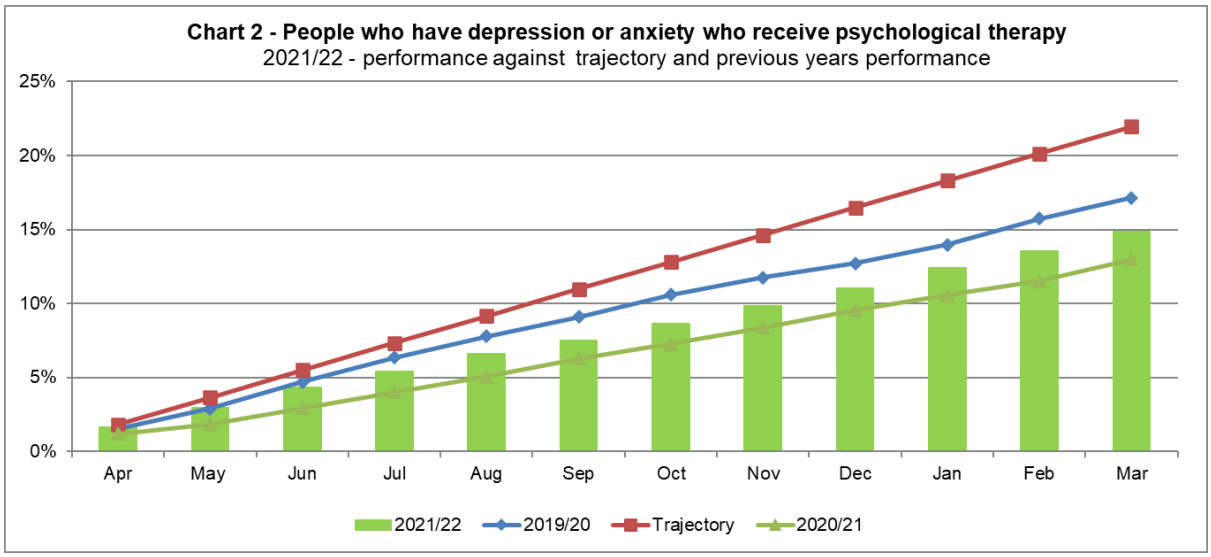
Mental Health Services

Improving Access to Psychological Therapies (IAPT)

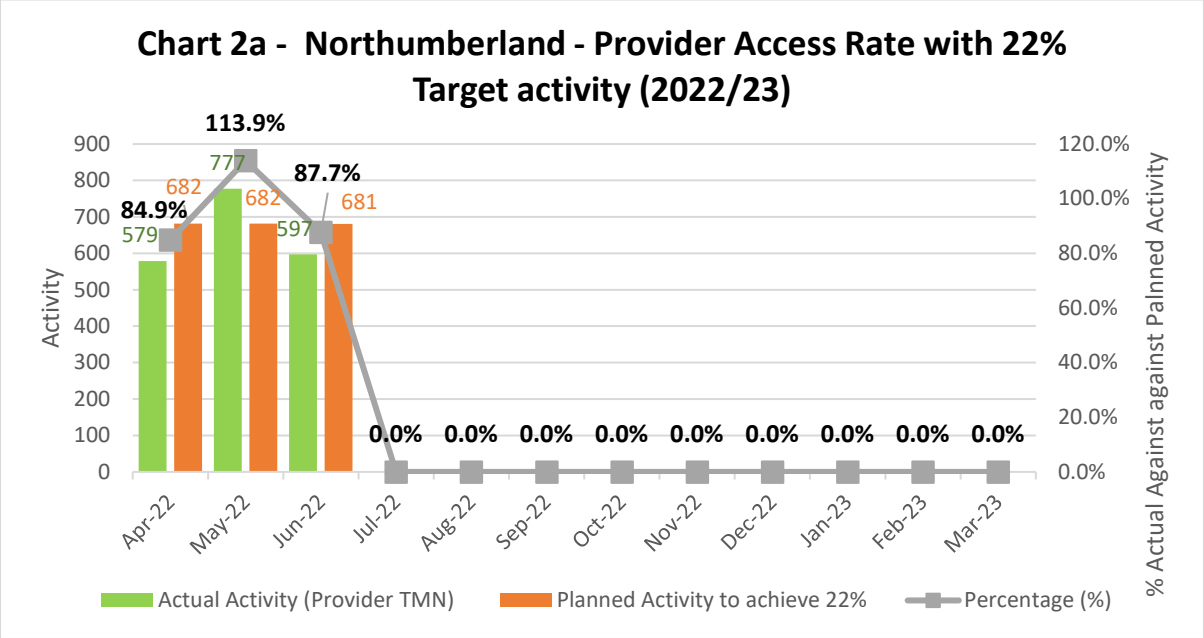
In September 2021, the CCG recommissioned IAPT services from Cumbria, Northumberland and Tyne and Wear Mental Health Foundation Trust who continue to sub-contract to, and work in partnership with, the previous provider Talking Matters Northumberland (TMN). This arrangement enables the excellent work 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.

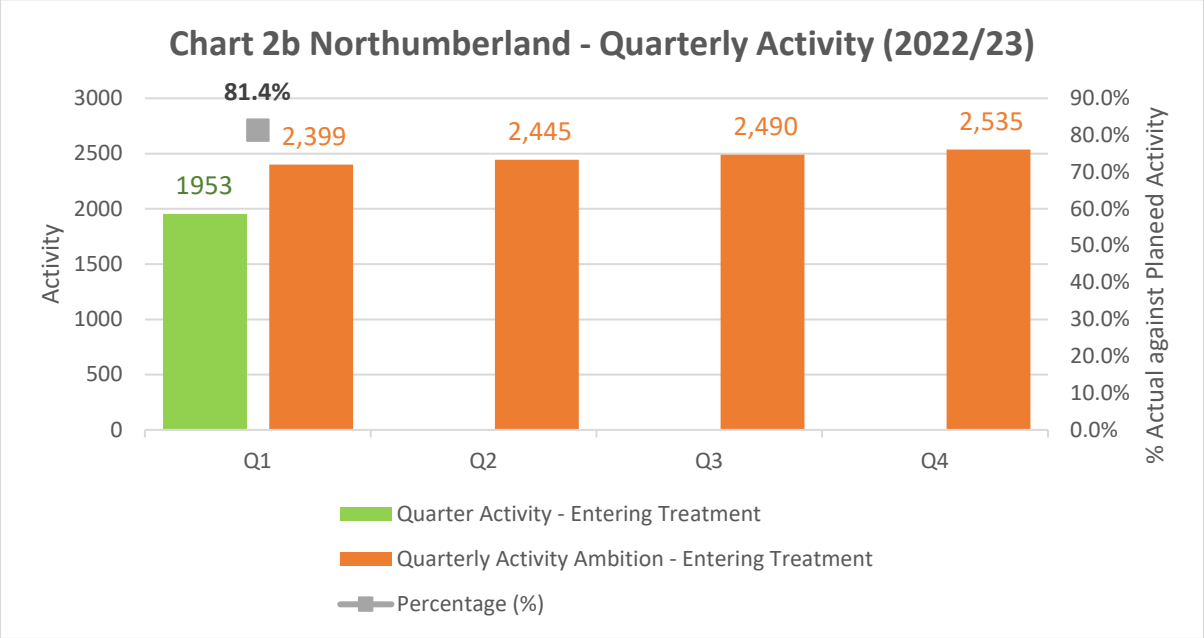
The constitutional target for recovery rates is 50% of IAPT service users. Following a wide range of collaborative working between the provider and the CCG, performance during April – June 2022 reported above the 50% target despite the pressure on the service.





The above measure is no longer recorded post April 2022, however, has been included to show performance throughout 2021/2022.

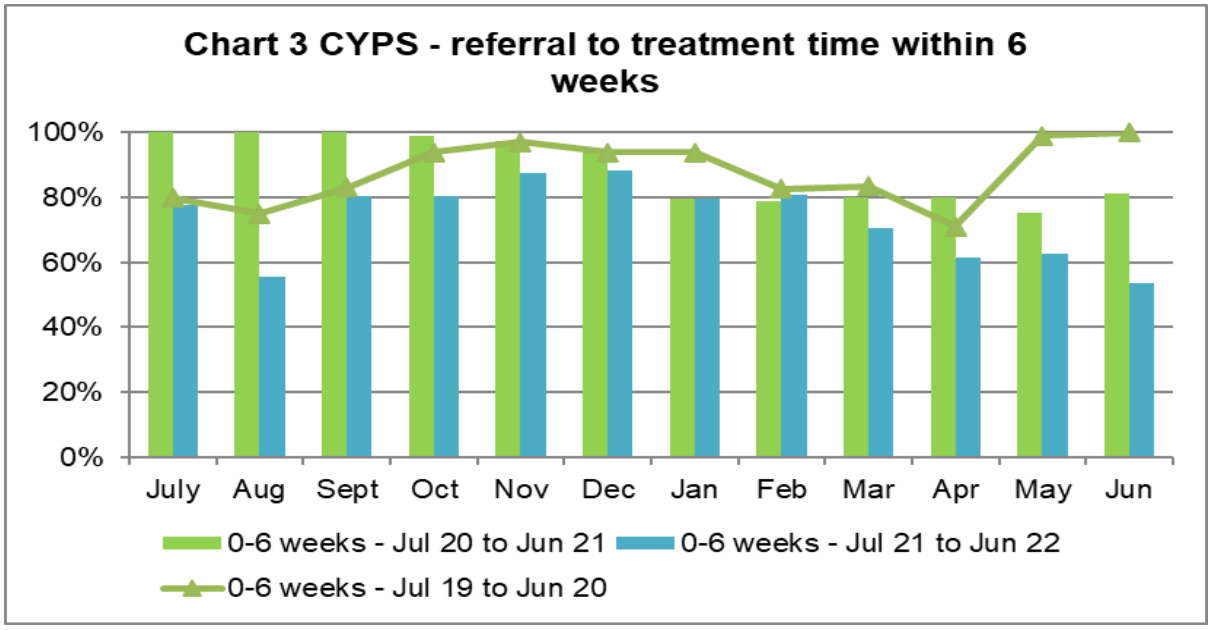




There was also an expectation that each year at least 22% of the population who experience depression and/or anxiety disorders receive treatment. The charts above shows that the performance during April – June is below the trajectory (with the exception of May 2022) but has improved as patients have increasingly begun accessing services as COVID restrictions eased. This is consistent with the national and regional picture. The service along with the CCG worked 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 was an expectation that no child or young person should wait longer than 18 weeks to be seen. The % of patients who were treated within 6 weeks of referral has reduced in the early part of 2022/23 reporting at 50-60%. The performance is in context with the significant demand on the service.



Dementia Diagnosis Rates

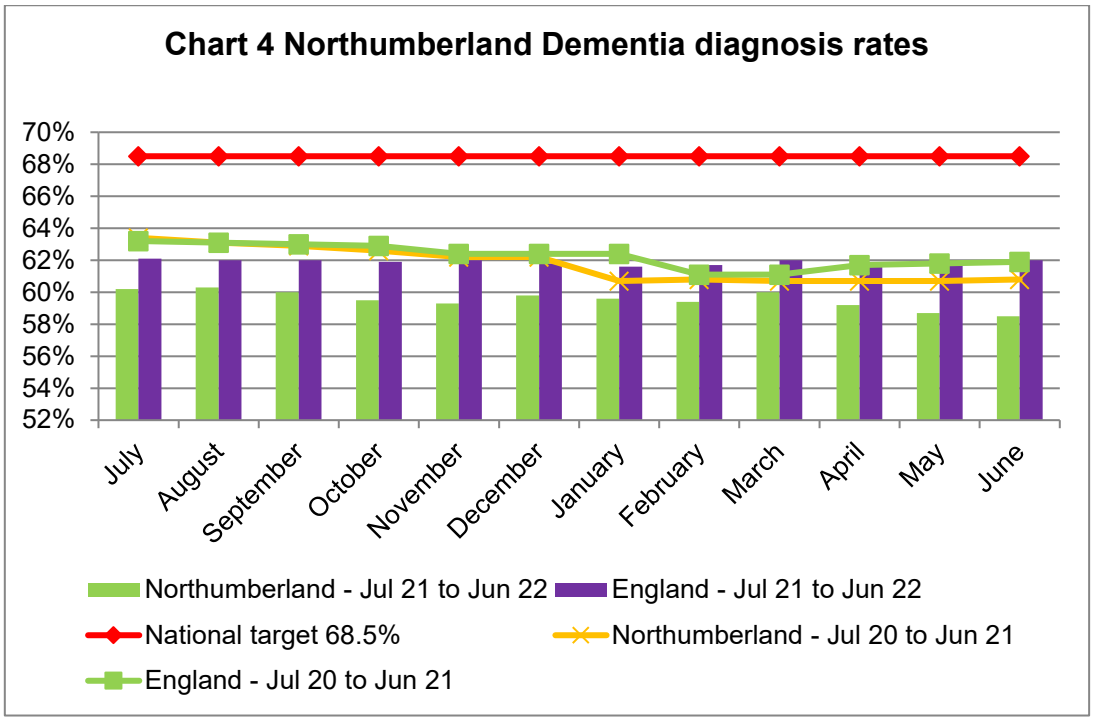


Chart 4 above shows the performance of the CCG underachieving against the 68.5%

NHS Constitution standard and the England average. The CCG reported 58.5% at the end of June 2022.

The reason around this performance was predominately around a shortage of psychiatry workforce which was a national picture and impacts on waiting times and diagnosis rates, and data analysis has shown that more referrals are needed into the memory assessment service in order to reach diagnosis rate requirements. Our provider CNTW, is going to look at their current service model and consider options with less reliance on consultant led clinics.

Dementia diagnosis was been identified within a Recovery Planning initiative overseen by NHSE/I. The CCG referenced the following actions which will seek to improve current performance:

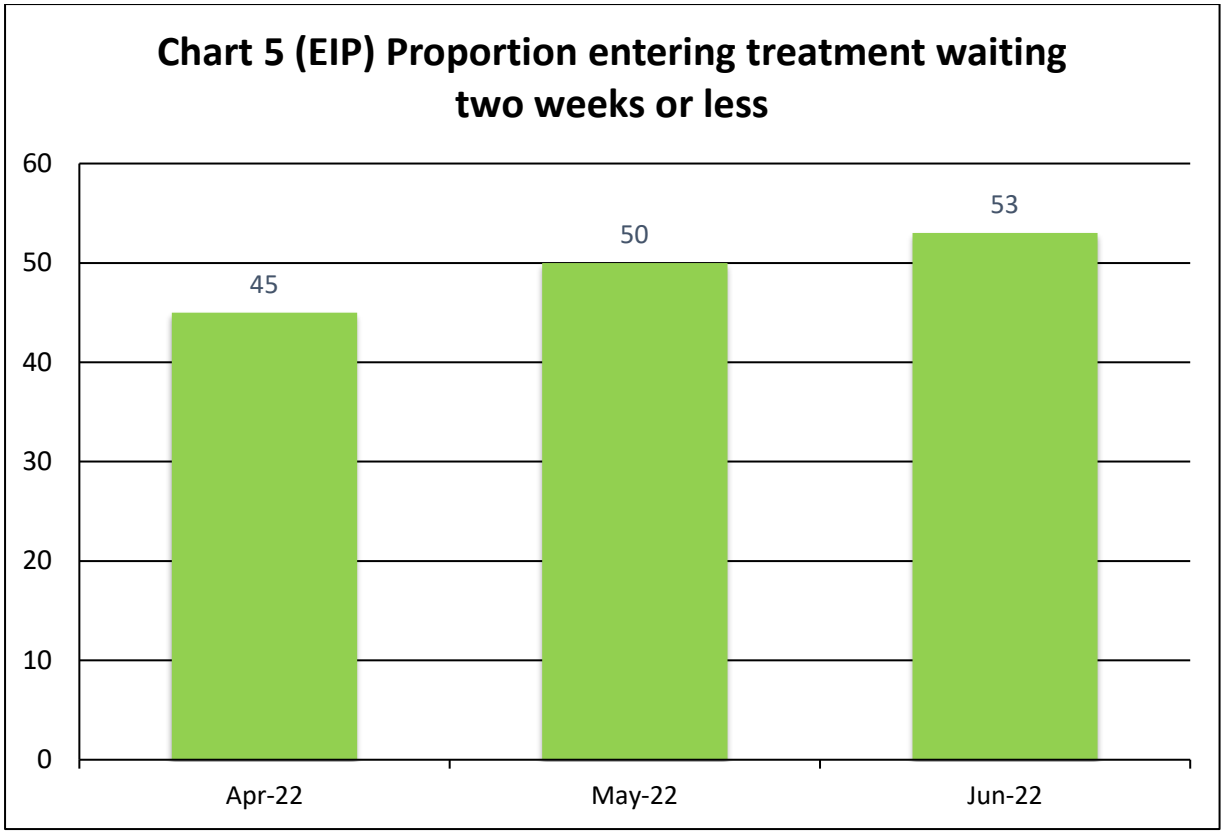
- Explore diagnosis and coding of clients in care homes.
- Review of memory assessment and management services being undertaken via CNTW SDIP. In Northumberland, a review of older people's strategy is taking place with the local authority.
- Review of those clients diagnosed with MCI by Primary Care and/or CNTW. Consideration will be given to formalisation of this and where this should be carried out.
- Awareness of raising of dementia across the county.
- In addition, CNTW has been successful in the bid for monies through the Diadem initiative. This work supports the identification of clients in care homes without a dementia diagnosis and allows for assessment and treatment as required.

Early Intervention in Psychosis

The methodology for early intervention indicators in psychosis have changed. This early intervention in psychosis treated within 2 weeks is no longer captured in the MHSDS (Mental Health Services Data Set).

The table and chart 5 below provide figures for the current EIP metrics. These are sourced from the metric download from NHS Digital.

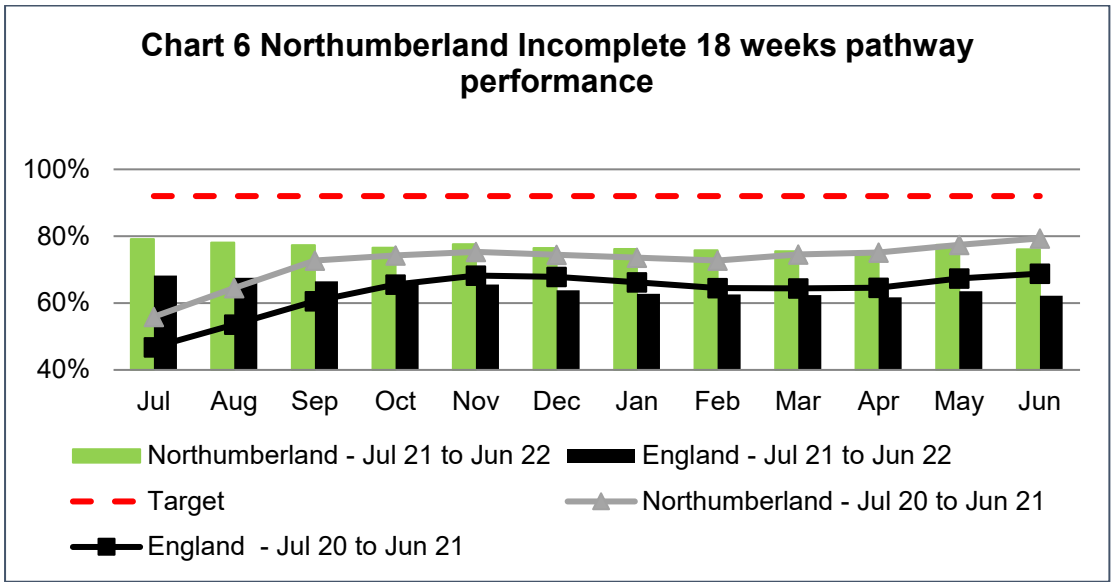
MEASURE		Apr-22	May-22	Jun-22
EIP23a	Referrals on EIP pathway entering treatment	20	20	15
EIP23b	Referrals on EIP pathway entering treatment within two weeks	10	10	10
EIP23c	Referrals on EIP pathway entering treatment more than two weeks	10	10	5
EIP23d	Open referrals on EIP pathway waiting for treatment	5	15	5
EIP23e	Open referrals on EIP pathway waiting for treatment within two weeks	*	*	*
EIP23f	Open referrals on EIP pathway waiting for treatment more than two weeks	*	*	*
EIP23g	Referrals on EIP pathway that receive a first contact	35	30	30
EIP23h	Referrals on EIP pathway that are assigned to care coordinator	20	20	15
EIP23i	Proportion entering treatment waiting two weeks or less	45	50	53

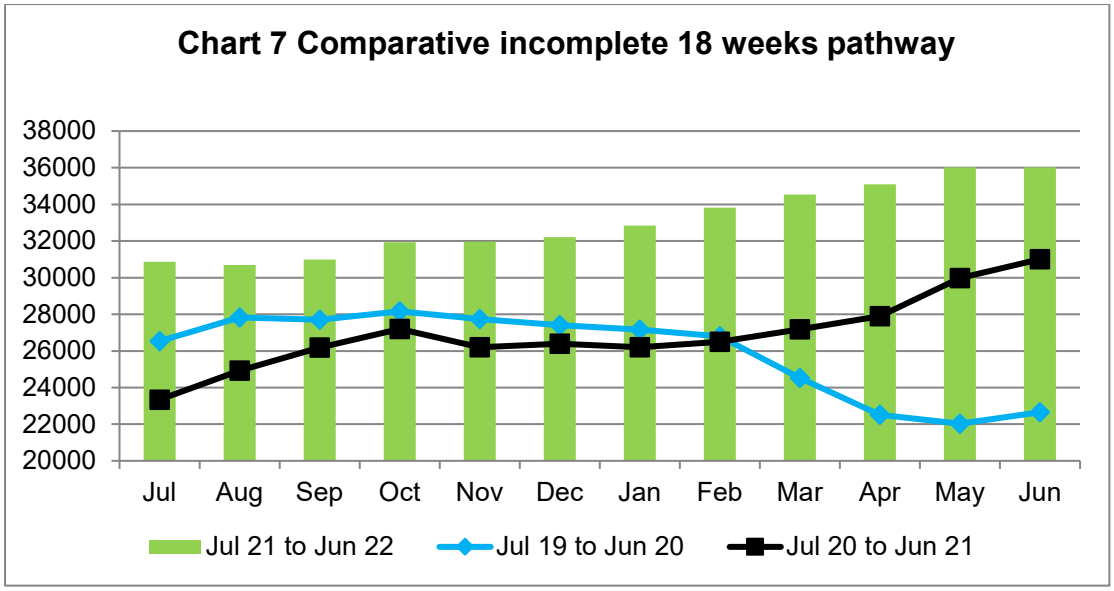


Planned Care

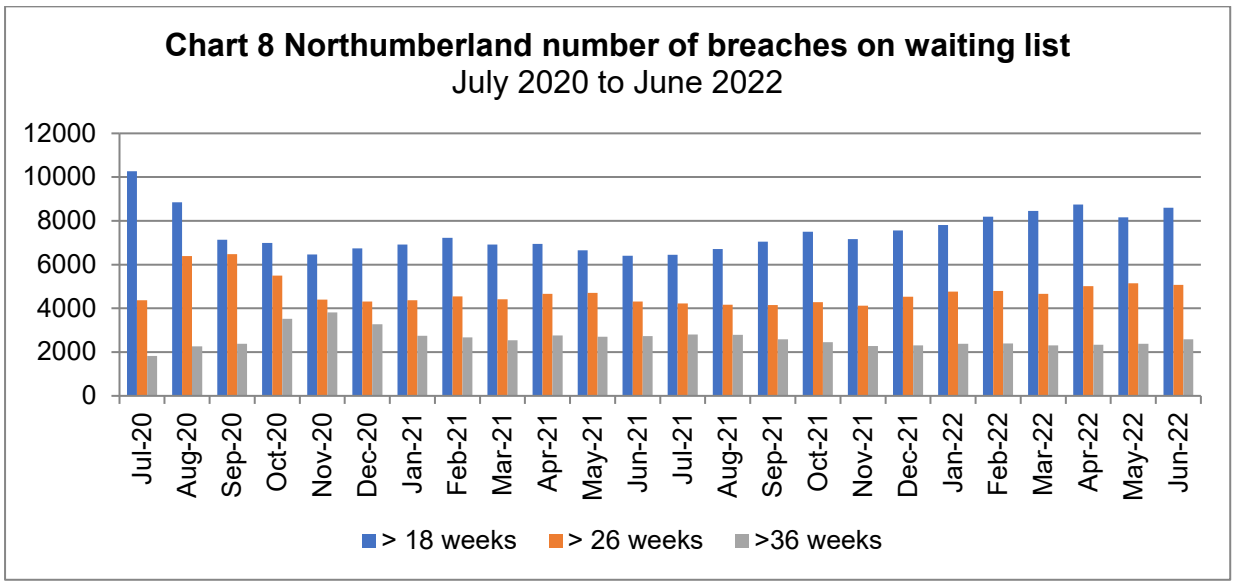
Patient Access to Services

Chart 6 below shows that our performance along with the national position has failed to achieve the 92% constitutional target for the incomplete waiting list indicator. However, performance in Northumberland continues to be better than the national average.



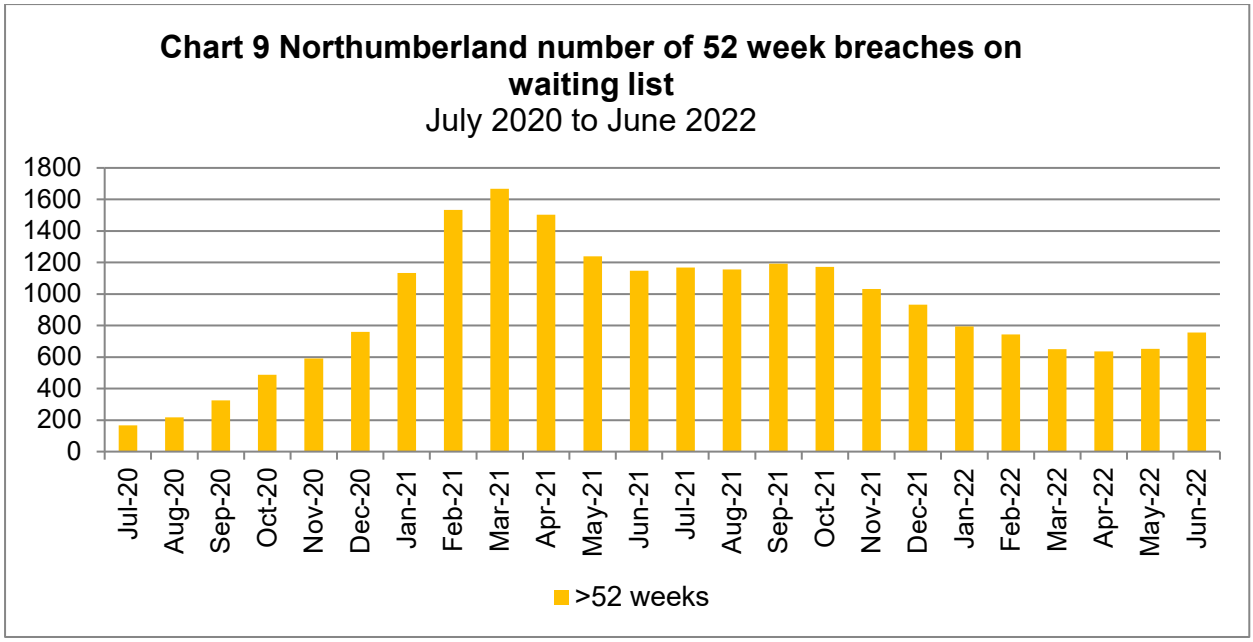


Not only has the volume of patients waiting for treatment increase, but the length of time also increased as well for many patients. A new range of metrics was introduced to review the breaches in excess of 18 weeks as shown below.



52 week waits

Following an increase in the volume of 52 week breaches from summer 2020, an improvement was noted with the number of breaches reducing during 2021/22 and remaining fairly static early 2022 with a slight increase in June 2022 reported.



At the end of June 2022, pressures were seen within Trauma and Orthopaedics, Urology and Plastics and there had also been a surge in cancer referrals. The number of 52+ week waiters has increased over a period of 4 months. The RTT compliance continues to show the legacy impact of the COVID-19 pandemic.

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 continues to be breached.

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.

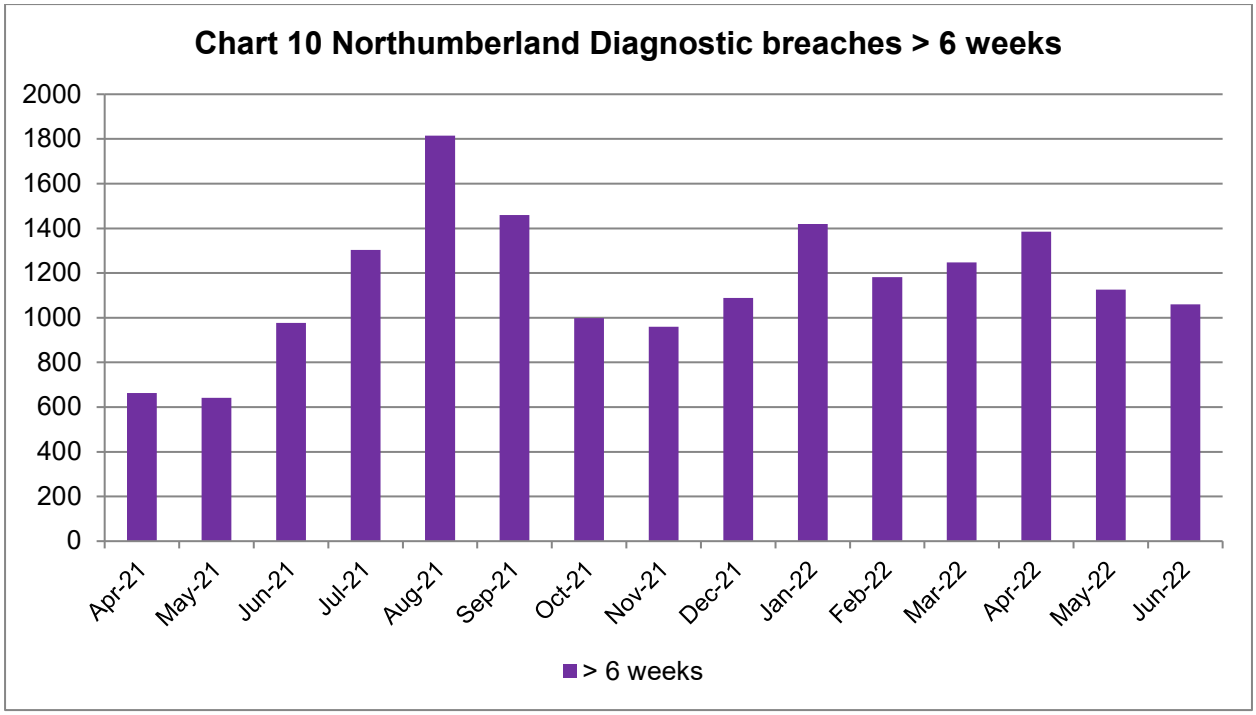


Chart 10 Northumberland Diagnostic breaches > 6 weeks
2000
1800
1600
1400
1200
1000
800
600
400
200
0
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
> 6 weeks

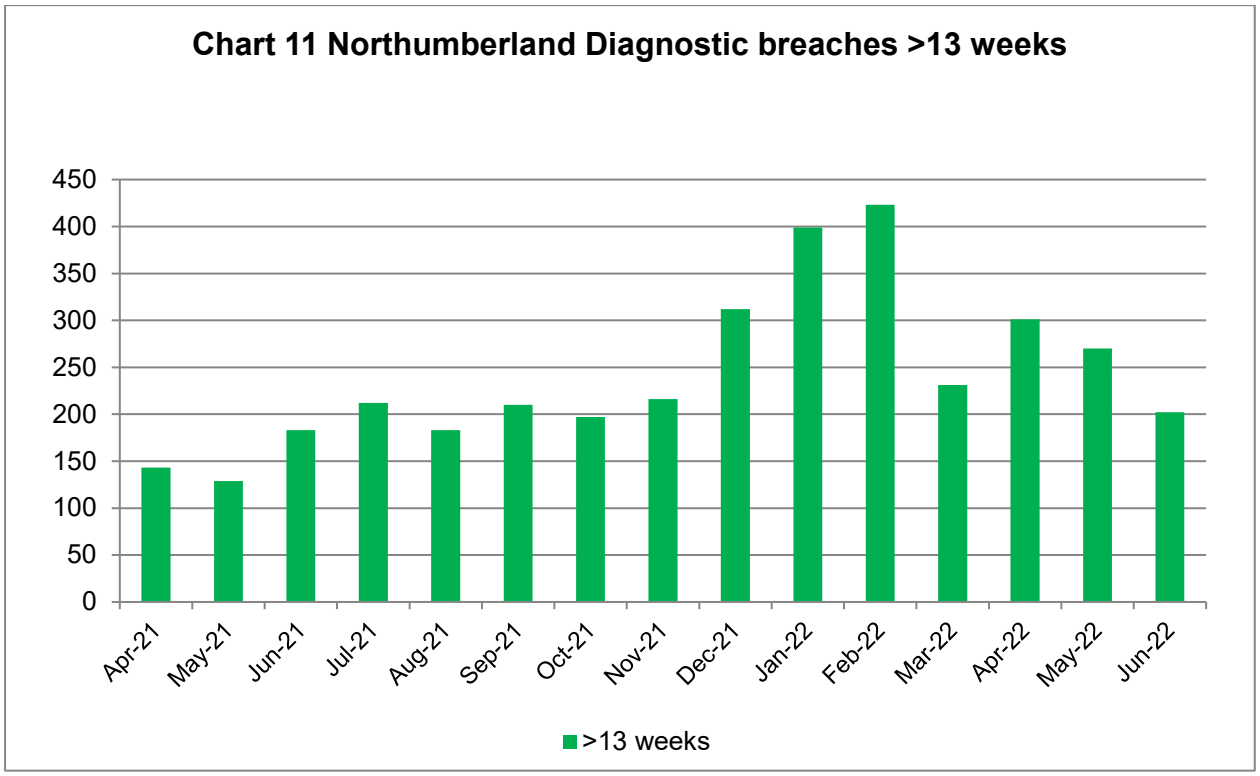


Chart 11 Northumberland Diagnostic breaches >13 weeks
450
400
350
300
250
200
150
100
50
0
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
>13 weeks

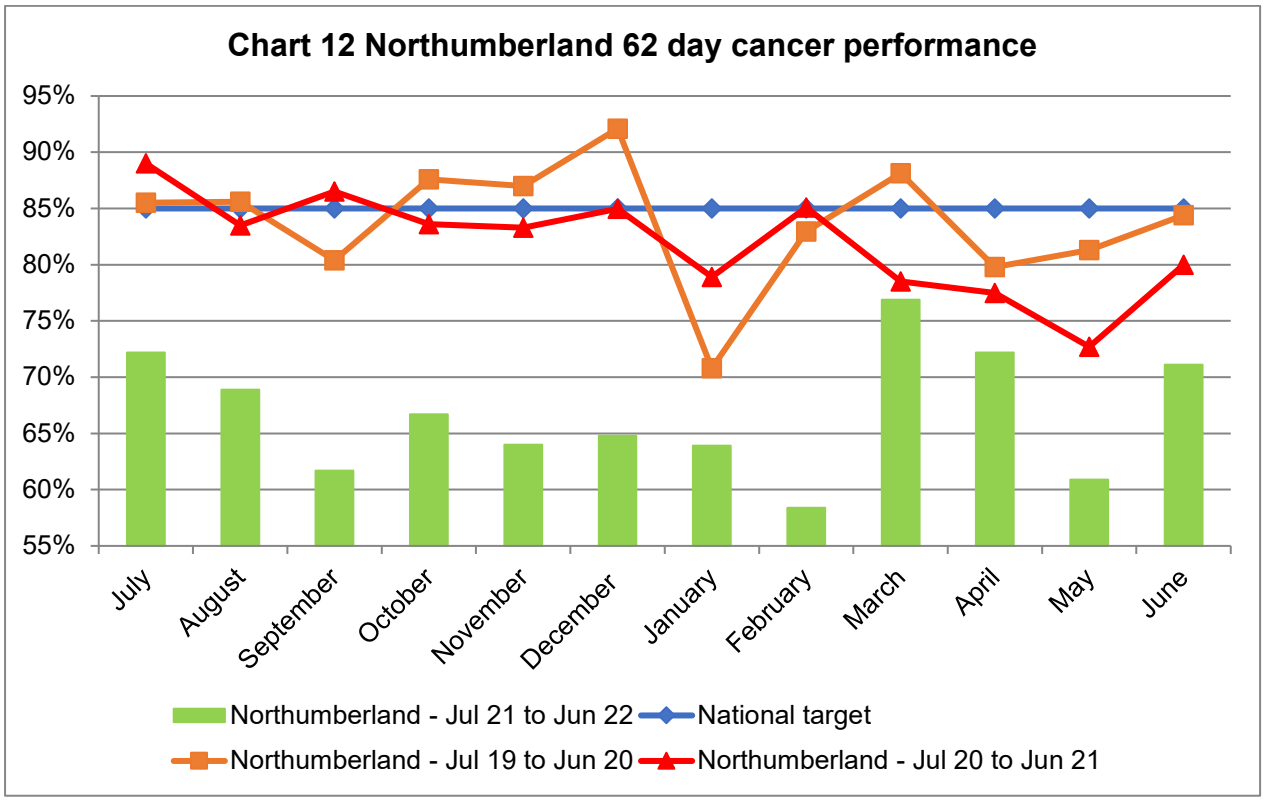
Cancer

Cancer Performance

The graph and tables below illustrate the continued difficulties to return to achieving the constitutional standards for cancer services.

In June 2022, performance in Northumberland was at 91.4% - slightly below the 93% 2 week wait standard. Specialties which fell below the standard were Lower Gastrointestinal and Skin. The 62 day performance standard is 85% and as of June 2022, Northumberland reported 71.1%. Within this standard, only a small amount of specialties continued to report above the 85% standard.

Whilst cancer performance standards remain difficult to achieve in all pathways, pressure had been noted particularly in gastrointestinal services, dermatology, urology and lung services.



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

July 2021 to June 2022 Target 93%

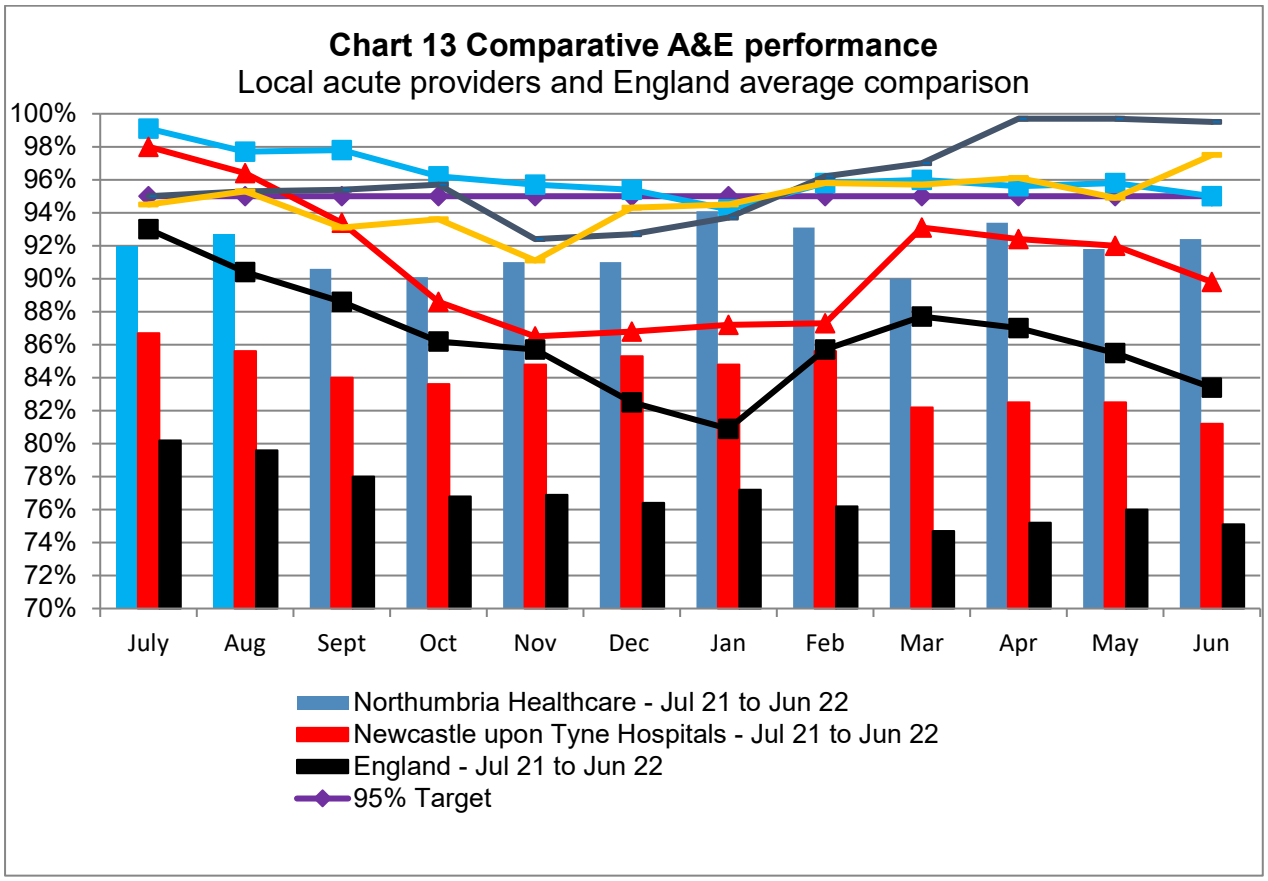
Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	2832	3069	237	92.3%
Lung	234	245	11	95.5%
Gynaecological	1767	1892	125	93.4%
Upper Gastrointestinal	1466	1529	63	95.9%
Lower Gastrointestinal	3388	3556	168	95.3%
Urological (Excluding Testicular)	1585	1619	34	97.9%
Testicular	56	58	2	96.6%
Haematological (Excluding Acute Leukaemia)	161	165	4	97.6%
Acute leukaemia	1	1	0	100%
Head and Neck	862	939	77	91.8%
Skin	2311	3792	1481	60.9%
Sarcoma	9	9	0	100%
Brain/Central Nervous System	1	2	1	50.0%
Childrens	11	16	5	68.8%
Other	8	8	0	100%
Total	**14692**	**16900**	**2208**	**86.9%**

62 days cancer performance from referral to commencing treatment in Northumberland

July 2021 to June 2022
Target 85%

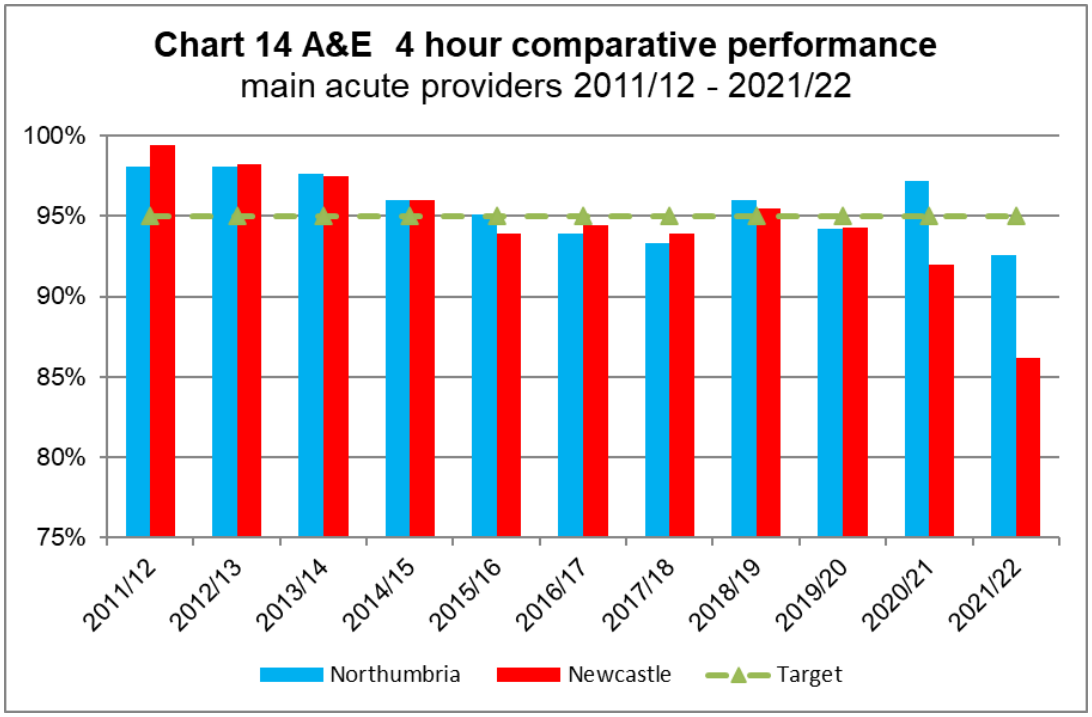
Tumour Type	Treated in Time	Total Treated	Breaches	% Meeting Standard
Breast	166	192	26	86.5%
Lung	32	70	38	45.7%
Gynaecological	37	72	35	51.4%
Upper Gastrointestinal	39	77	38	50.6%
Lower Gastrointestinal	89	150	61	59.3%
Urological (Excluding Testicular)	185	313	128	59.1%
Testicular	5	5	0	100%
Haematological (Excluding Acute Leukaemia)	55	70	15	78.6%
Acute leukaemia	1	1	0	100%
Head and Neck	42	48	6	87.5%
Skin	224	314	90	71.3%
Sarcoma	2	4	2	50.0%
Brain/Central Nervous System	1	1	0	100%
Other	7	8	1	87.5%
Total	**885**	**1325**	**440**	**66.8%**

Urgent Care Accident and Emergency Wait Times

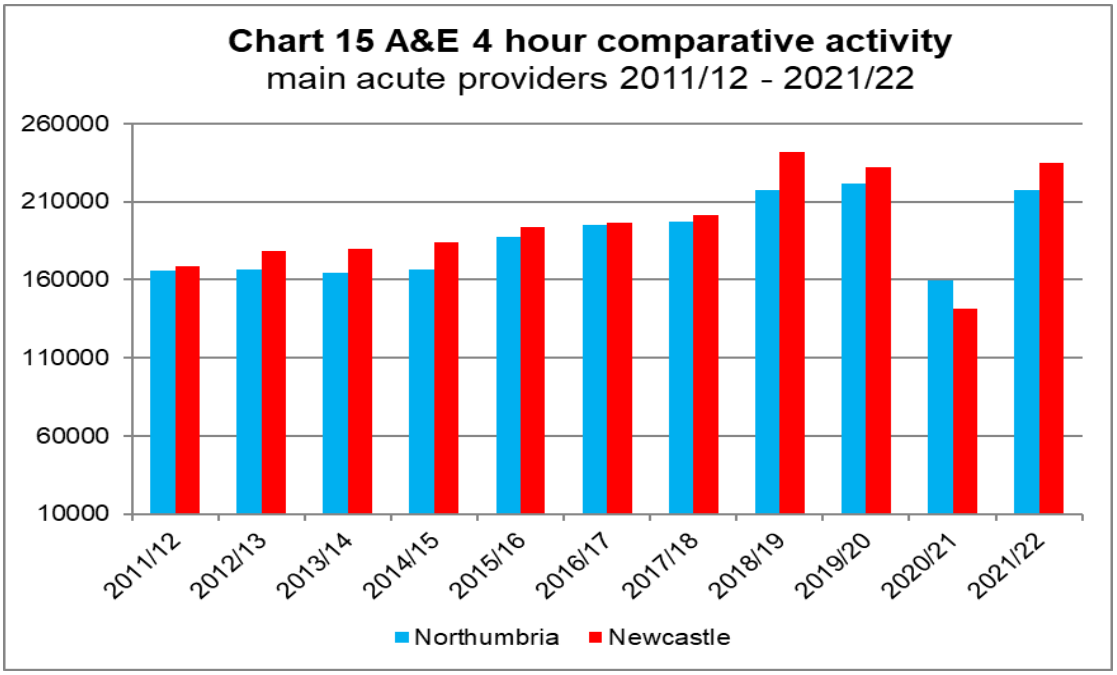


Local providers have traditionally shown some of the strongest performance nationally to ensure that patients were either treated or admitted to a ward within a maximum of four hours when they attended an accident and emergency department.

Chart 13 above shows that although reporting below the standard, 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.



Ambulance Response Times

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

Response times continued to be pressured and in June 2022, NEAS continued to meet only one indicator – Category 1 response time.
A three-year programme to increase capacity has been identified to enable patients to be responded to in a timely manner and minimise risk to life and outcomes.

Actions included recruitment of additional paramedics, Clinical Care Assistants and health advisors and the implementation of a sickness absence plan which his focussed on mental health and wellbeing.

The Trust reviewed lessons learned in relation to themes identified following patient safety incidents and updated information will present a report at a future Quality Review Group in relation to system pressures and learning.

A Strategy Transformation Plan is in development and once finalised will be presented to the Quality Review Group. The plan will consist of key headline and strategic objectives.

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 reminder 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

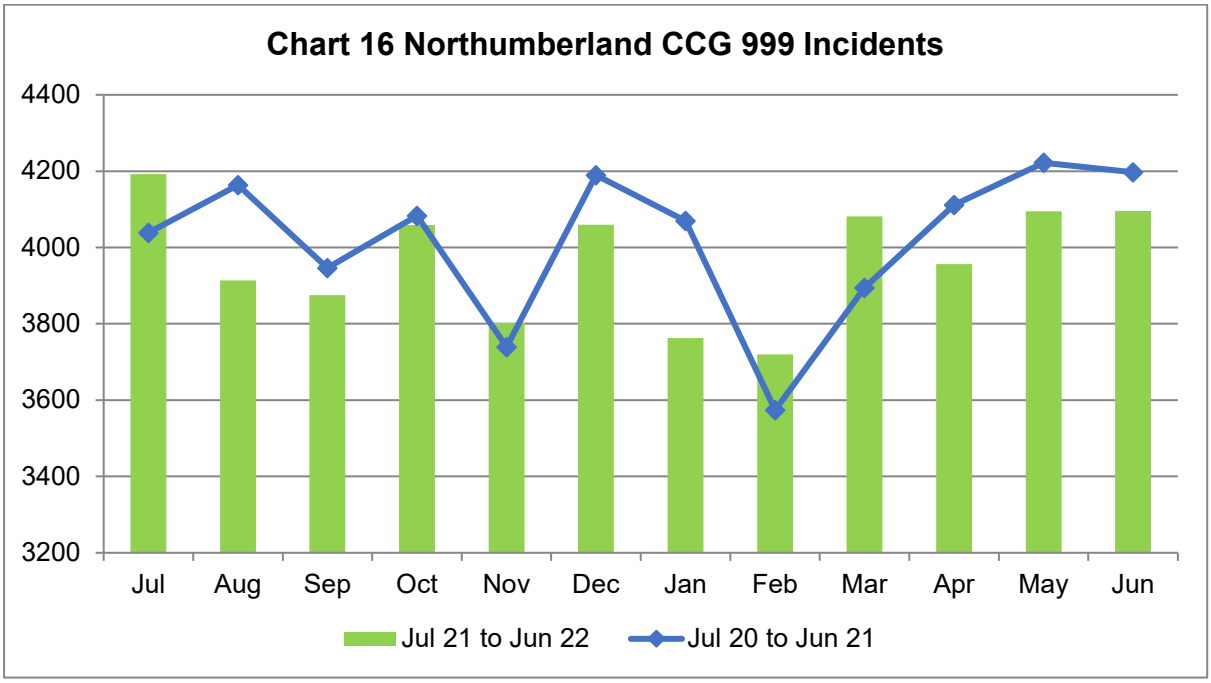
The metrics capture both the average and the 90th percentile performance to give a better profile of performance as it focuses on the variation in response waiting times. NEAS started to report on the new metrics in January 2018.

When considering the performance in the charts below the volume of patients in each category should be noted. A 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%

Apr 22 to Jun 22	Category 1	Category 2	Category 3	Category 4
Incidents	940	7,270	2,538	250
Percentage	8.5%	66.1%	23.1%	2.3%

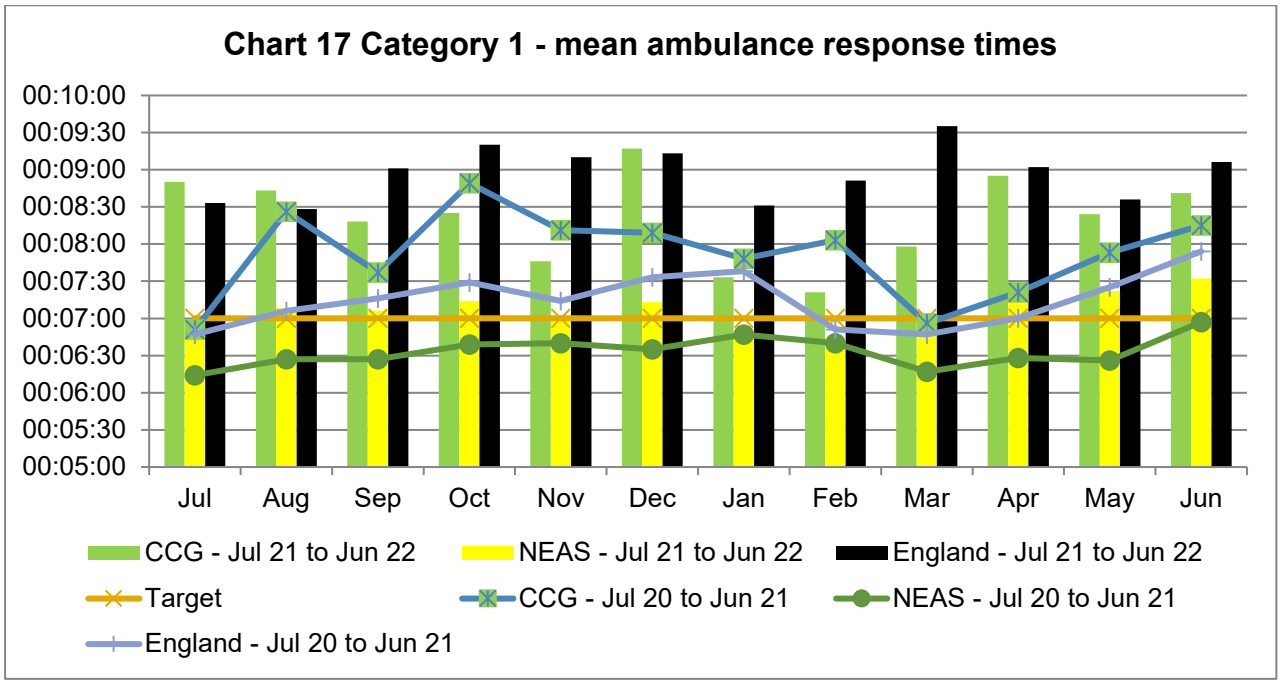
The volume of incidents across Northumberland varied throughout the year on a month-by-month basis as shown on the chart below. The variation followed a similar profile to 2020/21.



	Northumberland CCG - July 2021 to June 2022 Performance											
Category	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
1 Mean (Target 7 mins)												
1 90th Centile (Target 15 mins)												
2 Mean (Target 18 mins)												
2 90th Centile (Target 40 mins)												
3 90th Centile (Target 20 hours)												
4 90th (Target 3 hours)												
Achieved (6)	1	1	0	0	1	1	3	3	1	1	1	0

	NEAS - July 2021 to June 2022 Performance											
Category	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
1 Mean (Target 7 mins)												
1 90th Centile (Target 15 mins)												
2 Mean (Target 18 mins)												
2 90th Centile (Target 40 mins)												
3 90th Centile (Target 20 hours)												
4 90th (Target 3 hours)												
Achieved (6)	2	1	1	1	1	1	3	3	2	1	1	1

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.
The charts outlined below show the comparative performance of Northumberland with both the overall performance of NEAS and England during the last 12 months.



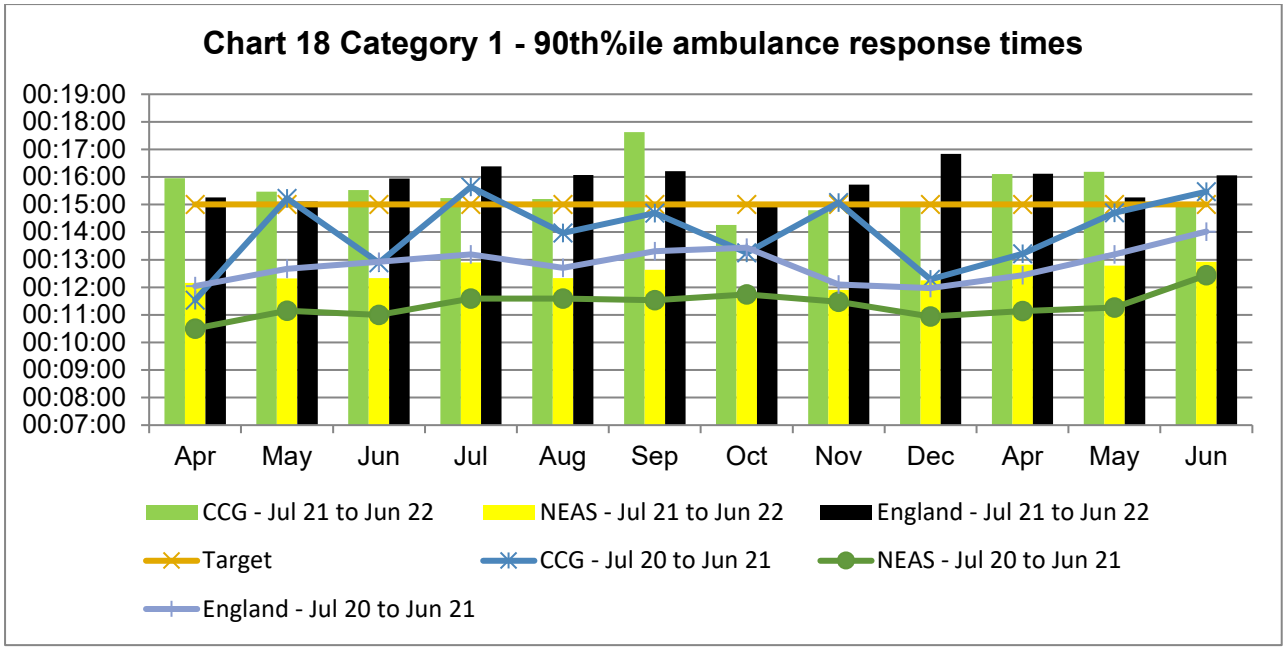


Chart 18 Category 1 - 90th%ile ambulance response times
00:19:00
00:18:00
00:17:00
00:16:00
00:15:00
00:14:00
00:13:00
00:12:00
00:11:00
00:10:00
00:09:00
00:08:00
00:07:00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Apr
May
Jun
CCG - Jul 21 to Jun 22
NEAS - Jul 21 to Jun 22
England - Jul 21 to Jun 22
Target
CCG - Jul 20 to Jun 21
NEAS - Jul 20 to Jun 21
England - Jul 20 to Jun 21

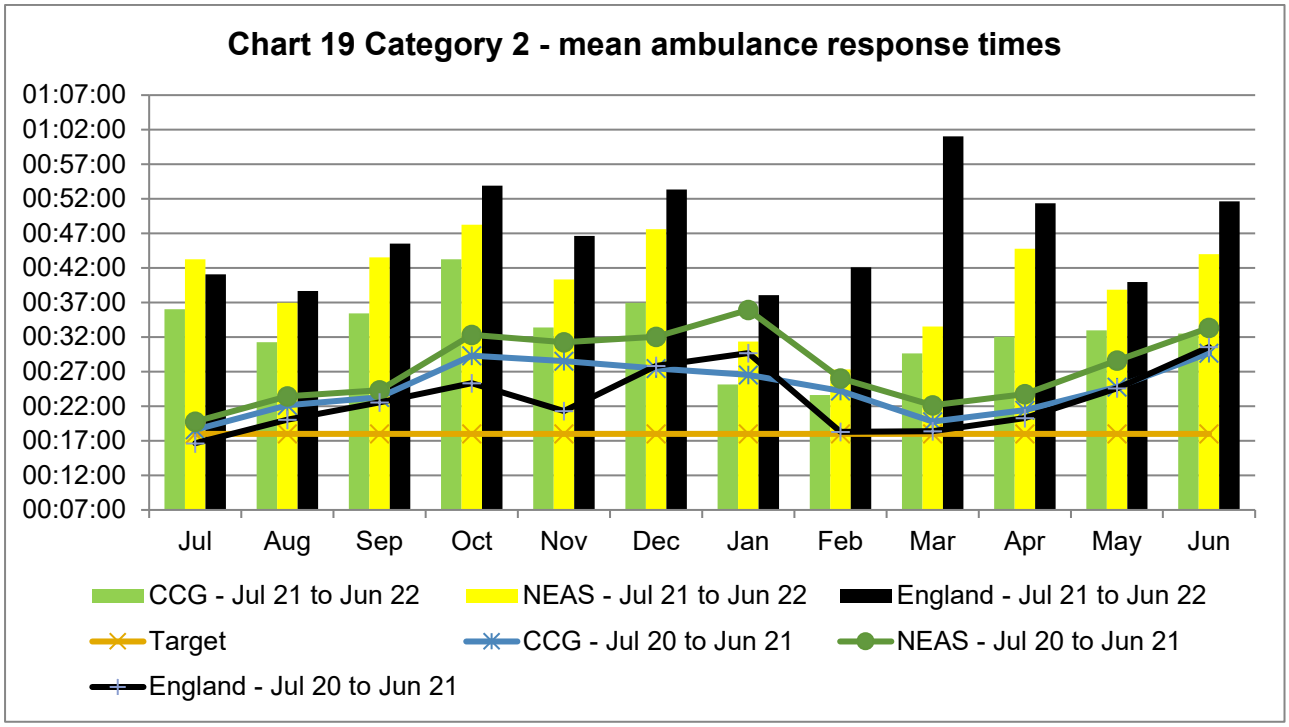


Chart 19 Category 2 - mean ambulance response times
01:07:00
01:02:00
00:57:00
00:52:00
00:47:00
00:42:00
00:37:00
00:32:00
00:27:00
00:22:00
00:17:00
00:12:00
00:07:00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
CCG - Jul 21 to Jun 22
NEAS - Jul 21 to Jun 22
England - Jul 21 to Jun 22
Target
CCG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

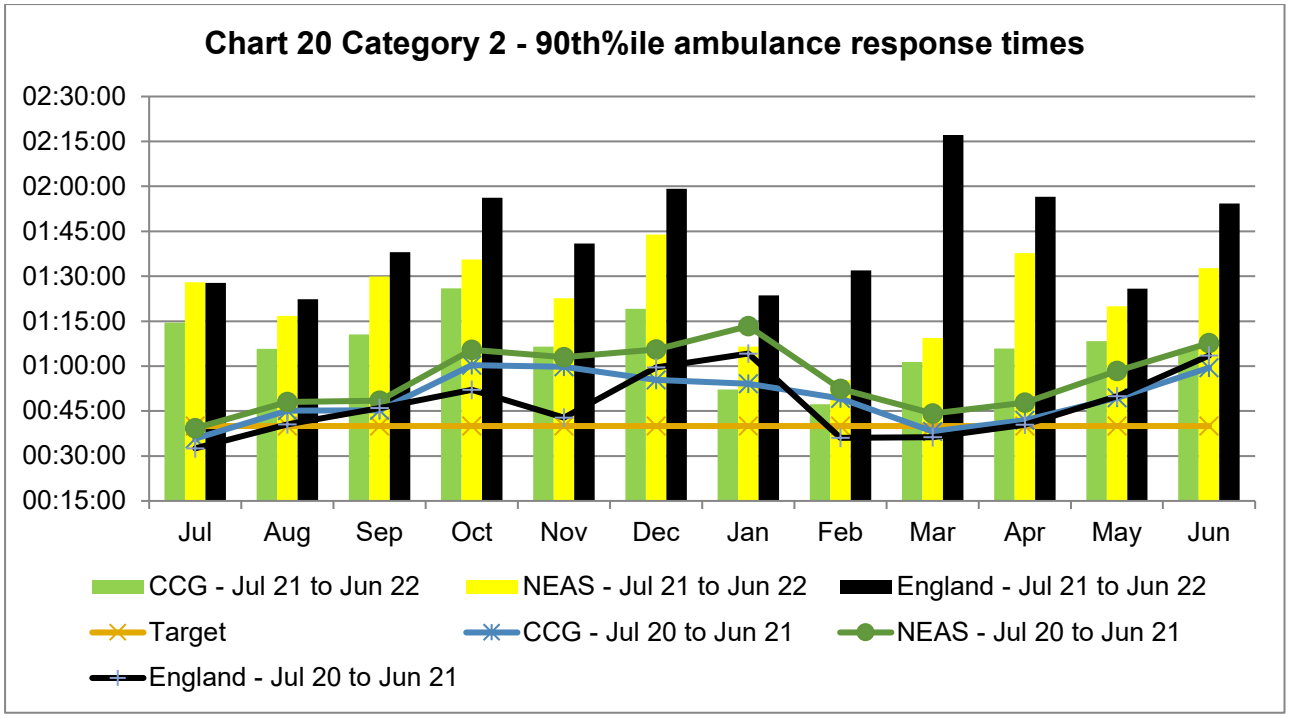


Chart 20 Category 2 - 90th%ile ambulance response times
02:30:00
02:15:00
02:00:00
01:45:00
01:30:00
01:15:00
01:00:00
00:45:00
00:30:00
00:15:00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
CCG - Jul 21 to Jun 22
NEAS - Jul 21 to Jun 22
England - Jul 21 to Jun 22
Target
CCG - Jul 20 to Jun 21
NEAS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

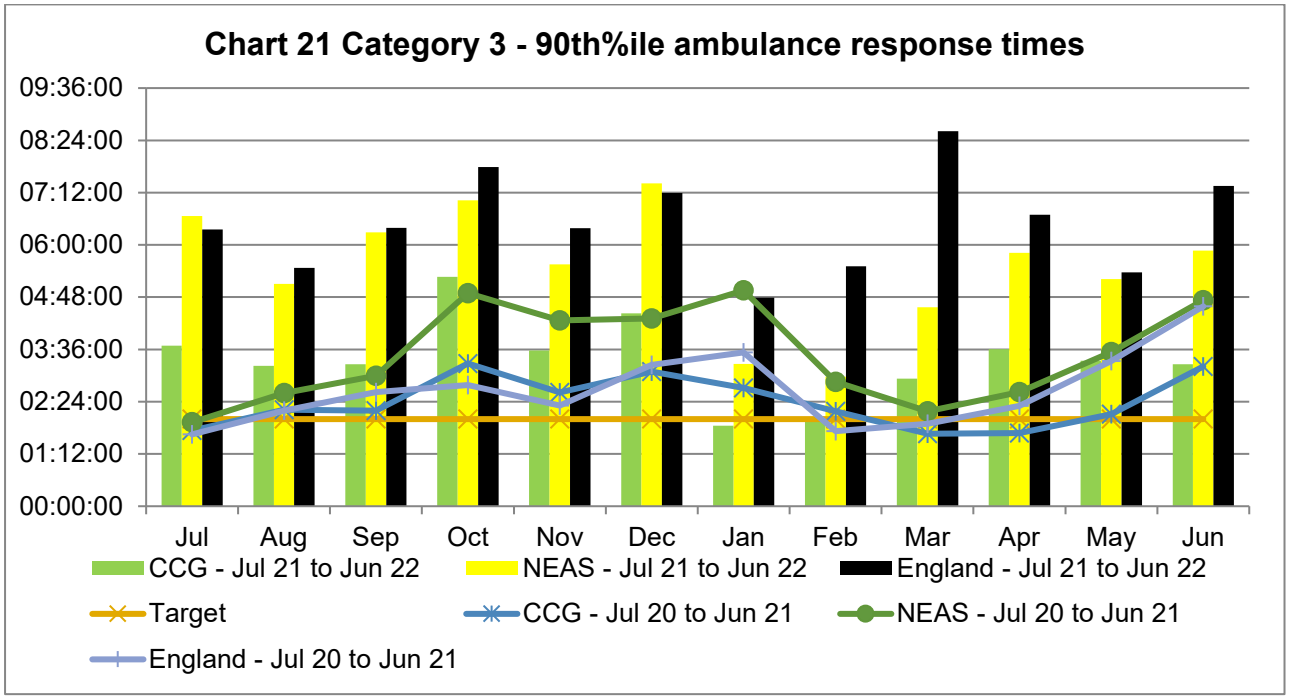
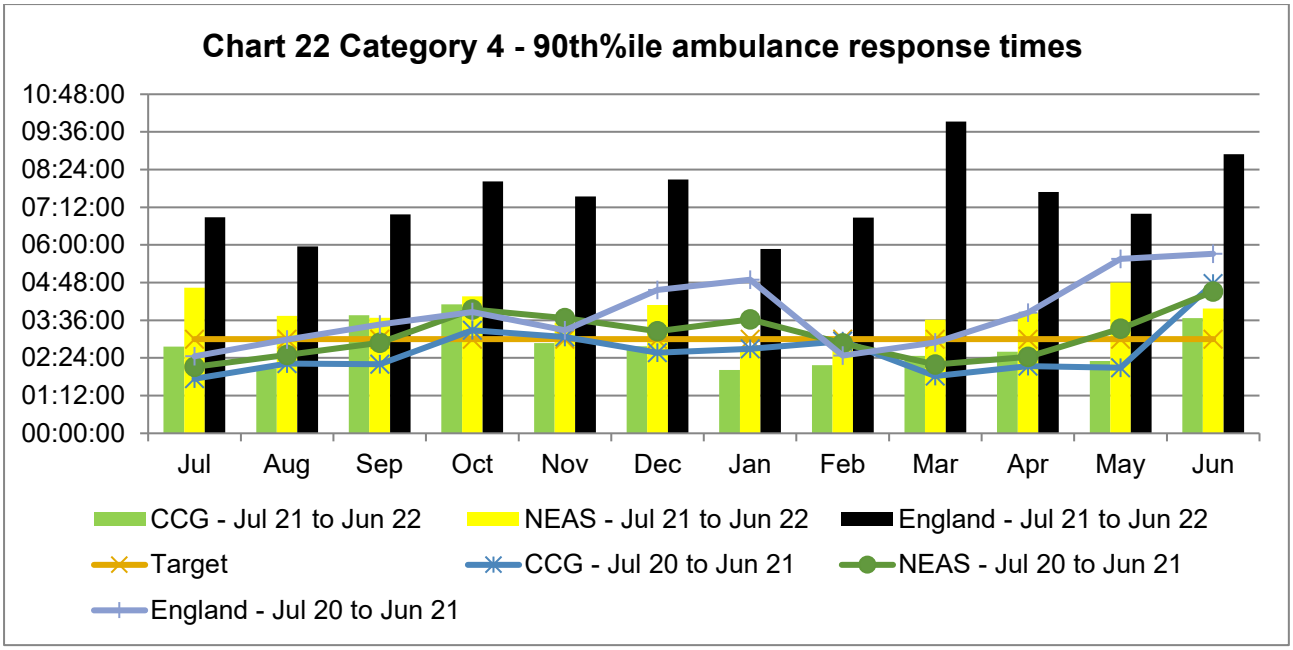


Chart 21 Category 3 - 90th%ile ambulance response times
09:36:00
08:24:00
07:12:00
06:00:00
04:48:00
03:36:00
02:24:00
01:12:00
00:00:00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
CCG - Jul 21 to Jun 22
NEAS - Jul 21 to Jun 22
England - Jul 21 to Jun 22
Target
CCG - Jul 20 to Jun 21
NEAS - Jul 20 to Jun 21
England - Jul 20 to Jun 21



Healthcare Acquired Infections

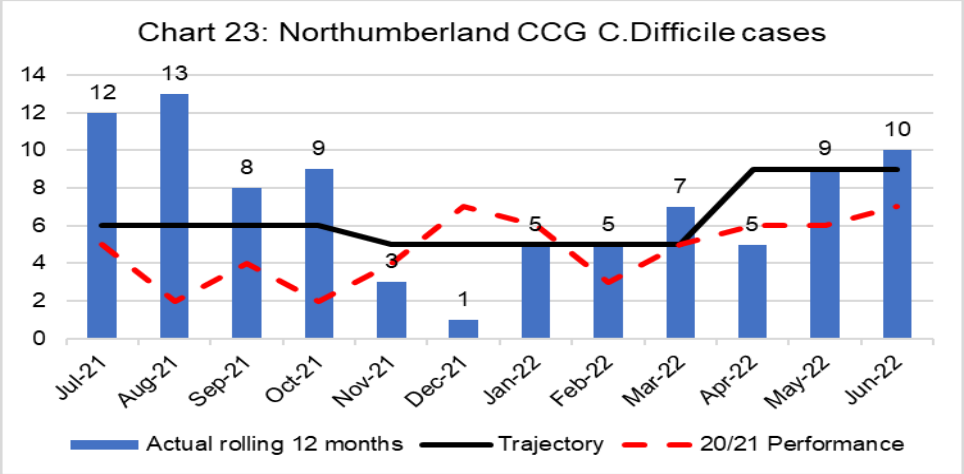
The CCG worked collaboratively with its local providers in reviewing the learning from cases and reviewing working practices to reduce the risk of future infections. The local providers conduct root cause analysis and study the trends in the incidence of cases. Regular meetings take place both at place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

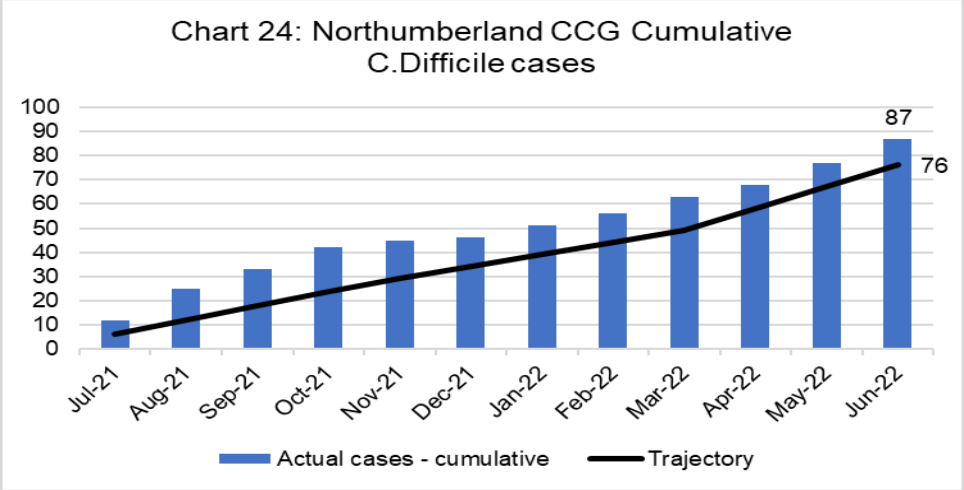
MRSA

There has been zero cases of MRSA bacteraemia reported between April 2022 – June 2022.

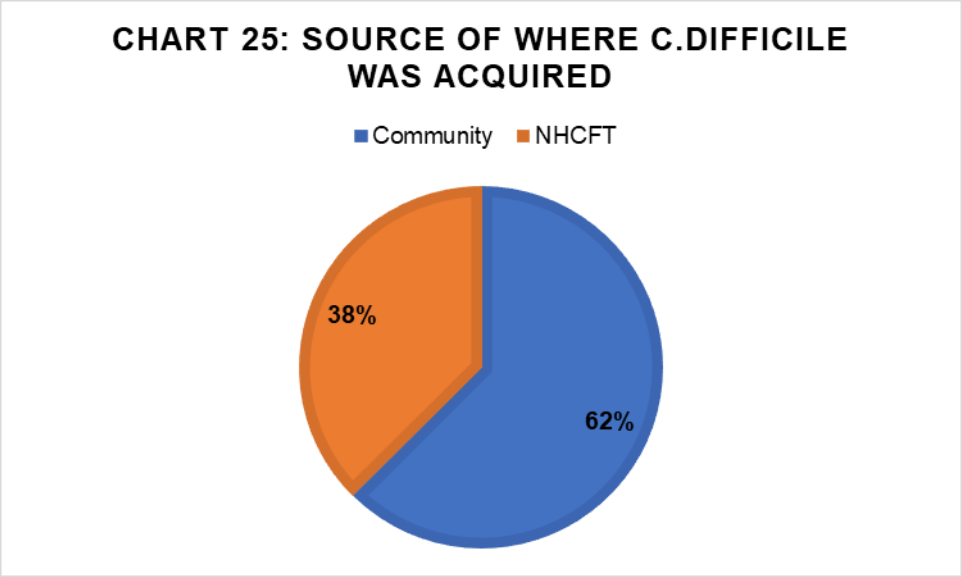
Clostridium Difficile

The charts below show the comparative number of cases on both a monthly basis over a 12-month rolling period along with the monthly trajectory.





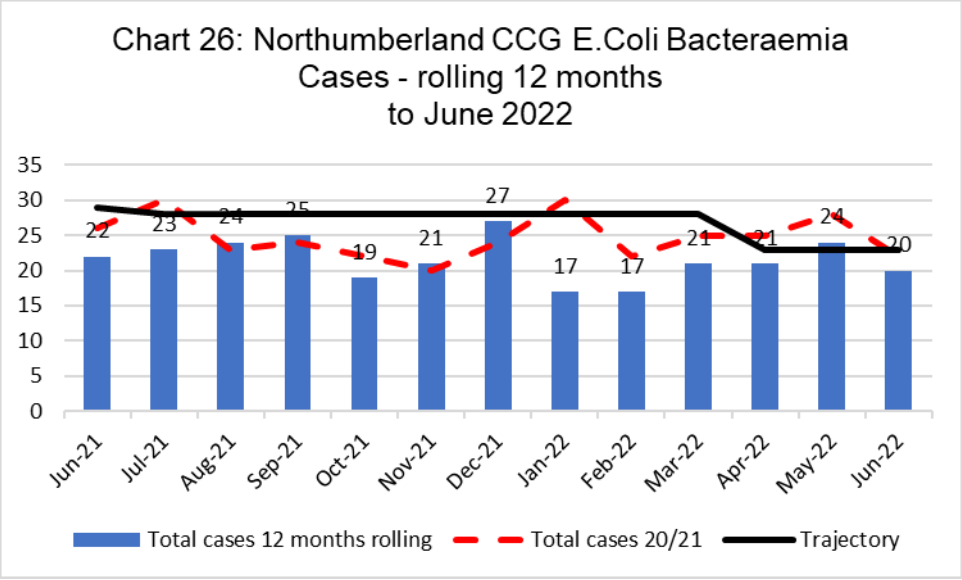
In April – June 2022, there was a total of 24 C.Difficile cases reported against a trajectory of 27. Chart 24 reports the cumulative figures over a 12-month period however, the year-to-date cases are within the trajectory for 2022. The chart below shows the split between community and hospital as to where the infection was acquired.

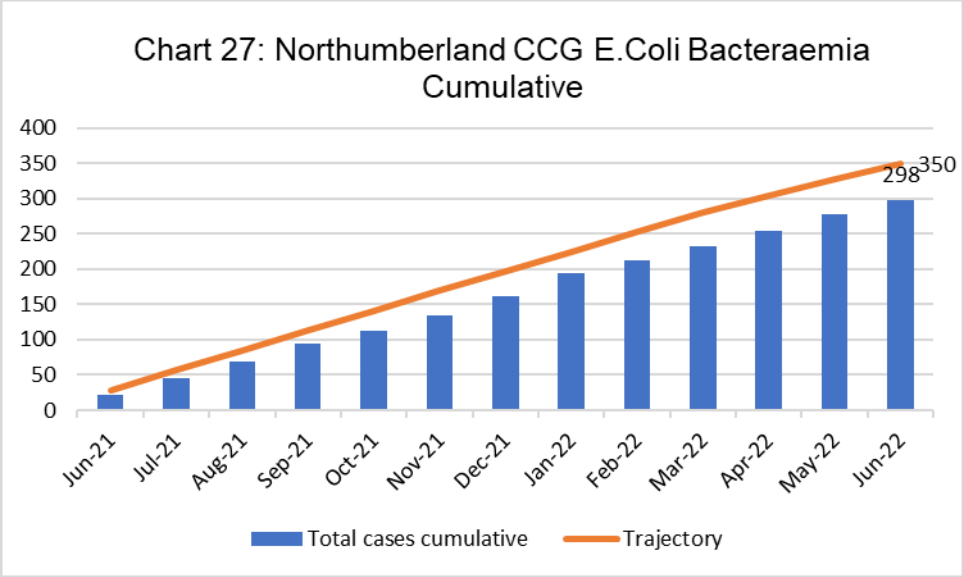


62% of cases reported April – June 2022 were community-acquired.

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.



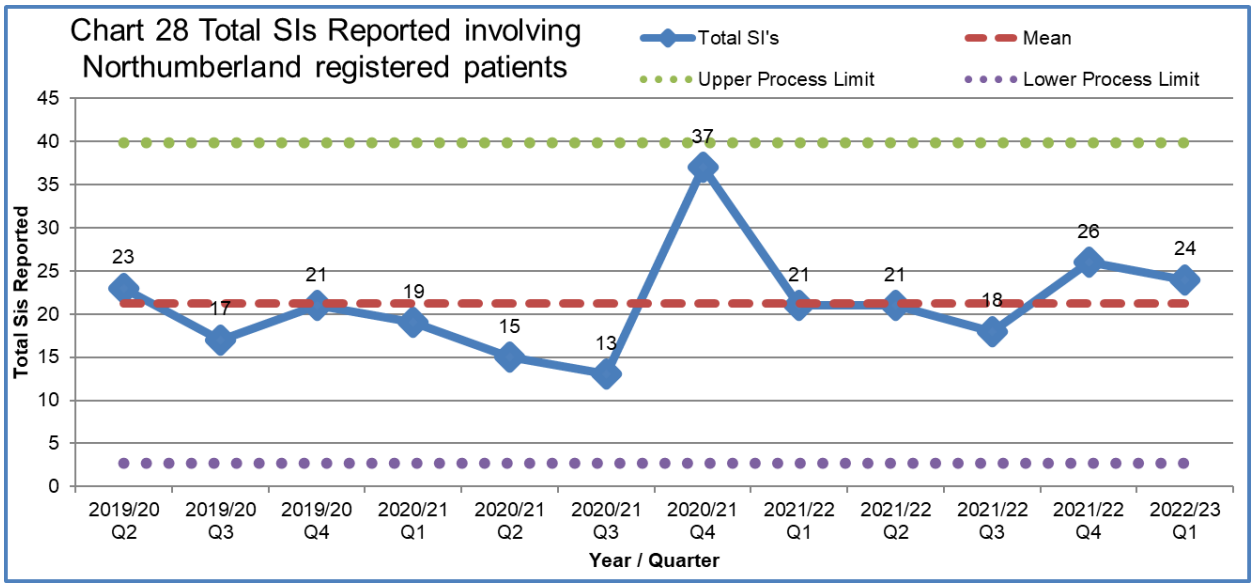


In April 2022 – June 2022, there was a total of 65 cases reported compared which is within the trajectory of 69. The charts above show the last 12 months to give a further insight into the monthly trends.

Never Events

There were zero never events reported during April 2022 – June 2022.

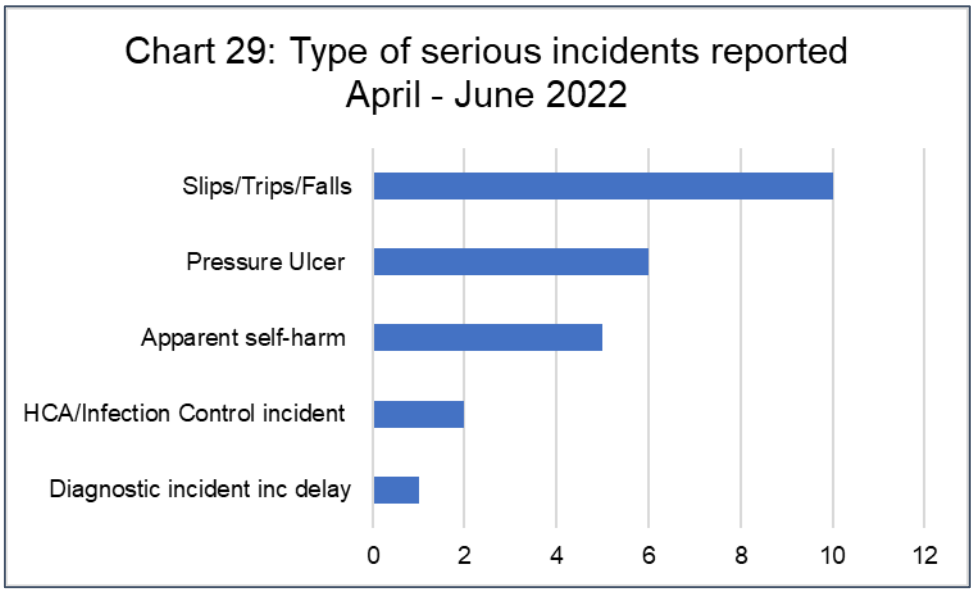
Serious Incidents



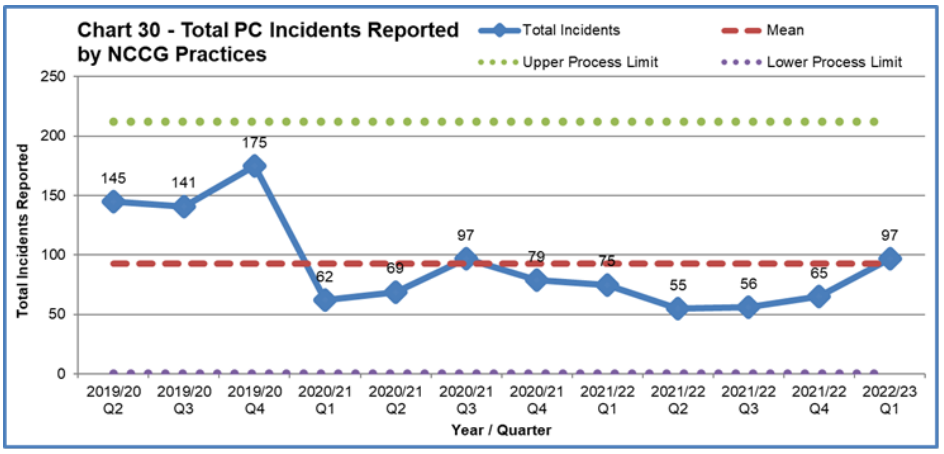
Total serious incidents reported

24 serious incidents were reported in quarter 1 2022/23 relating to Northumberland. The chart above provides a breakdown of the number of Serious Incidents reported per quarter from 2019/20 to provide a breakdown of the reporting over each quarter. All serious incident and never event reports received are taken to the CCG Serious Incident Panel for review and consideration for sign off.

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



Safeguarding Incident Management System (SIRMS)



Northumberland GP practices reported 97 incidents onto the SIRMS during April – June 2022. As demonstrated in the chart above Northumberland practices have reported more incidents than April – June 2021 when 69 were reported.

Care Homes

The COVID-19 Care Homes & Care Settings Outbreak Prevention and Control Team met weekly throughout the pandemic and was stood down in April 2022. The CCG along with system colleagues continued to monitor any COVID-19 outbreaks within nursing, residential and specialist residential settings and Domiciliary and ISL settings. Outbreak Control Team meetings are held, if necessary, to discuss support.

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 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 they 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 April to June 2022, we have engaged on a regular basis with the public, community and voluntary community sector (VCS) organisations, local community groups and patient participation groups.

We continue to work closely with Healthwatch Northumberland to act on engagement which they have carried out independently and feed this into the CCG's decision-making processes. Furthermore, the Chair of Healthwatch Northumberland and the Local Medical Committee Chair are members of the Primary Care Commissioning Committee and represent the public in this decision-making committee.

Our engagement activities this quarter 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:

Primary Care Network Engagement Working Group

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 continues to hold the PCN Engagement Working Group meetings. Membership of the group includes representatives from 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 ensures two-way communication with primary care and the wider health economy takes place and provides the CCG with an opportunity to hear local themes and issues.

Your NHS Online Community

The CCG continued to benefit from the online private community platform called 'Your NHS Online Community' which we share with Northumbria Healthcare NHS Foundation Trust. 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 helped us build up community insights by gathering questions and concerns about issues.

The Online Community enables us to carry on ‘testing the temperature’ in communities and picking up specific feedback to improve our services and has gone from strength to strength. In April 2021 membership stood at 197, and by April 2022 grew to 276 members who we were able to seek views from, test ideas and scenarios and actively involve.

GP Practice Relocations, Mergers and Branch Closures

Throughout this quarter the CCG has continued to provide support to GP practices who have applied 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.

Improving Access

At the start of 2022, the CCG undertook an extensive piece of research and engagement, to gather patient views on accessing healthcare at General Practices.

Prior to the COVID-19 pandemic, a number of new ways of accessing care at GP practices had started to be introduced, but these changes, in particular the use of non-face-to-face appointments, had to be accelerated rapidly to ensure the safety of patients and staff. In Northumberland, we accepted that this had taken place without taking into account the views of both patients and staff, so we proactively decided to carry out this research to understand exactly where people’s concerns may lie.

The CCG commissioned Explain Market Research to engage with the Northumberland population to better understand their views. The engagement project ran between January and February and a number of methods were adopted including a survey, which was completed by 2,750 individuals online and 87 paper copies were submitted.

The results of the engagement were presented to the Primary Care Commissioning Committee in May 2022 and shared with practices and stakeholders this quarter. The findings emphasised that access to primary care is of crucial importance to patients and that there are strong feelings about how this can best be achieved to meet people’s needs and expectations. The engagement also revealed that there is a need for more communication to ensure that patients know about all of the different options they have available to them, both in terms of access arrangements but also the range of healthcare professionals who can support them.

Once we had this insight from the engagement project, it means we could support meaningful action, involving patients, staff and other stakeholders in developing solutions, many of which may well be tailored specifically for different communities or areas of the county.

Involvement Strategy for the North East and North Cumbria Integrated Care Board

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

Citizens' Panel engagement for the ICB

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

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

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

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

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

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

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

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

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

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

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

Governance

Equality, Diversity, and Inclusion (EDI) was governed by and reported into the Governing Body (GB) . The GB ensured we were compliant with legislative, mandatory, and regulatory requirements regarding equality and diversity and inclusion. We developed and delivered national and regional diversity related initiatives within the CCG, provided a forum for sharing issues and opportunities and monitored the achievement of key EDI objectives.

Equality Strategy

Our refreshed Equality Strategy for 2021-2024, highlighted the aims set out within the 'We are the NHS: People Plan 2020/21 – action for us all'. The strategy 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 continued to utilise the Equality Delivery System (EDS2) framework and used the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED). And we also use the tool 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 encouraged a diverse range of people to apply to and work for us as we recognise the benefits such diversity brings to the quality of our work and the nature of our organisation. We continued to offer guaranteed interviews to applicants with a disability who are identified as meeting the essential criteria for any advertised roles; 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 was embedded into our governance process and sign off from the Governing Body is required for monitoring and completion.

Accessible Information Standard

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

Health Inequalities

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

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

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

Through working with NECS, 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 Continued to monitor the health profiles and data available which detail the health challenges of our population including the Joint Strategic Needs Analysis (JSNA) and Public Health Profiles.

Further information can be found at:

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 brought 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 were met and tackle local inequalities in health.

The Chairman of the Board was 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

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

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

ACCOUNTABILITY REPORT [2]

Samantha Allen

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

Accountable Officer

30th June 2023

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

Accountability Report

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

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

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

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

Corporate Governance Report

Members Report

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	

Composition of Governing Body

The Governing Body membership consisted 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
- 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

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 are available to the public, if you would like any further information relating our register of interest please email your enquiry to nencicb-nt.enquiries@nhs.net

Personal data related incidents

The CCG reported no data incidents to the Information Commissioners Office in the first quarter of 2022/23.

Modern Slavery Act

The CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

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

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

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).

NHS Northumberland Clinical Commissioning Group statutory functions are set out under the National Health Service Act 2006 (as amended).

The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

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

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Northumberland 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 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 was to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. 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.

One meeting of the Governing Body was held during the period April 2022 to June 2022; membership and attendance was as follows:

Title	Member	Attendance
Clinical Chair (Chair)	Graham Syers	1/1
Deputy Lay Chair (Deputy Chair)	Janet Guy	1/1
Two Lay Governors:		
Lead on audit and conflict of interest	Steve Brazier	1/1
Lead on corporate finance and patient and public involvement	Karen Bower	1/1
The Accountable Officer	Mark Adams	1/1
One registered nurse	Annie Topping	0/1
One secondary care specialist doctor	Prof Marios Adamou	1/1
The Locality Director North	Dr Chris Waite/Tony Brown	1/1
The Medical Director and Locality Director Central and Blyth Valley	Dr John Warrington	1/1
The Locality Director West	Dr Ben Frankel	4/7
The Medical Director	Dr Robin Hudson	1/1
The Chief Operating Officer	Siobhan Brown	1/1
The Chief Finance Officer	Jon Connolly	1/1

Title	Member	Attendance
The Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	1/1

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 undertook a proportion of its work through committees. Each committee had 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 was 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 was 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 was 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. One meeting of the Audit was held during the period April 2022 to June 2022; membership and attendance was as follows:

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

The Committee's main activities 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) was 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 was 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.

No meetings were held in the period April to June 2022.

Northumberland Primary Care Commissioning Committee

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

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

NHS England had 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 was 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 two meetings of the NPCCC were held in the period April to June 2022 with attendance by members as follows:

	Member	Attendance
Lay Chair	Janet Guy (Chair)	2/2
Lay Governor for Corporate Finance and PPI	Karen Bower	2/2
Chief Operating Officer	Siobhan Brown	1/2
Chief Finance Officer	Jon Connolly	1/2
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	2/2
Service Director for Integration and Transformation	Rachel Mitcheson	2/2
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	2/2

The Corporate Finance Committee

The Corporate Finance Committee's (CFC) principal function was 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 was 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 1 meeting of the CFC was held during the period April to June 2022 with attendance by members as follows:

Title	Member	Attendance
Lay Governor for Corporate Finance and Patient and Public Involvement (Chair)	Karen Bower	1/1
Lay Governor for Audit and Conflict of Interest	Steve Brazier	1/1
Clinical Chair	Dr Graham Syers	1/1
Business Director (Finance and Commissioning)/Locality Director and Medical Director	Dr John Warrington	1/1
Chief Operating Officer	Siobhan Brown	0/1
Chief Finance Officer	Jon Connolly	1/1
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	1/1
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	1/1

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 was 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 3 meetings of the CMB were held during the period April to June 2022, membership and attendance was as follows:

Title	Member	Attendance
Medical Director (Chair)	Dr Robin Hudson	2/3
Medical Director and Locality Director (Central and Blyth) (Deputy Chair)	Dr John Warrington	1/3
Clinical Chair	Graham Syers	3/3
Locality Director (North)	Dr Chris Waite	1/3
Locality Director (North)	Tony Brown	2/3
Locality Director (West)	Dr Ben Frankel	3/3
Executive Director of Nursing, Quality and Patient Safety	Annie Topping	2/3
Service Director of Transformation and Integrated Care	Rachel Mitcheson	3/3
Chief Operating Officer	Siobhan Brown	2/3
Chief Finance Officer	Jon Connolly	1/3
Executive Director of Commissioning, Contracting and Corporate Governance	Paul Turner	3/3
Public Health Consultant	Dr James Brown	1/3

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) met on a bi-monthly basis. One meeting was held during the period April to June 2022; membership and attendance was as follows:

Title	Member	Attendance
Executive Director of Nursing, Quality and Patient Safety (Chair)	Annie Topping	1/1
Deputy Director of Quality and Patient Safety	Claire Coyne	1/1
Governing Body Secondary Care Doctor	Dr Marios Adamou	0/1
Acting Head of Quality and Patient Safety for Adults	Leesa Stephenson	0/1
Senior Clinical Quality Officer (NECS)	Sara Anderson/Kim Ewen	1/1
Locality Manager representative	Diane Gonsalez	1/1
Communications and Engagement Manager	Emma Robertson	1/1

Title	Member	Attendance
Head of Performance and Assurance	David Lea	0/1
Medicines Optimisation Team Representative	Susan Turner	1/1
Public Health Commissioner	Dr James Brown	0/1

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 was 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 one meeting of the MOG was held during the period April to June 2022; membership and attendance was as follows:

Title	Member	Attendance
CCG Locality Director/GP Prescribing Lead (Chair)	Dr Chris Waite	1/1
CCG Prescribing Management Lead	Alan Bell	1/1
NECS - Senior Medicines	Helen Seymour	1/1

Optimisation Pharmacist		
NECS - Medicines Optimisation Pharmacist	Susan Turner	1/1
Finance Lead	Subject to availability	1/1

The group regularly monitors prescribing budgets, implements strategies to ensure cost effective prescribing and agrees the budget setting formula for practices. 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.

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 had 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 was 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 were 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 was 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
- 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 included 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 employed 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 was an important element of the CCG's business planning processes.

The risk management policy outlined:

- 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 was 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 set the 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 strategic and corporate risk registers. The CCG adopted a bottom-up approach to the generation of its risk registers. The purpose was 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 Q1 2022/23 strategic and corporate risks have been monitored by the relevant governance committees. The strategic and the corporate risk registers have been reviewed by the Audit Committee, Governing Body and the Clinical Management Board. The strategic risk register covered all the CCG's main activities including financial, clinical and organisational activities and identifies the principal objectives and targets that the organisation was 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 covered 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 had 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 also had 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 acted 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 had 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 were 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 adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which was set out in the Risk Management Policy. Throughout this three-month period the CCG identified and managed a range of risks, both strategic and operational.

Risk 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 in Quarter 1 2022/23 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 have led to impact on organisational performance at provider level, reputational impact on the CCG a threat to the delivery of safe, high-quality services.

The risks were 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 was a risk that the CCG did 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 was 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 was a risk that the CCG was 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 have resulted in poor patient outcomes, potentially unsafe services, failure of statutory obligations and reputational damage to the CCG.

This risk was 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 were 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 ICS there was 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 have resulted 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 was 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 was a risk that the CCG was 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 have resulted 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 was mitigated by the work of the CCG's Quality Safeguarding Group which was established as a sub-committee of the Clinical Management Board. There were 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 was a risk that the CCG did 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 was 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 was in place across the CCG and its member practices.

Mental Health Investment Standard (MHIS)

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

This risk was 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 was a risk that they could led 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 have resulted in capacity or operational delivery gaps. This could have led to reduced operational output, a failure to deliver against statutory duties and damage to the CCG's reputation.

This risk was mitigated by robust business continuity arrangements.

Capacity and Capability

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

This may have resulted 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 was 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 was 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 was 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 was a risk that the CCG would not be able to access the insight and intelligence necessary to make informed decisions on population health needs based on evidence.

This may have resulted in a widening of existing health inequalities and unmet need within our patient and population communities.

This risk was 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 improved the health and wellbeing of the local population, there was 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 have resulted in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.
This risk was 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 potentially failing in its duties to commission services which improve the health and wellbeing of the local population, there was 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 have resulted in a derogation of patient care, failure to deliver statutory duties and associated reputational damage to the CCG, litigation and financial pressures.

This risk was 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

Potential 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 may suffer or they have poor experience, the could CCG breaches its Outcomes Framework, or suffers reputational damage.

The CCG released 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 was 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 have resulted in reputational damage, legal challenge and unsustainable prescribing cost growth to the CCG.

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

Coronavirus (COVID-19)

There was 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 have resulted in large work backlogs, impacts to staff welfare, impacts to patient welfare, increased costs.

This risk was 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 was a potential that COVID-19 expenditure was 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 was 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 was 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 have led to increased financial pressure and reputational damage to the CCG.

This risk was actioned by robust action plans in place in areas of concern such as spinal, cancer and other specialties. The CCG worked 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

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control was based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the clinical commissioning group, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
A system of internal control was in place in the CCG for the operating period 01 April – 30 June 2022.

The Internal Audit service was an important aspect of assurance on the system of internal control through a risk-based programme of work. This provided assurance on key systems of control within the CCG through formal reporting to Audit

Committee. The Head of Internal Audit also has direct access to the Audit Committee Chair as required.

Statutory and mandatory training was undertaken by all members of staff during 2022/23, including compliance with health and safety requirements and information governance requirements. The CCG was committed to a process of continuing professional development, directed through the formal appraisal system.

The CCG had a range of policies in place which contribute to the system of internal control. The three policy areas are corporate, human resources and information governance with a suite of standard operating procedures to support them. Policies were reviewed and revised on a regular basis determined by their revision date.

Annual audit of conflicts of interest management

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

Data Quality

We receive data on quality, performance, finance and contracts which brings together the key strands of provider management responsibility. This ensures that no single aspect of this element of business is seen in isolation and provides an explicit link between finance, quality and performance issues.

Data was also received in relation to human resources, statutory and mandatory training and freedom of information requests which inform the governing body of progress and issues in those areas.

The Governing Body considered the data received to be of an acceptable standard.

Information Governance

The NHS Information Governance Framework set the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework was 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 placed high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We established an information governance management framework and have developed information governance processes and procedures in line with the Data

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

There were processes in place for incident reporting and investigation of serious incidents. We 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 was considered at the Clinical Management Board. The CCG had also appointed a Caldicott Guardian and Senior Information Risk Owner.

The Data Security & Protection (DSP) Toolkit is an online system which allows NHS Organisations and partners to assess themselves against Department of Health and Social Care Information Governance policies and standards. All NHS organisations are required to carry out self-assessments.

NECS Information Governance and Information Technology teams supported CCGs with their Toolkits; this included collecting evidence and uploading this to the CCG Toolkits ready for final publication by 30 June 2022. All CCGs were able to report a 'Standards Met' performance and published on time. Due to the abolition of the CCGs on 1 July 2022, NHS Digital made the requirement for internal audit optional. As a result no internal audits were undertaken

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

We comply with our statutory duty to respond to requests for information. During the reporting period we received 39 requests under the Freedom of Information Act 2000. All requests were responded to within the statutory timescales.

The CCG has had no serious information governance breaches in this reporting period.

Business Critical Model

We had a Business Continuity Management Plan, which was a live document and was formally approved by the Governing Body in January 2020. This plan was be formally reviewed once the current Major Incident - COVID 19 – has been stood down in order that we are able to do a full debrief and include all recommendations into the plan. The current plan was still fit for purpose. We do not have any business-critical models.

Third party assurances

The CCG relied on several external support services providers in respect of some of its business functions, including the North of England Commissioning Support (NECS), the NHS Shared Business Service (SBS), Electronic Staff Records (ESR)

(IBM), Northumbria Healthcare NHS Foundation Trust (payroll), Capita (primary care co-commissioning), NHS Digital (GP payments) and the NHS Business Services Authority (BSA).

These organisations provided service auditor reports (SARs) as part of the evidence of assurance on their internal system of controls as required by their customers. These service auditor reports are considered by the Audit Committee and internal audit also consider service auditor reports as part of the overall year-end internal audit opinion.

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

Control Issues

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

The CCG had a robust system of internal control and there were no significant internal control issues currently facing the CCG. The CCG has assurances from the Head of Internal Audit and from other sources to support this assessment.

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

The CCG 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 was 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 was acting consistently with this duty was supported by the following committees:

Audit Committee – provided the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance. The 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 had in place.

Appointments and Remuneration Committee – made 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 was delegated by the Governing Body to the Chief Finance Officer, who was the Governing Body's professional expert on finance and ensures, through robust systems and processes, the regularity and propriety of expenditure was fully discharged.
The Chief Finance Officer was 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 had a responsibility to ensure its expenditure did not exceed the aggregate of its allotments for the financial period. This responsibility was delegated to the Governing Body which approved 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 approved and reviews the CCG's Scheme of Delegation and Standing Financial Instructions (SFIs). The Governing Body was held to account for the monitoring and overall delivery of financial performance and compliance with SFIs.

Counter fraud arrangements

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

Through our contract with Audit One, we have had 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 Q1 2022/23.

Whistleblowing arrangements

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

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1st April 2022-30th June 20222 for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Overall Opinion

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

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

Opinion Area	Commentary
Audit Coverage	Internal Audit coverage in Quarter 1 2022/23 focused on: • Assurance Framework & supporting processes • Transition Programme • Outstanding Audit Recommendations and Risk
Design and operation of the Assurance Framework and supporting processes	The Governing Body Assurance Framework and Strategic Risk Register was presented to both the Audit Committee and the Governing Body. The Governing Body Assurance Framework was last presented to the Audit Committee on 9 th June 2022 and to the Governing Body on 25 May 2022. The Governing Body Assurance Framework is based on the CCG's strategic objectives and an analysis of the principal risks to achieving those objectives. It continued to reflect the impact of the transition to an ICB and managing the Covid-19 pandemic in alignment with the CCG's corporate objectives. The key controls that have been put in place to manage the risks have been documented, and the sources of assurance for individual controls have been identified. The Governing Body Assurance Framework therefore provides the CCG with a comprehensive mechanism for the management of the principal risks to meeting its strategic objectives and supports the compilation of the Annual Governance Statement. The CCG has developed risk management processes that are operating within the organisation. The Audit Committee oversees the risk management agenda and reports to the Governing Body. It provides assurance to the Governing Body on the systems and processes by which the organisation leads, directs and controls its functions in order to achieve its strategic objectives
Transition Programme	AuditOne continued to have involvement during the transition period through:

Opinion Area	Commentary
	• Attendance at two weekly ICS steering group meetings and liaison with NECS who provided project support. • Attendance at a checkpoint meeting with lead officers at the CCG (16 th February 2022) and a further, more formal check and challenge session covering North Cumbria and the North places which was held on 10th May 2022. Through attendance and receipt of supporting papers, it was observed that risks and issues were being reported through the project groups supported by NECS. No concerns were raised around completion of the activities required to sign off on due diligence process. • It could be confirmed that the outcome of the CCG Closedown Due Diligence process was reported to the Audit Committee. At its meeting on 9th June 2022, the Committee was provided with a copy of the assurance letter that had been issued by the Accountable Officer to the Chief Executive Designate of the ICB, that a robust due diligence process has been undertaken to prepare for the closedown of the CCG
Brought forward Internal Audit assurances	The Head of Internal Audit Opinion given for the year ended 31st March 2022 gave a level of assurance of 'substantial'. There were no material issues identified to be brought forward for consideration in this opinion statement
Response to Internal Audit recommendations	The implementation of internal audit recommendations is a key indicator of the organisation's engagement with us and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues, so these are not subject follow-up by AuditOne. At 30th June 2022, there were only two outstanding audit recommendations, both were medium priority and had not passed the target implementation date. These related to the operation of the risk register and management of conflicts of interest in appointment processes and upon the conclusion of the CCG will be superseded. This demonstrates that the CCG has continued to have a positive approach to internal audit recommendations, which improves the strength of its system of internal control, risks and governance.
Significant factors outside the work of internal audit	While the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the internal audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsourced many of its functions, assurances from third parties are equally as important when the CCG draws up its Governance Statement. Assurances are provided on an annual basis therefore nothing is available at this time for the Q1 period.

Carl Best

Associate Director of Audit, AuditOne

Date: 26th September 2022

Definitions of Assurance Levels

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

Review of 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 provided 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 reporting period were structured around the key risks and issues.

The Audit Committee

The Annual Internal Audit Plan, as approved by the Audit Committee, enabled 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 was 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 was 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 reporting period, 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.

Data security

We have adopted and implemented the Department of Health and Social Care's guidance, 'Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents.'

The organisation had a standard operating procedure in place for the reporting of level three information governance incidents to the Information Commissioner. This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach.

Conclusion

My review confirms therefore that there is a sound system of internal control in place across NHS Northumberland CCG and that there are no significant control issues currently facing the CCG.

In accordance with the statutory duties for clinical commissioning groups, as laid down in the Health and Social Care Act 2012, I certify that the continued delivery of those statutory duties was discharged through NHS Northumberland Clinical Commissioning Group during 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 Committee and 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.

During the period 1 April to 30 June 2022 Northumberland CCG had three senior managers (2021/22, two) 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 30 June 2022.

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

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Dr Graham Syers	Clinical Chair	15-20	-	-	-	-	15-20
Janet Guy	Deputy Lay Chair	5-10	-	-	-	-	5-10
Karen Bower	Lay Governor	0-5	-	-	-	-	0-5
Steve Brazier	Lay Governor	0-5	-	-	-	-	0-5
Professor Marios Adamou	Secondary Care Specialist Doctor	0-5	-	-	-	-	0-5
Mark Adams	Accountable Officer	5-10	-	-	-	-	5-10
Jon Connolly	Chief Finance Officer	20-25	-	-	-	-	20-25
Siobhan Brown	Chief Operating Officer	30-35	-	-	-	-	30-35
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	20-25	-	-	-	7.5-10	30-35
Dr John Warrington	Medical Director/Locality Director/Business Director	15-20	-	-	-	-	15-20
Dr Ben Frankel	Locality Director	0-5	-	-	-	-	0-5
Dr Chris Waite	Locality Director	5-10	-	-	-	-	5-10
Tony Brown	Locality Director	5-10	-	-	-	-	5-10
Dr Robin Hudson	Medical Director	15-20	3	-	-	7.5-10	25-30

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	25-30	3	-	-	-	25-30
Rachel Mitcheson	Service Director – Transformation and Integrated Care	10-15	-	-	-	0-2.5	15-20
Dr James Brown	Consultant in Public Health	20-25	-	-	-	0-2.5	20-25
Pamela Lee	Consultant in Public Health	10-15	-	-	-	-	10-15

Notes to senior manager remuneration report 3 months to June 22

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

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%.

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

Dr James Brown is employed by Northumberland CCG in a Consultant in Public Health role. 90% is recharged to Northumberland County Council.

Pamela Lee is employed by Northumberland CCG in a Consultant in Public Health role. This is recharged in full to Northumberland County Council.

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

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

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 the 3-month period to 30 June 2022 is shown below:

Table 2: Northumberland CCG staff sharing arrangement for the 3 months to 30 June 2022 (this has been subject to audit)

Name	Title	Salary (bands of £5,000) £ 000	Expense payments (taxable) to nearest £100 £00	**TOTAL** (bands of £5,000) £ 000
Mark Adams	Accountable Officer	35-40	-	35-40
Jon Connolly	Chief Finance Officer	40-45	4	40-45
Rachel Mitcheson	Service Director – Transformation and Integrated Care	25-30	-	25-30

Table 3: 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	50-55	-	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 4: 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 5. Northumberland CCG senior officers pension benefits at 30 June 2022 (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 30 June 2022	Lump sum at pension age related to accrued pension at 30 June 2022	Cash Equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
		(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	-	-	15-20	35-40	321	-	315	-
Siobhan Brown	Chief Operating Officer	0-2.5	-	25-30	10-15	355	-	357	-
Annie Topping	Executive Director of Nursing, Quality & Patient Safety	0-2.5	0-2.5	35-40	110-115	918	-	678	-
Dr John Warrington	Medical Director/Locality Director/Business Director	0-2.5	-	20-25	40-45	376	-	379	-
Dr Ben Frankel	Locality Director	-	-	10-15	20-25	186	-	179	-
Dr Chris Waite	Locality Director	-	-	5-10	15-20	196	-	143	-
Tony Brown	Locality Director	-	-	15-20	-	234	-	234	-
Dr Robin Hudson	Medical Director	0-2.5	0-2.5	20-25	30-35	353	8	364	-
Paul Turner	Executive Director of Commissioning, Contracting and Corporate Governance	-	-	20-25	30-35	280	-	280	-

		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 30 June 2022	Lump sum at pension age related to accrued pension at 30 June 2022	Cash Equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£000	£000	£000	£000	£000	£000	£000	£000
Rachel Mitcheson	Service Director – Transformation and Integrated Care	0-2.5	-	35-40	75-80	615	1	620	-
Dr James Brown	Consultant in Public Health	0-2.5	-	25-30	40-45	402	1	407	-
Pamela Lee	Consultant in Public Health	-	-	25-30	80-85	-	3	4	-

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

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

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

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

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	-

		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
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.

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 in the 3 months to 30 June 2022.

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

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

Fair pay disclosure (This has been subject to audit)

Table 7: Percentage change in remuneration of highest paid director

	Salary and allowances %	Performance pay and bonuses %
The percentage change from the previous financial year in respect of the highest paid director	0	(100.0)
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	(5.0)	(100.0)

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

The percentage change from the previous financial year for performance pay and bonuses is a reduction of 100% as there were no performance pay or bonuses paid to employees in the 3 months to 30 June 2022.

Pay ratio information

Table 8: Remuneration of Northumberland CCG staff

3 Months to 30 June 2022	25th percentile	Median	75th percentile
All staff remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£47.673	£56,164	£108,835
Salary component of 'all staff' remuneration based on annualised, full time equivalent remuneration of all staff (including temporary and agency staff)	£41,660	£56,164	£108,835
2021/22			
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

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 annualised 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 annualised banded remuneration of the highest paid director in Northumberland CCG in the 3 months to June 2022 was £120-125k (2021/22: £125-130k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Table 9: Remuneration ratios

Period	25th percentile remuneration ratio	Median remuneration ratio	75th percentile remuneration ratio
3 months to June 2022	2.6:1	2.2:1	1.1:1
2021/22	3.2:1	2.3:1	1.2:1

In the 3 months to June 2022, no employee (2021/22, no employee) received remuneration in excess of the highest paid director excluding shared staff posts; where shared staff posts are senior managers of the CCGs, these are disclosed separately in the 'Shared Arrangements' disclosure.

Annualised remuneration ranged from £23,000 to £170,000 (2021/22: £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 3 months to June 2022 remuneration ratios remain at a consistent level to 2021/22 remuneration ratios due to marginal changes to the overall number, composition and remuneration of the workforce.

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

Staff numbers and costs are analysed by permanent employees and ‘other' for the 3 months to 30 June 2022.
Permanently employed refers to members of staff with a permanent (UK) employment contract directly with the CCG.

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

The figures exclude lay members of the Governing Body.

Table 10: Northumberland CCG average number of people employed

	Permanent Employees	Other	Total
Average number of people employed	54.97	1.12	56.09

Average number based upon full time equivalent.

Table 11: Northumberland CCG staff costs

	Permanent Employees	Other	Total
Staff costs	£'000	£'000	£'000
Salaries and wages	767	20	787
Social security costs	85	-	85
Employer Contributions to NHS Pension scheme	127	-	127
Apprentice Levy	-	-	-
Total Staff costs	**979**	**20**	**999**

Staff costs exclude lay members of the Governing Body

Staff composition

The CCG has a staff headcount of 67 employees (including non-executives and chair) as at the 30 June 2022. This includes 4 very senior managers and 63 other CCG Employees.

Below is the gender split for the headcount:

Table 12: Northumberland CCG staff gender profile at 30 June 2022

	Total	Male	%	Female	%
Very Senior managers	4	2	50	2	50
Other CCG employees	63	22	35	41	50
Total CCG employees	**67**	**24**	**36**	**43**	**64**
Governing Body members	14	10	71	4	29

*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 for 2022 relates to the 3-month period from April to June 2022 compared to the 12-month period reported in 2021/22.Total days lost has reduced in the 3-month period as total days lost in 2021/22 were impacted by a small number of long-term absences which were actively supported and managed.

Table 13: Northumberland CCG staff sickness absence data

	2022 Q1 Number	2021/22 Number
Total days lost	158	777
Average working days lost	**3.0**	**14.5**

Staff turnover

Staff turnover of permanent employees is reported as a percentage of the average number of people employed. The staff turnover for the 3 months to 30 June 2022 was 14%. (2021/22: 13%)

Staff engagement

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

Staff policies

The CCG has a suite of staff policies in place. The CCG has taken steps throughout the period 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 the 3 months to June 2022 there were no employees of Northumberland CCG who were trade union representatives.

Expenditure on consultancy

There was no consultancy expenditure incurred in the 3 months to June 2022 (2021/22, 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 2022 and 30 June 2022, for more than £245 per day and

that last longer than six months.

Table 14: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the 3 months to 30 June 2022.	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 3 months to 30 June 2022. This figure should include both on payroll and off-payroll engagements.	18

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

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

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 report is also included in this Annual Report from page 136.

ANNUAL ACCOUNTS

NHS Northumberland CCG - Annual Accounts 3 months to 30 June 2022

CONTENTS **Page Number**

The Primary Statements:

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

	Note	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Other operating revenue	2	-	(100)
Total operating revenue		**(0)**	**(100)**
Staff costs	3	999	3,926
Purchase of goods and services	4	153,850	614,346
Depreciation charges	4	17	551
Other operating expenditure	4	32	136
Total operating expenditure		**154,898**	**618,959**
Comprehensive Net Expenditure for the period		**154,898**	**618,859**

The notes on pages 124 to 135 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 (as restated) £'000	1 April 2021 (as restated) £'000
Non-current assets:				
Property, plant and equipment		-	-	551
Right-of-use Assets	6	181	-	-
Total non-current assets		**181**	**-**	**551**
Current assets:				
Contract and other receivables	7	986	1,432	677
Cash and cash equivalents	8	-	213	376
Total current assets		**986**	**1,645**	**1,053**
Total assets		**1,167**	**1,645**	**1,604**
Current liabilities:				
Trade and other payables	9	(24,142)	(32,464)	(32,270)
Lease Liabilities	6	(67)	-	-
Borrowings	10	(1,658)	-	-
Total current liabilities		**(25,867)**	**(32,464)**	**(32,270)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(24,700)**	(30,819)	(30,666)
Non-current liabilities				
Lease Liabilities	6	(114)	-	-
Total non-current liabilities		**(114)**	**-**	**-**
Assets less liabilities		**(24,814)**	**(30,819)**	**(30,666)**
Financed by Taxpayers' Equity				
General fund		(24,814)	(30,819)	(30,666)
Total Taxpayers' Equity		**(24,814)**	**(30,819)**	**(30,666)**

The notes on pages 124 to 135 form part of this statement

The financial statements on pages 120 to 135 were approved and authorised for issue by the Board on 27th June 2023 and signed on its behalf by:

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

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

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

	General fund £'000
Changes in taxpayers' equity for the three months to 30 June 2022	
Balance at 01 April 2022	(30,819)
Changes in CCG taxpayers' equity for the three months to 30 June 2022	
Net operating expenditure for the financial period	(154,898)
Net Recognised CCG expenditure for the financial period	**(154,898)**
Net funding	160,903
Balance at 30 June 2022	**(24,814)**

	General fund £'000
Changes in taxpayers' equity for 2021-22	
Balance at 01 April 2021 (as restated)	(30,666)
Changes in CCG taxpayers' equity for 2021-22	
Net operating costs for the financial year	(618,859)
Net Recognised CCG expenditure for the Financial Year	**(618,859)**
Net funding	618,706
Balance at 31 March 2022 (as restated)	**(30,819)**

The notes on pages 124 to 135 form part of this statement

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

	Note	3 months to 30 June 2022 £'000	12 months to 31 March 2022 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(154,898)	(618,859)
Depreciation and amortisation	4	17	551
Decrease / (increase) in trade & other receivables	7	446	(755)
(Decrease)/Increase in trade & other payables	9	(8,322)	194
Net Cash Outflow from Operating Activities		**(162,757)**	(618,869)
Net Cash Outflow before Financing		**(162,757)**	(618,869)
Cash Flows from Financing Activities			
Grant in Aid funding received		160,903	618,706
Repayment of lease liabilities	6	(17)	0
Net Cash Inflow from Financing Activities		**160,886**	618,706
Net Increase/(Decrease) in Cash & Cash Equivalents	8	**(1,871)**	(163)
Cash & Cash Equivalents at the Beginning of the Financial Period		**213**	376
Cash & Cash Equivalents at the End of the Financial Period		**(1,658)**	213

The notes on pages 124 to 135 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

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

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

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **Pooled Budgets**

Where the CCG 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 CCG's funding is via Resource Allocation. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific 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 CCG of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.6 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Notes to the financial statements

1.7 **Leases**

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

1.7.1 **The CCG as Lessee**

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

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

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

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

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

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

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

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

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

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

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

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

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

1.8 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Cash and bank balances are recorded at current value.

1.9 **Clinical Negligence Costs**

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

1.10 **Non-clinical Risk Pooling**

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.11 **Financial Assets**

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the CCG has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial assets for the CCG are classified at amoritised cost.

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

1.11.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Notes to the financial statements

1.11.2 **Impairment**

For all financial assets measured at amortised cost or at fair value the CCG recognises a loss allowance representing the expected credit losses on the financial asset.

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

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

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

1.12 **Financial Liabilities**

Financial liabilities are recognised when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

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

1.13 **Value Added Tax**

Most of the activities of the CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 **Losses & Special Payments**

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

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

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

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

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

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

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

1.15.2 **Sources of estimation uncertainty**

The following assumption about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.The main estimate in 2022-23 related to prescribing expenditure which is two month in arrears and is based on BSA profiling. The accrual within the accounts is for May and June, and is £9.8m (21-22 was £5.4m but for one month only).

1.16 **Adoption of new standards**

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

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

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

Impact assessment

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

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

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

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

As of 1 April 2022, the CCG recognised £198k of right-of-use assets and lease liabilities of £198k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was nil impact to tax payers' equity.

The CCG has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position.

2 Other Operating Revenue

	3 months to 30 June 2022			12 months to 31 March 2022		
	Total	Admin	Programme	Total	Admin	Programme
	£'000	£'000	£'000	£'000	£'000	£'000
Other non contract revenue	-	-	-	100	24	76
Total other operating revenue	**-**	**-**	**-**	**100**	**24**	**76**

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

3 Employee benefits and staff numbers

3.1 Employee Benefits

	3 months to 30 June 2022			12 months to 31 March 2022		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	787	767	20	3,073	3,066	7
Social security costs	85	85	0	327	327	0
Employer Contributions to NHS Pension scheme	127	127	0	525	525	0
Apprentice Levy	0	0	0	1	1	0
	999	**979**	**20**	**3,926**	**3,919**	**7**

3.2 Average number of people employed

	3 months to 30 June 2022			12 months to 31 March 2022		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Total	**56.09**	**54.97**	**1.12**	**53.26**	**53.10**	**0.16**

3.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit Schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

3.3.1 Accounting valuation

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

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

3.3.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the 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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

4 Operating expenses

	3 months to 30 June 2022			12 months to 31 March 2022		
	Total	Admin	Programme	Total	Admin	Programme
	£'000	£'000	£'000	£'000	£'000	£'000
Services from other CCGs and NHS England	840	329	511	2,537	1,418	1,119
Services from Foundation and other NHS Trusts	101,977	-	101,977	397,438	-	397,438
Purchase of healthcare from non-NHS bodies	18,055	-	18,055	83,239	-	83,239
Purchase of social care	3,592	-	3,592	13,796	-	13,796
Prescribing costs	13,906	-	13,906	56,394	-	56,394
GPMS/APMS and PCTMS	14,458	-	14,458	57,458	-	57,458
Supplies and services – clinical	689	-	689	2,351	-	2,351
Supplies and services – general	30	23	7	191	158	33
Establishment	54	28	26	276	184	92
Premises	138	20	118	471	146	325
Audit fees	58	58	-	58	58	-
Non-audit services	-	-	-	3	3	-
Other professional fees	51	51	-	92	92	-
Legal fees	-	-	-	22	22	-
Education, training and conferences	2	2	-	20	20	-
Depreciation	17	17	-	551	-	551
Chair and Non Executive Members	32	32	-	132	132	-
Clinical negligence	-	-	-	4	4	-
Total operating expenditure	**153,899**	**560**	**153,339**	**615,033**	**2,237**	**612,796**

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 CCG is Mazars LLP. The audit fee for the period to 30 June 2022 including VAT, was £58k (£58k in 2021-22).

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

The expenditure within Other Professional fees includes £12k for internal audit services provided by AuditOne (£51k in 2021-22).

5 Better Payment Practice Code

Measure of compliance	3 months to 30 June 2022 Number	3 months to 30 June 2022 £'000	12 months to 31 March 2022 Number	12 months to 31 March 2022 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,735	40,558	7,792	153,402
Total Non-NHS Trade Invoices paid within target	1,692	40,478	7,762	152,590
Percentage of Non-NHS Trade invoices paid within target	**97.52%**	**99.80%**	**99.61%**	**99.47%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	66	104,894	265	400,378
Total NHS Trade Invoices Paid within target	66	104,894	263	400,376
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**99.25%**	**99.99%**

6 Leases

6.1 Right-of-use assets

3 months to 30 June 2022	Buildings excluding dwellings £'000
Cost or Valuation at 01 April 2022	
IFRS 16 Transition Adjustment	198
Cost/Valuation at 30 June 2022	**198**
Depreciation 01 April 2022	-
Charged during the period	17
Depreciation at 30 June 2022	**17**
Net Book Value at 30 June 2022	**181**

6.2 Lease Liabilities

3 months to 30 June 2022	Buildings excluding dwellings £'000
IFRS 16 Transition Adjustment	198
Interest expense relating to lease liabilities	(17)
Lease liabilities at 30 June 2022	**181**

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

6.3 Lease liabilities - Maturity analysis of undiscounted future lease payments	30 June 2022 £'000
Within one year	(67)
Between one and five years	(114)
After five years	-
Balance at 30 June 2022	**(181)**
Effect of discounting	-
Included in:	
Current lease liabilities	(67)
Non-current lease liabilities	(114)
Balance at 30 June 2022	**(181)**

6.4 Amounts recognised in Statement of Comprehensive Net Expenditure	3 months to 30 June 2022 £'000
Depreciation expense on right-of-use assets	17
Interest expense on lease liabilities	0
Balance at 30 June 2022	**17**

6.5 Amounts recognised in Statement of Cash Flows	3 months to 30 June 2022 £'000
Total cash outflow on leases under IFRS 16	(17)
Balance at 30 June 2022	**(17)**

7 Contract and other receivables

	30 June 2022 £'000	31 March 2022 £'000
NHS receivables: Revenue	59	1,018
NHS prepayments	2	-
NHS accrued income	25	80
Non-NHS and Other WGA receivables: Revenue	164	107
Non-NHS and Other WGA prepayments	736	141
Non-NHS and Other WGA accrued income	-	65
VAT	-	21
Total contract & other receivables	**986**	**1,432**

7.1 Receivables past their due date but not impaired

	30 June 2022 £'000	31 March 2022 £'000
By up to three months	-	7
By three to six months	-	-
By more than six months	-	-
Total	**-**	**7**

8 Cash and cash equivalents

	30 June 2022 £'000	31 March 2022 £'000
Balance at start of period	213	376
Net change in period	(1,871)	(163)
Balance at end of period	**(1,658)**	**213**
Made up of:		
Cash with the Government Banking Service	-	213
Made up of:		
Bank overdraft: Government Banking Service	(1,658)	0
Balance at end of period	**(1,658)**	**213**

9 Trade and other payables

	30 June 2022 £'000	31 March 2022 (as restated) £'000
NHS payables: Revenue	2	484
NHS accruals	387	1,897
Non-NHS and Other WGA payables: Revenue	2,141	7,391
Non-NHS and Other WGA accruals	20,272	21,080
Social security costs	51	51
VAT	16	-
Tax	44	57
Other payables and accruals	1,229	1,504
Total trade & other payables	**24,142**	**32,464**

Other payables include £553k outstanding pension contributions as at 30 June 2022 (£596k in 2021-22) - £57k for CCG employees (£59k in 2021-22) and £496k for Primary Care through Delegated Co-Commissioning (£537k in 2021-22).

10 Borrowings

	Current 30 June 2022 £'000	Current 31 March 2022 £'000
Bank overdrafts:		
Government banking service	1,658	-
Total Borrowings	**1,658**	**-**

The CCG completed a BACS payments run on 30 June 2022 which was due to clear the bank account 05 July 2022 to enable it to clear balances owed to suppliers prior to the merger. This resulted in the CCG having a credit ledger cash position of £1,658k. This is acceptable and only reflects a timing difference between the drawdown process and cash being available in the bank account on 1 July 2022. This is only a technical adjustment and the amount that the CCG has overdrawn its bank account is recorded in note 10 Borrowings above.

11 Financial instruments

11.1 Financial assets	Financial Assets measured at amortised cost 30 June 2022 £'000	Financial Assets measured at amortised cost 31 March 2022 £'000
Contract and other receivables with NHSE bodies	59	1,039
Contract and other receivables with other DHSC group bodies	25	59
Contract and other receivables with external bodies	165	172
Cash and cash equivalents	0	213
Total financial assets	**249**	**1,483**

11.2 Financial liabilities	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Financial Liabilities measured at amortised cost 31 March 2022 (as amended) £'000
Loans with external bodies	1,656	-
Trade and other payables with NHSE bodies	126	481
Trade and other payables with other DHSC group bodies	366	1,963
Trade and other payables with external bodies	23,722	29,912
Total financial liabilities	**25,870**	**32,356**

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

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

12 Pooled Budgets

Under s75 of the 2006 NHS Act, the CCG has entered into a pooled budget agreement with 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 CCG'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 3 months to 30 June 2022 Expenditure £'000	Amounts recognised in Entities books ONLY 12 months to 31 March 2022 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	7,055	26,708

13 Related party transactions

Details of related party transactions are as follows:

		3 months to 30 June 2022				12 months to 31 March 2022			
		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	24	0	658	0	3,805	0	1,058	0
VALENS MEDICAL PARTNERSHIP	Dr John Warrington	2,185	0	57	0	8,709	0	562	0
PONTELAND MEDICAL GROUP	Dr Robin Hudson	496	0	128	0	1,606	0	94	0
SELE MEDICAL PRACTICE	Dr Ben Frankel	568	0	169	0	2,574	0	293	0
WIDDRINGTON SURGERY	Dr Chris Waite	0	0	0	0	469	0	0	0
NORTHUMBERLAND HEALTH AT WIDDRINGTON & FELTON SURGERIES	Dr Chris Waite	279	0	1	-5	310	0	49	0
NORTHUMBERLAND LMC	Dr John Warrington	14	0	7	0	76	0	7	0
NHS NORTH OF ENGLAND CSU	Mark Adams	551	0	125	0	2,478	0	52	0
Non Director Related Organisations									
ADDERLANE SURGERY		57	0	10	0	269	0	14	0
BEDLINGTONSHIRE MEDICAL GROUP		329	0	72	0	1,633	0	130	0
BELFORD MEDICAL GROUP		274	0	22	0	1,130	0	59	0
BELLINGHAM PRACTICE		156	0	0	-3	608	0	26	0
BRANCH END SURGERY		184	0	35	0	900	0	68	0
BURN BRAE MEDICAL GROUP		440	0	28	0	1,867	0	70	0
CHEVIOT MEDICAL GROUP		171	0	0	-7	634	0	48	0
COQUET MEDICAL GROUP		408	0	54	0	2,000	0	102	0
CORBRIDGE MEDICAL GROUP		383	0	20	0	1,520	0	82	0
CRAMLINGTON MEDICAL GROUP		177	0	7	0	696	0	35	0
ELSDON AVENUE SURGERY		146	0	0	-2	551	0	19	0
FELTON SURGERY		0	0	0	0	315	0	0	0
FORUM FAMILY PRACTICE		295	0	17	0	957	0	52	0
GABLES MEDICAL GROUP		256	0	20	0	1,024	0	63	0
GAS HOUSE LANE SURGERY		249	0	0	-2	1,111	0	125	0
GLENDALE SURGERY		134	0	33	0	593	0	37	0
GREYSTOKE SURGERY		480	0	0	-11	1,665	0	82	0
GUIDE POST MEDICAL GROUP		484	0	212	0	2,229	0	179	0
HALTWHISTLE MEDICAL GROUP		234	0	5	0	909	0	40	0
HAYDON & ALLENDALE MEDICAL PRACTICE		144	0	79	0	757	0	89	0
HUMSHAUGH AND WARK MEDICAL GROUP		256	0	33	0	1,069	0	31	0
MARINE MEDICAL GROUP		481	0	28	0	1,901	0	86	0
NETHERFIELD HOUSE SURGERY		221	0	9	0	900	0	33	0
PRUDHOE MEDICAL GROUP		228	0	5	0	923	0	42	0
RAILWAY MEDICAL GROUP		1,063	0	110	0	4,593	0	327	0
RIVERSDALE SURGERY		165	0	25	0	708	0	53	0
ROTHBURY PRACTICE		24	0	236	0	944	0	261	0
SCOTS GAP MEDICAL GROUP		102	0	12	0	570	0	64	0
SEATON PARK MEDICAL GROUP		764	0	29	0	2,971	0	133	0
UNION BRAE AND NORHAM PRACTICE		296	0	37	0	1,312	0	68	0
VILLAGE SURGERY		485	0	137	0	2,329	0	218	0
WELL CLOSE MEDICAL GROUP		1,023	0	131	0	3,147	0	221	0
WHITE MEDICAL GROUP		331	0	28	0	1,390	0	73	0
HADRIAN PRIMARY CARE ALLIANCE LTD		96	0	51	0	421	0	19	0
NORTHUMBRIA PRIMARY CARE		66	0	0	0	51	0	0	0

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.

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 CCG has had a significant number of material transactions with entities for which the DHSC is regarded as the parent department which included Northumbria Healthcare NHS FT; Newcastle upon Tyne Hospital NHS FT; Cumbria, Northumberland, Tyne & Wear NHS FT; 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

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of NHS Northumberland CCG will transfer to the North East and North Cumbria Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

15 Financial performance targets

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

National Health Service Act Section Duty	Duty	3 months to 30 June 2022		12 months to 31 March 2022		Duty
		Target	Performance	Target	Performance	Achieved
223H(1)	Expenditure not to exceed income	154,898	154,898	621,011	618,959	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	154,897	154,897	620,911	618,859	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	1,362	1,362	6,315	5,236	Yes

16 Prior period adjustment

The 2021/22 comparative figures included within the accounts have been restated to remove an accrual of £3,095k which was previously included in error. This was initially recognised as expenditure within the CCG in 2019/20. The impact of this change has been to reduce trade and other payables (non-NHS and other WGA accruals) within the Statement of Financial Position at 1 April 2021 and 31 March 2022 and increase the opening general fund balance within the Statement of Changes in Taxpayers' Equity at 1 April 2021.

Independent auditor's report to the Members of the NHS North East and North Cumbria Integrated Care Board acting as the Governing Body of NHS 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 period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2022/23, and the Accounts Direction issued by the NHS England with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its net expenditure for the period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

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

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

Conclusions relating to going concern

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

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

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

Other information

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

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

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risks of override of controls) and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

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

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

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

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- addressing the risk of fraud in expenditure recognition through testing payments in the pre and post year end period to ensure they were recognised in the right year, sample testing material period-end payables and provisions and reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care.

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

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit

of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

We have not completed our work on the CCG's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in January 2023, we have not identified any significant weaknesses in arrangements for the period ended 31 March 2023.

We will report the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

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

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

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

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

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

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

We are required to report to you if:

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

Use of the audit report

This report is made solely to the Members of the Governing Body of the NHS North East and North Cumbria Integrated Care Board, acting on behalf of NHS 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 NHS North East and North Cumbria Integrated Care Board, acting on behalf of NHS Northumberland CCG , those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the NHS North East and North Cumbria Integrated Care Board, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources and complete the work necessary to provide assurance to the NAO on the whole of government accounts return.

Cameron Waddell,
Partner
For and on behalf of Mazars LLP

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

3 July 2023