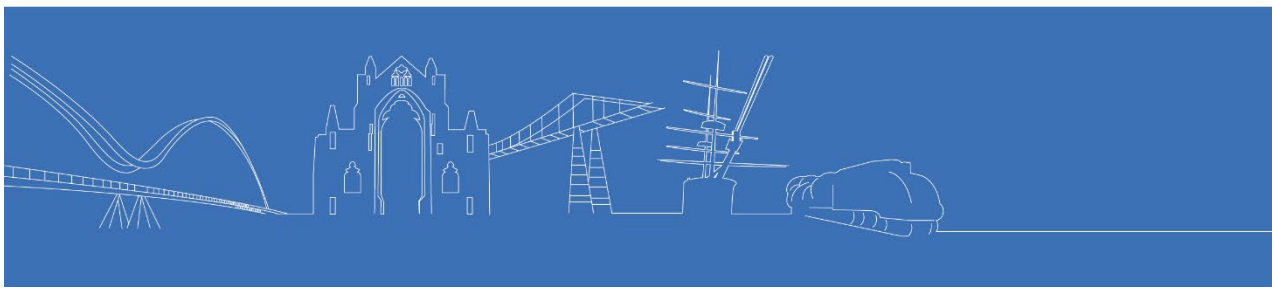
NHS
Tees Valley
Clinical Commissioning Group

Annual report
and accounts

1 April - 30 June 2022



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Statement from the Accountable Officer

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

This report provides an overview of our role and responsibilities as a CCG, planning and purchasing health care services on behalf of our population. As an organisation we have continued to enjoy the close collaboration with partners to help support and co-ordinate the response to various surges and the recovery of services following the pandemic. Our work has continued to be led by local clinicians, working closely with our five local authorities and local NHS providers, to ensure a continued focus on the specific health needs of our population.

NHS Tees Valley CCG is proud of its legacy, and since the formation of South Tees, Hartlepool and Stockton-on-Tees (HAST) and Darlington CCGs back in 2013, and then the subsequent merger to Tees Valley CCG in 2020, there have been significant achievements which have brought positive impact to patients across the region.

Looking forward, we played a key role in the establishment and transition to the Integrated Care Board (ICB) in July 2022. ICBs are now accountable for NHS spending and performance, taking on the planning functions of CCGs.

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

Mr David Gallagher

Accountable Officer

Dr Boleslaw Posmyk

Chair

Performance Report[1]

Samantha Allen

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

Accountable Officer

26th June 2023

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

Performance Overview

About NHS Tees Valley CCG

The following overview section is intended to describe the CCG, our purpose, our objectives and any risks to the achievement of those objectives up to 30 June 2022. It also outlines how the CCG has performed during the period and gives an overview of the organisation without the need to look further in the report.

About Us

NHS Tees Valley CCG became a statutory body in April 2020, under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. Our organisation was established in its current form as a statutory body following the merger of three predecessor CCGs: Darlington CCG, Hartlepool and Stockton-on Tees CCG and South Tees CCG. We follow governing principles, rules and procedures to ensure integrity, honesty and accountability in our day-to-day activities.

As a clinically led organisation, which brings together 80 local GP practices and other health professionals to plan and design services to meet the needs of our local population of approximately 710,000 people. We buy, manage and pay for a range of local healthcare services on behalf of patients across the Tees Valley (Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees areas) including the healthcare local people receive at hospitals and in the community. This process is known as commissioning. From 1 April 2022 to 30 June 2022, we had a total budget for this period of approximately £0.34billion which we received from NHS England.

Our 80 GP practices, make up 14 Primary Care Networks (PCNs) across five locality areas: 1 in Darlington, 3 in Hartlepool, 3 in Middlesbrough, 1 in Eston, 2 in Redcar & Cleveland and 4 in Stockton-on-Tees. More information about our primary care networks can be found on our website.

We commission a specific set of healthcare services that include:

- General planned inpatient and day-case hospital services
- General urgent care services from hospitals, NHS 111 and local ‘out of hours’ services
- General maternity and children’s services
- Community services
- Non-specialised mental health services
- Continuing health care and free nursing care services
- Medicines prescribed by the GP practices within the CCG
- Other non-specialised diagnostic and treatment services, such as x-ray or hearing aid services.

Our delegated authority from NHS England is to commission primary care services delivered in General Practices (GPs). These services **exclude**:

- Specialised services
- Primary care services such as dentists, opticians and pharmacists
- Oral surgery and dental services from hospitals
- Healthcare for members of the armed forces
- Healthcare for people in prison.

The majority of non-CCG commissioned services, including specialised services, are commissioned by NHS England. The UK Health Security Agency (UKHSA) (known as Public Health England up to October 2021) is responsible for commissioning screening and vaccination services. Local public health services including school nursing and health visitor services are commissioned by the local authorities (councils).

As the Health and Care Act completed its passage through Parliament, Clinical Commissioning Groups were replaced by Integrated Care Boards (ICBs) in July 2022. ICBs are now accountable for NHS spending and performance, taking on the planning functions of CCGs across the ICS area.

This new arrangement will include a strong focus on local working at 'place' level, and we have anticipated this change by developing strong local teams across the Tees Valley. With a culture of joint working underpinned by our partnership working, our local systems are well placed to adapt to this new landscape.

Our Vision, Objectives and Values

Our vision remained to work inclusively, innovatively and efficiently with our public and partners to commission high quality services that impact positively on the physical and mental health of the people in the Tees Valley.

<u>Our Objectives</u>

These are our strategic high-level goals that set out our ambitions and importantly, how we will achieve them. The importance of the involvement of patients, public and partners in our work is reflected throughout. Our Governing Body receives regular updates on how we are moving towards delivering these objectives.

Our strategic objectives are:

1. Use evidence and the voice of local people, clinicians and stakeholders to maintain and improve our commissioned services

2. Work with partners to respond to the health needs of the local population including the ongoing Covid-19 response and recovery

3. Develop new ways of working and be an excellent employer, through a culture of engagement and inclusion, to continue to be a high performing organisation

4. Support the development of the new Integrated Care System facilitating the engagement of our member practices and Primary Care Networks

5. Deliver statutory duties and constitutional standards including the monitoring of quality, safety, safeguarding and performance of commissioned services along with delivering value for money and financial balance

6. Ensure an effective closedown of the CCG with safe transfer of statutory duties, commissioning responsibilities and staff to the successor organisation (subject to legislation.

Values

As a member of the NHS family, the Tees Valley Clinical Commissioning Group shares the NHS values described in the national NHS Constitution. The NHS Constitution is a document that describes the commitments made to people who use NHS services. It includes the values that the NHS believes are important when delivering NHS care and services.

There are six values in the NHS Constitution. By living these values, we work to ensure we deliver the best possible care for patients:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts.

We also developed our own values that reflect the way we work:

- People focussed – Putting people at the centre of everything we do
- Partnership – Achieving more working with others
- Innovative – Aspiring to find better ways of doing things
- Inclusive – Valuing people's differences
- Efficient – Getting the best value in all that we do
- Trust – Honest and open about what we can and cannot do.

Our Priorities

Our responsibility for commissioning started with developing an understanding of the needs of the population and then planning services to meet those needs. Services are obtained through contracts with organisations that provide health services.

We then monitored those services through the contracts to ensure that high quality care is delivered. In the Tees Valley area, we face some major health challenges.

NHS Tees Valley Clinical Commissioning Group (the CCG) has an annual duty to review national planning guidance and agree a range of priorities for the financial year that form the basis of our annual operating plans. The 2022/23 NHS Priorities and Operational Planning Guidance was published on 24th December 2021. The guidance set out priorities for the year ahead:

- 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.
- Respond to Covid-19 ever more effectively – delivering the NHS Covid-19 vaccination programme and meeting the needs of patients with Covid-19.
- Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- 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. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- Improve timely access to primary care.
- 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.
- 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.
- 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.
- Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
- 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.

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.

Our Constitution

Our Constitution sets out our duties as a CCG and how we make decisions, outlining our responsibilities as commissioners of care for people in Darlington, Hartlepool, Middlesbrough,

Redcar & Cleveland and Stockton-on-Tees. It describes our governing principles, rules and procedures that we adopt for the day to day running of our CCG.

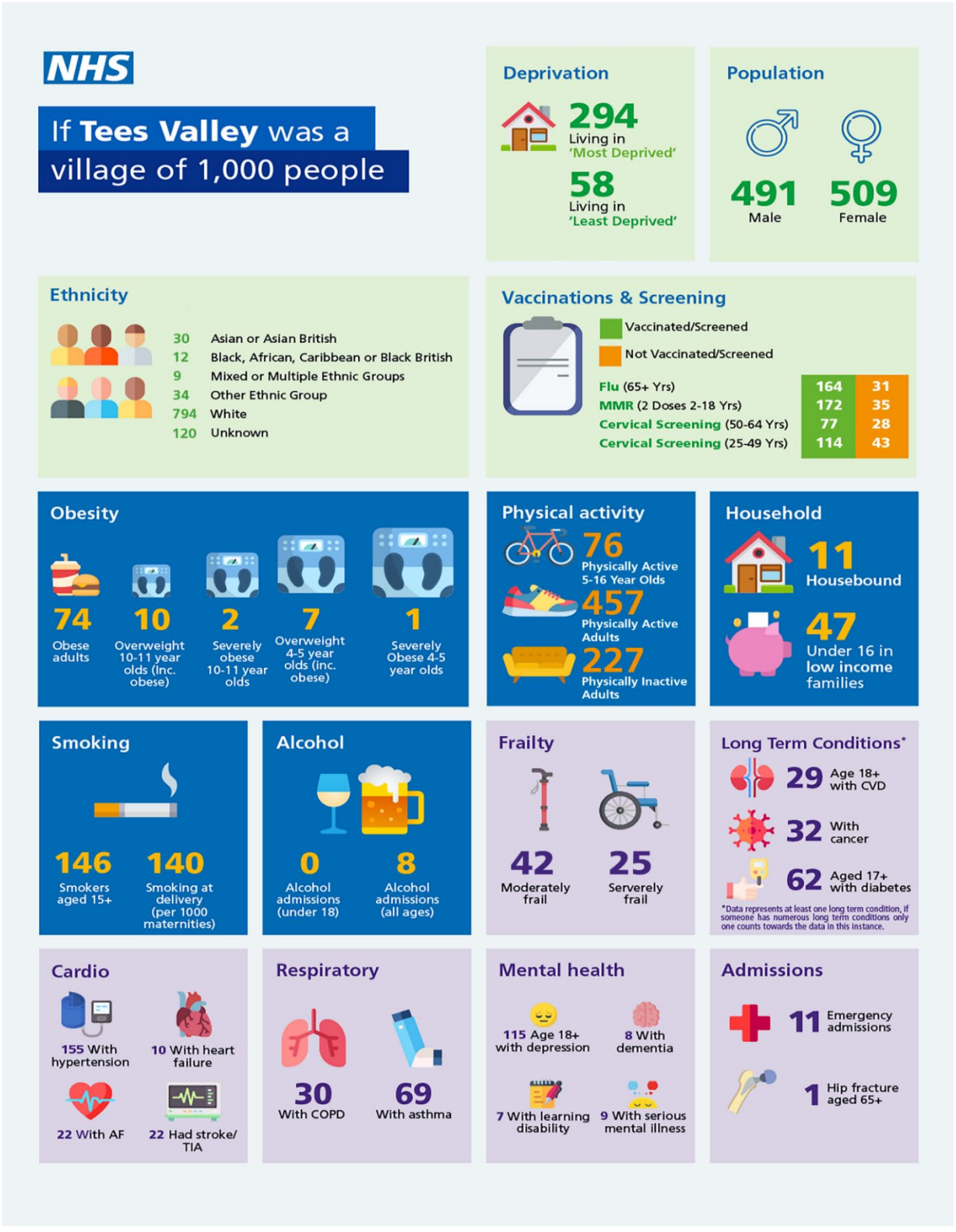
We worked in close partnership with those providing care in the area, such as local voluntary and community sector (VCS) organisations, Healthwatch, NHS Trusts, GP Practices and our five coterminous Local Authorities to make sure that health and care services continue to meet the needs of our population. All GP practices in the Tees Valley CCG played a key role in shaping how the CCG works by developing and signing up to our Constitution.

The Constitution clearly detailed:

- Who we were as an organisation
- Our membership
- How we formed our Governing Body and the standards that its members must uphold
- How we made decisions
- Who within the organisation had the delegated authority to make decisions on behalf of the CCG, and
- How we managed conflicts of interest.

About Our Population

The graphic below represents the local population health statistics.



Covid-19 Response

Covid-19 Vaccination Programme

Coronavirus is likely to remain with us for years to come, but thanks to the roll out of the vaccination programme the chances of people getting seriously ill and not surviving are now much lower.

In the final stages of our phase 4 programme (between April and June 2022) we have seen a positive increase in the number of young people coming forward, as well as an increase in the number of patients coming forward to take advantage of the evergreen offer (first, second and/or first booster). This is the result of a significant and sustained effort from all partner organisations (Health and Local Authority) within Tees Valley to continually promote, educate and reassure patients about the importance of getting vaccinated against Covid-19.

We know this approach takes considerable investment of time and resources; however this type of activity is essential in addressing vaccine hesitancy and building confidence with communities, and in reaching those residents within the Tees Valley who may otherwise not come forward. We have focused all efforts on targeting our mobile and pop-up provision into those areas with lowest uptake and highest deprivation and/or health inequalities to help minimise issues of accessibility by providing a more flexible solution to those who need it and increased numbers of vaccine to ensure availability to all who require it.

We have begun working with our partners, primary care networks and community pharmacy sites to ensure we are ready to deliver our phase 5 COVID-19 seasonal booster vaccination plans in September, prioritising the vaccination of older adult care home residents and care home staff as well as housebound residents before the wider roll out to the remaining eligible cohorts in our community.

Recovery of Services

We continued to work with providers to ensure safe restoration of services to pre-Covid-19 levels of activity. Throughout the pandemic we sought assurances that guidance for making premises Covid-19 secure were being followed and providers were aware of, and implementing, the latest Infection Prevention Control guidance for their service area.

To support recovery in elective surgery we worked with providers (both NHS and Independent Sector) to clinically triage their waiting lists and ensured that primary care colleagues and patients were aware of this. The CCG leadership and co-ordination of the planning process across Trusts ensured that robust and ambitious plans were progressed to enable recovery of activity in line with national expectations.

The CCG continued to drive collaboration across the Tees Valley through the progression of the Tees Clinical Services Strategy. The aim of the strategy is to deliver sustainable services that maximise the resource available within Tees Valley and provide the best possible outcomes to patients.

It has been well documented that the pandemic has compounded the health inequalities prevalent across our population and focussed action on health inequalities is now required to improve the lives of those living with the worst health outcomes. A central part of the Covid-19 recovery response is aimed at tackling health inequalities by increasing the scale and pace of NHS action.

Respiratory Services

We continued to work closely with partners during the year to support continued implementation of a range of pathway improvements aimed at responding to the ongoing Covid-19 pandemic, alongside continual service transformation. Services such as the Tees-wide Respiratory Advice Service, providing enhanced primary care respiratory support to patients as part of our Covid-19 response, and the Pulse Oximetry@Home service, responding to national emerging guidance in relation to enhanced home monitoring for Covid-19 positive patients, continued to be accessible to proactively monitor and prevent escalation to emergency services where possible and as where needed to support responding to the Covid-19 pandemic.

In addition to proactive Covid-19 pathways of care, the CCG also commissioned post- Covid-19 pathways across Teesside, securing access to a multidisciplinary team approach to care, to assess and triage complex patients dealing with post Covid-19 symptoms. Alongside this enhanced multidisciplinary team approach, additional rehabilitation support was also commissioned.

A five-year workstream to increase access to pulmonary rehabilitation services was also continued during the year with the aim of improving access, uptake and outcomes and to enable patient choice so that patients are able to access care in a way that suits their needs, via mechanisms including face-to-face and digital options. This programme includes exploration of digital innovation, development of various methods for patients to access rehabilitation, increased presence of services within the community and partnership working with other rehabilitation services.

Access to spirometry diagnostics in a primary care setting was significantly impacted due to Covid-19, because of a number of infection, prevention and control factors. In response to this, the CCG designed and commissioned a new pathway to restore access to this valuable respiratory diagnostic tool to ensure that patients can equitably access diagnostic spirometry.

Our Achievements 1 April – 30 June 2022

In the final months as a CCG, we closely monitored performance against agreed operational plans and performance frameworks linked to the detailed plans in place. A robust governance structure is set up to support this process (described in the Governance Statement) and regular assurance checks are undertaken by NHS England to ensure plans are in progress.

The following section sets out our achievements against our objectives.

Summary table of achievements

Objectives	Examples of work in relation to our objectives
Use evidence and the voice of local people, clinicians and stakeholders to maintain and improve our commissioned services	• The CCG Governing Body included GPs, nurses, a clinical pharmacist, and a retired hospital doctor, with the organisation benefiting greatly from expertise drawn from a range of other clinicians working in local GP practices. • The CCG worked closely member practices and engaged with patients and stakeholders on reconfiguration e.g., Hartfields Medical Centre. • The CCG worked closely with PCNs on the development of plans for the delivery of enhanced access from 1st October 2022.
Work with partners to respond to the health needs of the local population including the ongoing Covid-19 response and recovery	• A 5-year Alternative Provider Medical Services (APMS) contract was secured by the CCG for Ravenscar Surgery in Redcar, to commence 1st October 2022. • The Tees Valley Neurodevelopmental Child and Family Support Service was formed, providing increased support for children and young adults aged 0-18 that exhibit neurodevelopmentally diverse traits. • A scheme commenced to focus on the early identification and management of heart failure within primary care, targeting identified PCNs and utilising a heart failure specialist nurse.
Develop new ways of working and be an excellent employer, through a culture of engagement and inclusion, to continue to be a high performing organisation	• The North East and North Cumbria ICS Development & Transition Programme Board developed a series of workstreams to manage the transition period, with CCG staff involved in these workstreams, providing valuable expertise in planning as well as opportunities for improving ways of working in the future. • Tees Valley CCG agreed to a co-ordinated approach to the ICS transition which supports information sharing and learning whilst also minimising duplication where appropriate. • A 'Hybrid Working' approach continued for all staff, embracing the principles of the NHS People Plan and allowing staff to benefit from increased flexibility.
Support the development of the new Integrated Care System facilitating the engagement of our member practices and Primary Care Networks	• The CCG and the ICB worked together with local authorities and other partners across the ICS to develop a five-year strategic plan for their system and places. • The Operational Pressure Escalation Level (OPEL) reporting tool continues to support all GP

Objectives	Examples of work in relation to our objectives
	practices to enable a wider system view of capacity and to support business continuity.
Deliver statutory duties and constitutional standards including the monitoring of quality, safety, safeguarding and performance of commissioned services along with delivering value for money and financial balance	• We continued 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. • The CCG was an active member in the North East and North Cumbria Urgent and Emergency Care Network, which brings together organisations across the ICS to ensure the quality, safety and equity of urgent and emergency care services in the region. • In-year breakeven against an in-year funding allocation of £340.8 million
Ensure an effective closedown of the CCG with safe transfer of statutory duties, commissioning responsibilities and staff to the successor organisation	• Through a robust project management approach, the CCG identified several potential issues and risks associated with the transition and ensured that appropriate controls were in place to support safe transition to the ICB. • The transfer of staff into the ICB was undertaken in line with national guidance and related legislation. • Working closely with other local NHS organisations, the CCG continued to support the regional working addressing equality, diversity and inclusion, sharing and learning from good practice, through the transition to the ICB. • We worked with our Commissioning Support Unit, Internal Audit and the other CCGs in the North East and North Cumbria to develop and implement a robust due diligence process to ensure the safe transfer of duties and responsibilities. This work was in line with the NHS England template.

Clinical Leadership

The CCG's Governing Body included clinicians with responsibility for ensuring that appropriate arrangements were in place to exercise the CCG's functions effectively, efficiently and economically, and in accordance with the principles of good governance. This clinical leadership group was made up of GPs working in local GP practices, a nurse, a clinical pharmacist and a retired hospital doctor, working together to assess local needs, decide

priorities and strategies, and to commission services on behalf of the Tees Valley population.

Our Medical Director, Dr Janet Walker, provided professional clinical advice and clinical leadership to the Governing Body contributing to the decision-making processes, strategic vision and direction of the CCG. Dr Janet Walker's work enabled the continued development of strong clinical leadership throughout every layer of the organisation. A significant part of the role is to support the development of primary care and to lead the clinical contribution to service transformation and delivery.

Clinical Lead roles within the CCG provided expert clinical advice to secure the best possible outcomes for our patients, whilst maintaining a consistent focus on quality. They advised and assisted us with taking forward our work to transform and improve health services.

Working with Local and Regional Partners

North East and North Cumbria Integrated Care System (ICS)

Over recent years, our CCG has been part of the North East and North Cumbria (NENC) Integrated Care System (ICS), which was a regional partnership between the organisations that meet health and care needs across the area, to coordinate and plan services that improve the health of the people of our region and reduce health inequalities.

The North East and North Cumbria Integrated Care System area is the largest in England and is responsible for the health services of more than three million people across 5,313 square miles. It is one of the most geographically diverse areas, from the Lake District in the west to large urban areas in the north east and more rural areas.

We have a strong history of working together across health and care in our region. The quality of some of our health and care services is consistently rated amongst the best in the NHS and we have an abundance of great care delivered by highly committed teams of health and care staff.

Despite this, overall public health faces some of the most significant challenges. Our ambition is to change this by working together. Although there have been many improvements in recent years - for example, the number of people dying from cancer or heart disease has decreased, fewer people are smoking and many are living longer - healthy life expectancy remains amongst the poorest in England.

We have high levels of unemployment, lower than average levels of decent housing, and significant areas of deprivation. These contribute to some of the starkest health inequalities, early death rates and highest sickness levels in England, driving much of the pressure that health and social care services have to manage.

Health and Care Act

Shortly after the end of 2021-22, the Health and Care Act received royal assent, confirming that Clinical Commissioning Groups would be replaced by Integrated Care Boards on 1 July 2022. From 1 July 2022, ICBs became accountable for NHS spending and performance, taking on the planning functions of CCGs.

By putting ICSs on a statutory footing this can empower them to better join up health and care services, improve population health and reduce health inequalities.

Each ICS is led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory Committee bringing together all system partners to produce a health and care strategy.

North East and North Cumbria transition and development

In the North East and North Cumbria ICS, we have been working at three broad areas of scale:

- Place and Neighbourhood
- Four Integrated Care Partnership areas
- Integrated Care System.

During 2021/22 we developed our System Development Plan which set out our approach, governance, workstreams and plans to transition to the North East and North Cumbria ICS.

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

The North East and North Cumbria ICS established an ICS Development & Transition Programme Board with a series of workstreams to manage this transition. CCG staff were involved in these workstreams, providing valuable expertise in planning for the transition and looking at opportunities for improving ways of working in the future.

Partners were also linked in where appropriate. All workstreams shared the approach of building on what is already working well at place and will be sharing this with wider stakeholders.

We worked with partners to collectively explore the best way to deliver ICB priorities across the ICS, ensuring we retain and strengthen the very best local, placed based working.

The Integrated Care Partnership (ICP) at NENC level will operate as a statutory Committee, bringing together the NHS and local authorities as partners to focus more widely on health, public health and social care. It will include representatives from the ICB, local authorities and

other partners such as NHS providers, public health, social care, and voluntary, community and social enterprise (VCSE) organisations.

Our NENC ICP will be responsible for developing an integrated care strategy to set out how the wider health and wellbeing needs of the local population will be met.

We also have a provider collaborative, a partnership arrangement involving our North East and North Cumbria provider Trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements. This will work across a range of programmes and help our providers work together to plan, deliver and transform services.

Our region's new ICB assumed its role on 1 July 2022, under the leadership of Professor Sir Liam Donaldson (Chair) and Samantha Allen (Chief Executive).

South ICP Workforce Group

Partners from health, adults and children's social care, public health, further and higher education, and colleagues from the voluntary and community sector come together as the South ICP Workforce Group. The group has a remit to collaboratively explore workforce challenges and opportunities across health and social care in the Tees Valley identifying and implementing solutions drawing on innovation and established practice.

In the first quarter of 2022/23 the group has focused on gaining a sound understanding of the Tees Valley workforce profile across health and social care along with enhancing our collective understanding of the key workforce issues facing our local organisations to develop a strategic workforce plan. We know, like many other parts of the country, that we have some real challenges. Partners in the Tees Valley highlighted the following workforce challenges and risks:

Summary of challenges and risks

- **Recruitment** - fewer applicants; less experienced staff applying; competition from other sectors
- **Retention** – novice fatigue; development and opportunities within organisation but not enough new entrants; challenging caseloads
- **Ageing** workforce & ageing population – significant shortages and increasing demand and complexity
- Meeting new expectations re. **flexibility** and working from home
- **Reputation** and perceptions of health and social care as a career
- **Cost of living increase** – alternative employment move to agency

However, in addition to developing a comprehensive understanding of shared issues, we were also able to identify opportunities to work together, reducing effort and duplication to

create new solutions. These opportunities were to: further enhance our commitment to cooperate rather than compete; promote health and social care careers as aspirational careers, actively engaging schools and colleges; explore how we can share training and development resources and enable the workforce to move around employers with less bureaucracy; and engage with our local communities more to share opportunities and reduce barriers leading to our workforce better representing the people we serve.

This intelligence along with our agreement to work more closely will inform the development of at Tees Valley (South ICP) Workforce Plan.

Integrated Care Board – Communities and People

We worked together with involvement leads across the new Integrated Care Board (ICB) footprint to develop stronger partnership arrangements, having conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how involvement will work once we become the North East and North Cumbria ICB. A strategy has been drafted based on these conversations and will act as a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission. The ICB will publish a Communities and People Involvement and Engagement Strategy following sign-off once the ICB formally meets.

In addition, we have explored a Citizen's engagement model, where we have considered Citizen's panels, juries and assemblies, with research being conducted with local stakeholders from partner organisations. Further information on this research can be found in the 'Engaging People and Communities' section of this report.

County Durham, Darlington and Teesside Mental Health and Learning Disabilities Partnership

Community Mental Health Transformation

We worked to develop a model of community-based mental health care that will:

- Be co-produced with multi-agency partners across the system (Service Users, Third Sector, Primary Care Networks (PCNs), Local Authorities, Mental Health Services and Acute Providers). This whole system approach will generate a set of core principles and aims which will underpin the delivery of adult community mental health service transformation
- Be supportive of what people want to achieve, rather than making individuals fit into systems
- Be based on provision for need, not diagnosis
- Include systemic approaches to the social determinants of mental ill health and health inequalities through existing public health strategies
- Be centred around a trauma informed approach putting psychological healing and connectivity at the heart of planning and delivery

- Be place based, supported by the development of community mental health hubs, coterminous with local authorities and PCNs, and
- That the model will enable local hubs to adapt and evolve based upon local needs leading to a genuine offer of local community defined placed based care.

Locally work to progress this model of community care includes:

- Community Hub working groups have been established in Hartlepool, Stockton, Middlesbrough, Redcar, and Darlington. Virtual hubs are now working well in Hartlepool and Middlesbrough, with work still in progress in the other locality areas.
- Hartlepool now have an established hub site as an early adopter and recruitment of a Team Manager is being progressed. Within Redcar, co-location into Skelton Civic Centre is expected by the end of 2022.
- Three rounds of recruitment for Community Navigator posts have taken place which have seen seven posts appointed too. A fourth round of recruitment will seek to fill the remaining vacancies.

Annual Health Checks

Annual health checks (AHC), delivered by primary care, are of paramount importance in addressing the reduction in health inequalities faced by people with learning disabilities and severe mental illness, which have been further highlighted during the pandemic. Strong clinical leadership at all levels within the CCG has been key in developing targeted strategies to reduce variation in practice in relation to the delivery of health checks.

To better support people with learning disabilities, the ICB is closely monitoring data at PCN and practice level, to identify early targeted work, to achieve the national target. This targeted work has been delivered through primary care planned education sessions and bespoke training at individual practice level, by ICB learning disabilities clinical lead and Tees, Esk and Wear Valleys NHSFT (TEWV).

The STOMP (Stopping over medication of people with a learning disability, autism or both) work continues, following successful pilot, currently been delivered in Holgate PCN and expanding to three more PCNs by the end of 2022/23. The collaborative approach between ICB and TEWV has resulted in improvements in care, communication between primary and secondary care and greater understanding and use of reasonable adjustments.

Through the Learning Disabilities Mortality Review (LeDeR) programme, actions have been identified from the learning and incorporated into training, and we are supporting the development of high-quality resources with the Northeast and Cumbria Learning Disability Network, including the Learning Disability Diamond Standards for Primary Care and the Preventative Adult Not Brought Strategy.

The pace of delivery of physical health checks for people with learning disabilities and/or severe mental illness has historically been a slow one, however, local incentive schemes have sought to bring the importance and life-enhancing value of their delivery into sharp relief.

For the six components of the physical health check for severe mental illness, at the end of 2020/21, Tees Valley CCG had an overall achievement of 33.7%. Despite the unprecedented challenges of the Covid-19 pandemic, data published for Q4 of 2021/22 shows that achievement of the delivery increased to 48.26%. Data for Q1 (2022/23) has recently been published and Tees Valley has seen a slight dip in achievement from Q4, out-turning at 46.13%. This still sees Tees Valley delivering more than the national average achievement of 43.5% and we continue to work in partnership to support primary care colleagues by sharing data, learning and examples of good practice to bring focus to this area.

In terms of achievement of the health check for people with a learning disability, primary care achieved 77% for 2021/22 meeting the national and local target. Data for Q1 (2022/23) across the Tees Valley was recorded at 15%, which is comparable to other years, however we are working with practices to support them in identifying and prioritising patients who have not received a face-to-face AHC over the last 12 months and patients with specific comorbidities.

Mental Health Support Teams – Mental Health and Wellbeing Support through Education

As part of the national programme to expand access to mental health care for children and young people, we continued to roll-out and embed Mental Health Support Teams through education. Local evaluation conducted by Teesside University early this year across Hartlepool and Stockton reported positive outcomes for children, young people and families. Parents and carers of the children and young people reported that they felt more equipped to deal with children's mental health and behaviours, and schools reported that they were working in a whole-school approach to mental health and wellbeing.

The children and young people who accessed and their parents/carers, reported improvements in all outcome measures which examined levels of anxiety, depression and health. Almost 2000 children and young people requested help and were supported, with around 40% receiving structured evidenced based therapies with improved mental health.

Recruitment has taken place for new teams, who will commence academic placements with Northumbria University in Autumn 2022. These teams will provide additional capacity into schools which will bring access for children and young people to around 55% across Tees Valley.

Youth People Helping Us to tell the I-Thrive Story

Young people agreed to help us communicate better what's available and how to access support for mental health and wellbeing. This is through helping us to tell the I-Thrive story. As part of a joint initiative with local youth groups and partner organisations we have been successful in securing £5,000, from the Child Health and Wellbeing Network for young people to help us tell the I-Thrive story.

Primary Care – Pilot Children and Young People (CYP) Mental Health Practitioner Role

A pilot scheme is underway to support children, young people and families presenting through GP practices to support mental health difficulties as and when they arise. Bytes and Redcar

Coastal PCN's are working together with Tees, Esk and Wear Valleys NHSFT (TEWV) to understand how integrated support can positively impact on children and young people getting the right support at the right time. Following a triage assessment by a qualified and experienced Children and Young People Mental Health Practitioner a range of interventions are offered including self-help, access to digital support and brief interventions, up to 6 sessions covering a range of presenting issues as well as supporting access to other structured mental health support including Mental Health Support Teams.

North East and North Cumbria Urgent and Emergency Care Network

The CCG was an active member of the North East and North Cumbria Urgent and Emergency Care Network, which brings together organisations across the Integrated Care System (ICS) to ensure the quality, safety and equity of urgent and emergency care services in the region.

The network provides a delivery team (based at North of England Commissioning Support), a Directory of Services (DoS) function and real time information through the UEC-RAIDR urgent care app, allowing providers to focus on operational delivery whilst the network provides operational and programme management support.

Urgent and Emergency Care (UEC) Strategic Board and Local A&E Delivery Board (LAEDB)

The UEC Strategic Board oversees the system's response to urgent and emergency care in ensuring patients the get right care in the right place whenever they need it with the aim of navigating urgent care access away from the emergency department and closer to people's homes. The vision is to reduce unwanted variation and improve quality, safety and equity for urgent emergency care provision by bringing together stakeholders to radically transform the system at scale and pace which could not be delivered by a single organisation.

The single Tees Valley-wide Local Accident and Emergency Delivery Board (LAEDB) continues to lead on the development of local plans to manage surge pressures. Our LAEDB has continued throughout the pandemic to provide system support and assurance in relation to Urgent and Emergency Care pressures including leading on the design, implementation, and participation in the daily ICP Incident Command and Co-ordination Centre (ICCC) calls which provide partners with the opportunity to share details of pressures and seek system support for mitigation or resolution.

The Surge Management Team have also supplemented the work of both the LAEDB and the UEC Strategic Board through continuing to provide a coordinated approach in communicating system pressures across the broader system as well as progressing several targeted pieces of work with individual systems and providers including the revision of the operational pressure escalation level (OPEL) triggers.

Spotlight on Our Work April – June 2022

Hartfields Medical Centre

Hartfields Medical Centre is one of five practices in the McKenzie Group Practice and is located in the Hartfields Extra Care Village in Hartlepool.

The CCG and McKenzie Group commenced an eight-week period of public engagement on 9 May 2022 to look at the impact of a possible permanent closure, whilst beginning to explore alternatives to being fully closed and fully open.

The engagement is targeting patients who are most likely to be affected by potential changes to services, who attended an appointment at Hartfields Medical Centre in the two years prior to the temporary closure in March 2020 or since it reopened in January 2022.

A survey has been sent to these identified patients, and the survey has also been made available to the wider community. Public engagement meetings also took place during May and June 2022 to gather feedback.

A full engagement report will be produced on the feedback of the engagement activity and any proposals for significant change will be subject to formal public consultation.

Review of Maternity Services: Ockenden Report

In December 2020, a report was published by Donna Ockenden requesting responses from all Trusts nationally (who provide maternity services) on their current position against the areas highlighted in the Ockenden report. The report highlighted several 'Immediate and Essential Actions' (IEAs) that Trusts were required to implement and re-double their efforts to bring forward lasting improvements in maternity services and maternity safety. On the 30 March 2022, the "Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust" was published detailing an additional 15 areas for national action.

Since the publication, as a CCG we worked closely with our local providers to progress the associated action plans, with local Trusts submitting the necessary evidence to NHS England and Improvement (NHSE/I). We have also regularly discussed and reviewed progress at our CCG Quality Committee with a report shared at the May 2022 meeting of which Trust representatives were in attendance.

Local maternity and neonatal systems (LMNSs) now have a greater responsibility for ensuring that maternity services are safe for all who access them and will be accountable to ICSs for doing so. Our LMNS, alongside NHSE/I are also continually monitoring the current position and progress against Ockenden actions through assurance visits and action plans for each Trust.

Community Diagnostic Centres

Part of the strategic plan for the health system in Tees Valley is to establish a new build Community Diagnostic Centre (CDC), that will enhance diagnostic services to meet future diagnostic capacity and demand, support faster earlier diagnosis and contribute to population health and tackling health inequalities. This will be achieved by accessing capital funding available to support systems in developing new build Community Diagnostic Centres for 2023/24 and 2024/25. This is being delivered collaboratively between North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, as part of a joint commitment to improving health outcomes for our population across Tees Valley and working closely with neighbouring CDC schemes to ensure the needs of our population on the borders of Teesside are also met.

The Tees Valley scheme is a hub and spoke design. There are designated spoke sites at Hartlepool University Hospital, Redcar Primary Care Hospital and the Friarage Hospital (Northallerton), which will provide good coverage across the Tees Valley and a mix of diagnostic services being delivered within these community settings and a central hub in Stockton Town Centre, which will open at the latter part of 24/25. There are opportunities to transform how diagnostic services are delivered in the future, dependent on our appetite and ability to align ways of working between services and across sites, to maximise opportunities for digital and technology advancement, and enable new and innovative ways for people to access and deliver healthcare services.

At the end of year one (2021/22), the Tees Valley CDC has delivered an additional 23,000 diagnostic tests in an eight-month period. Funding was secured for continuation into year 2 (2022/23) and will see delivery of an additional 60,000 diagnostic tests across radiology, cardiology, respiratory services.

Priorities at the start of 2022/23 included a refresh of governance and programme arrangements to ensure they were appropriate to this next stage of the programme implementation. This has included set up of a new Delivery Board and strengthening the central programme team and providing additional resource into key areas of the programme. Establishing robust plans for recruitment of additional workforce across all services is underway and has been a priority for the programme, to create new jobs and training opportunities for people across Teesside as part of our CDC Workforce strategy. This strategy ensures retention, training and development of the existing workforce by offering exciting career paths and ensuring the culture and working environment supports colleagues to work at their best, with the necessary support in place.

A partnership board has also been established with Stockton Borough Council to ensure effective working relationships are developed, that there are clear communications, governance and decision making between our respective schemes and that timelines are aligned to enable us to meet the requirements of the NHS England CDC capital funding rules.

Healthcare Financial Management Association (HFMA) Northern Awards

A huge well done to our finance colleagues across the North Cumbria and North East. The team have won the 'small team' award at the Healthcare Financial Management Association (HFMA) Northern Awards (Healthcare Financial Management Association). The team were recognised for their approach to coming together as a new team and working collaboratively to support the delivery of both CCG and ICB/ICS objectives over the last year.

Clinical Services Strategy

The programme of transformational work covered by the Tees Valley Integrated Care Partnership (ICP) Clinical Services Strategy continues to be progressed, the vision for the programme of work remains ‘To ensure the best possible care outcomes to every member of our population across the Tees Valley,’ delivered in the most cost effective and sustainable way through the best use of resources.

A key aspect in progressing this work has been through the development and establishment of Managed Clinical Networks. These networks offer a new way of delivering services to patients with health professionals and organisations from primary, secondary, and tertiary care working in a coordinated way to ensure equitable provision of high quality, clinically effective care for the Tees Valley system. Each network is a linked group of health professionals and organisations working together without the constraints of organisational or professional boundaries. They offer a new way of designing and delivering services to patients and are intended support a focus on services and patients rather than upon buildings and organisations. This approach ensures that existing health service resources and staff can focus on what matters - patients and their problems.

The focus of the programme continues to be on recovery from the Covid-19 pandemic, mitigating further risk from surge in the system whilst improving the service offerings for our patient population.

Progress continues in relation to the provision of Urgent and Emergency Care services, Maternity, Paediatrics and Young Peoples services, Diagnostics, Critical Care and Surgical services. A further eight clinical services have also been brought into scope of the surgical priorities being Hot Gallbladder pathway; Tees Valley Abscess Pathway; Oesophageogastric Emergencies; Breast Service; Endocrine; Bariatric; Paediatric & General Surgery on call rota.

Continuing Healthcare

Work continues to improve Continuing Healthcare (CHC). Building on the work in the past year, there has been a strong focus on clearing the backlog of CHC reviews which has delivered both significant quality and financial improvements. Multi-disciplinary training for staff on use of the equity and choice policy continues to ensure consistency, and work with local authority partners has been a focus through interagency CHC-focussed meetings, as has the development of a suite of new CHC policies for implementation by the ICB.

We continued to ensure that eligibility assessments are carried out in patients' usual place of residence to better reflect individuals' needs and reduce hospital stays. In over 90% of cases, these assessments are now completed outside of hospital. Assessments carried out outside of hospital more accurately reflect patients' needs and assessments post discharge ensure there are no inappropriate discharge delays due to waiting for a CHC assessment. This is of benefit to both the patient being assessed and hospital bed capacity. Performance continues to meet all NHS England performance standards.

Medicines Optimisation

Tees Valley Primary Care Pharmacy Network meetings continued during Q1 to ensure essential prescribing updates are communicated to the primary care pharmacy network; primary care networks and practice employed pharmacy staff as well as NECS employed pharmacy staff across Tees Valley.

Clinical education events have taken place involving planning with local clinical specialists to develop education events for primary care prescribers; including follow up opioid prescribing awareness events, menopause management, and promoting antimicrobial stewardship and prudent antibiotic prescribing

There has been a focus on safe prescribing in primary care, assisting GP practices to ensure they have systems and processes in place to ensure medicines are prescribed and monitored safely, e.g. assisting to identify patients prescribed valproate who need a pregnancy prevention programme in place.

A Cow's Milk Protein Allergy (CMPA) prescribing guide has been developed working with a local paediatric consultant to develop a CMPA management and prescribing guideline for primary care; essential as Tees Valley is an outlier in terms of volume and prescribing costs of these products.

Support continues to be provided to care homes across Tees Valley, both in terms of supporting proxy ordering (a digital solution to ordering repeat prescriptions for care home residents); and the medicines reconciliation service, to assist with medication issues when residents are accepted into a care home.

The medicines call pathway is a new service where the medicines optimisation team take referrals from the Continuing Healthcare (CHC) team to optimise prescribing for patients to assist in managing the extent of social care interventions needed with these patients.

Primary Care Network Estates Strategies

Primary Care Network Estate Strategies have been developed to support the 80 Tees Valley GP Practices working in their 14 Primary Care Networks (PCNs) to:

- Build a picture of their current services and estate
- Outline future health and care models and assess the estate needs

- Carry out 3 Facet Surveys (Condition, Functionality & Statutory Compliance) on the GP Practice buildings
- Identify short, medium and long term requirements to achieve their estate vision
- Develop a pipeline of schemes ready for when funding becomes available.

As part of the ICB we will work with each of the PCN's to develop plans for the implementation of their PCN Estates Strategies and prioritise the pipeline of schemes that come out of the plans to support decision making when funds are available to invest into the Primary Care Estate.

Nunthorpe Branch Site

Borough Road & Nunthorpe Medical Group had struggled with their Nunthorpe branch site which was undersized for the services they wanted to provide and had limited options for improvement due to the location. The CCG approved the development of a new building which was completed and opened for the provision of services on 27th June 2022. The new building will enable the provision of services to the patients registered with Borough Road & Nunthorpe Medical Group and will support the impact of an increased list size due to housing developments happening within the practice's boundary.

Primary Care Networks (PCNs)

PCNs have several 'core deliverables' set nationally through the GP contract which they continue to deliver upon. Contractual requirements for PCNs in 2022/23 included delivery of structured medication reviews, enhanced health in care homes, extended hours [until 30th September 2022], preparing for enhanced access [from 1st October], early cancer diagnosis, social prescribing, personalised care [proactive social prescribing], cardiovascular disease prevention and diagnosis and tackling neighbourhood inequalities.

A key focus during April - June 2022 for PCNs has been on the development of plans for the delivery of enhanced access from 1st October 2022. This was supported by allowing all PCNs the opportunity to attend a time out session, the development of a local planning framework by the commissioners, responding to contractual queries and attending national webinars.

PCNs across Tees Valley continue to work together as networks and come together with wider system partners to develop new and collaborative ways of working, with progress being made to plan for the recruitment of additional roles through secondary and mental health providers.

During this time PCNs have continued to respond to the Covid-19 vaccination programme and delivering vaccines to eligible patients whilst continuing to deliver primary medical care services to patients as part of their every-day general practice requirements and responding to the backlog in care. In June 2022, an end of year report was developed to highlight the key progresses and successes of the PCNs throughout 2021/22 and commissioners aim to build on this to support PCNs in 2022/23 and beyond.

Newlands Medical Centre

Newlands Medical Centre received national recognition for being in the Top 20 for 'Silver We Invest in People' employers. This means they have been recognised nationally for how they invest in their team and how they train and empower their staff. Newlands are now also eligible to submit a supporting statement for the Investors in People Awards 2022, which takes place on 15 November 2022.

Maintaining our Delegated Functions of Commissioning Primary Care

We successfully procured a 5-year Alternative Provider Medical Services (APMS) contract for Ravenscar Surgery in Redcar, to commence 1st October 2022 following the short-term emergency procurement in 2021/22, securing longer term primary medical care for the patient population registered at the practice.

Collaboration with Cleveland Local Medical Committee (CLMC) continued to provide additional support to practices in managing their responsibilities associated with Care Quality Commission (CQC) registration.

We continued to support GP practices to manage the Covid-19 response requirements as set out by NHS England, reducing any unnecessary additional administrative burden where possible and freeing up clinical capacity as much as possible to ensure that focus could be maintained on priority clinical care areas.

The Local Improvement Scheme re-commenced in April, maintaining a focus to seek improvements on learning disability annual health checks and flu immunisations and providing practice staff with the opportunity to attend dedicated training and education time out sessions.

The Operational Pressure Escalation Level (OPEL) reporting tool remains embedded across all GP practices to enable not only a wider system view of capacity and demand pressures, but to allow focused support to be directed to maintain business continuity of primary medical care services.

The Family Support Service in Tees Valley

The formation of the Tees Valley Neurodevelopmental Child and Family Support Service, jointly commissioned by the CCG and all five local authorities and managed by Daisy Chain, saw increased support for children and young adults aged 0-18 that exhibit neurodevelopmentally diverse traits, covering conditions such as Autism and Sensory processing issues, Attention Deficit Hyperactivity Disorder (ADHD) and Foetal Alcohol Spectrum Disorder (FASD). From its mobilisation in December 2021 up until the end of June 2022, 3123 families across the Tees Valley have engaged with the service, which provides drop-in sessions across the Tees Valley where families and carers can discuss issues in a safe space amongst professionals in the field and parents and carers in similar situations.

Review Health Assessments for Children in our Care

It was highlighted that due to having multiple contracts with different service specifications for Review Health Assessments (RHAs), the offer was inconsistent across the Tees Valley. Following engagement with children and young people (and their families) we produced a new service specification for Review Health Assessments, which covers the whole of the Tees Valley, ensuring that every child or young person receives the same high-quality support. The newly designed and commissioned service went live across the Tees Valley on 1 April 2022.

Employer Recognition Scheme and Commitment to the Armed Forces

We were pleased to receive the Silver Award in the Employer Recognition Scheme which evidences our support for Reservists, Cadet Force, Veterans and their families. We continue to work with our colleagues across the North East and North Cumbria through the Armed Forces Health Network to share information and good practice to help improve the health services that our Armed Forces (both current and past) come into contact with.

Cardiovascular Disease (CVD)

We were successful in securing a bid from NHS England to support the early identification and management of heart failure within primary care. A programme of work has commenced targeting a number of Primary Care Networks (PCNs) utilising a heart failure specialist nurse, reviewing patient lists, identifying potential heart failure patients and improving their heart failure management, in turn increasing the prevalence of heart failure across the Tees Valley, reducing admissions and providing our patients with better outcomes.

We completed a CVD self-assessment with all of our PCNs which has allowed us to identify any gaps across primary care in relation to CVD, an action plan has been developed to target the areas of needs highlighted to support our PCNs to fully achieve the CVD service requirements.

Proactive Care @ Home

We have started to roll out a new way of supporting patients with long term conditions in primary care, ensuring that those who require the most support are seen as quickly as possible. The new way of working is being piloted across 26 practices in the Tees Valley and uses new pathways and protocols to help practices recall patients. This new way of working also supports practices in using the wider clinical workforce and supports patients being offered clinical care where needed, as well as broader social support to help them manage their long-term condition.

Diabetes

Diabetes Prevention Programme

We continued to support the implementation and embedding of the NHS Diabetes Prevention Programme across the CCG including the transition to a new provider to ensure referrals continued to increase to enable people identified as at risk of diabetes had the opportunity to participate and reduce their risk.

National Diabetes Audit Quality Improvement Collaborative

Tees Valley CCG in partnership with County Durham CCG were successful in becoming part of the National Diabetes Audit (NDA) Quality Improvement Collaborative. Both CCGs decided to focus on the uptake of Urine Albumin-Creatinine Ratio (uACR) testing as part of the Diabetes Annual Review as this had been highlighted in the NDA as an area with low uptake leading to significant complications in later life. This project has been fully rolled out in Darlington and engagement continues across other localities.

Lost Insulin

The CCG received funding to implement a pilot across Hartlepool, Stockton-on-Tees, Middlesbrough and Redcar & Cleveland to identify people with diabetes on insulin who have not been attending for their diabetes annual review. Once identified patients would be contacted by a Diabetes Specialist Nurse/Diabetes Consultant to encourage them to book an annual review with their GP practice. Historically patients under the care of a Diabetes Specialist Nurse or Consultant do not regularly attend their annual reviews which leaves them at risk particularly with regard to foot and eye checks.

Low Calorie Diets

The CCG supported the roll out of a fully funded Low Calorie Diet 12-month pilot which is due to go live in September 2022 provided by Changing Health. The pilot is based on the findings from the DIRECT study which took place in Newcastle which the aim to enable diabetes remission through weight loss and lifestyle changes.

Post Covid-19

We commenced evaluation of the Post Covid-19 service offer and launched a communication and engagement strategy as an ICB in Tees Valley during the summer 2022/23. Services have been set up across all areas of the TV to provide assessment and management where appropriate for patients experiencing symptoms of Covid-19 for longer than 12 weeks.

We are working alongside colleagues in Durham to evaluate the Post Covid-19 Assessment Services; this will enable us to compare and contrast the outcomes utilising the same methodology. We are pre-empting this requirement for detailed evaluation and commencing now to ensure that we have a good understanding of how successful the service has been.

Part of this includes development of an updated communications and engagement strategy including:

- Launching a social media toolkit alongside our health and social care colleagues with messages to direct the public to resources to support them
- Resources collated onto the ICB webpage including patient leaflets/information packs and a video developed by the ICB Clinical Lead for Respiratory
- Attendance at Primary Care Time Out sessions to provide information on:
  - How to access self-help information/resources.
  - Services that are available within local communities i.e. Restart in South Tees and Tees Active Physical Activity offer.
  - Information on the secondary care Post Covid Assessment pathways.
- Development of a second public survey to gather local views on what services/support people have accessed and how useful they have found this to be.

The ICB established a Tees Valley Steering Group to provide governance around all the Post Covid-19 work and drive forward the communications and engagement work.

Spirometry

We worked with our three local GP Federations to develop an interim diagnostic spirometry service; this was initially intended to ensure that patients who had been waiting for spirometry during the pandemic could be assessed and to therefore reduce the backlog.

Home Oxygen Assessment and Review Services

We conducted patient, public and stakeholder engagement to understand the views of those who have accessed or been referred into our Home Oxygen Assessment and Review service. This valuable feedback is being used to develop a revised service model aimed at meeting the needs of patients across the Tees Valley.

Teledermoscopy Device Roll Out

Advances in dermatology care mean that it is possible to take and send detailed images of skin problems to specialist clinicians, to improve access to a diagnosis and management plan in a primary and community setting or expedite referrals to appropriate skin specialists for support. We purchased teledermoscopy devices and associated equipment to improve our dermatology pathways and are in the process of providing these devices to every practice who needs one.

Palliative and End of Life Care Strategy

We conducted patient, carer, public and stakeholder engagement in 2021 to better understand people's current experiences of palliative and end of life care across the Tees

Valley. This valuable information was used to support a series of stakeholder engagement sessions aimed at designing local palliative and end of life care services. We used all of this information to support the development of a new strategy to transform services where needed and put plans in place to work together to implement a new co-designed vision for the Tees Valley.

Targeted Lung Health Checks

Work progressed on the implementation of the Targeted Lung Health Check Programme. The focus during April to June 2022 was to continue to work with system partners, including public health, primary care, and secondary care colleagues to operationalise the service, with a key focus on the IT integration, Information Governance processes, clinical pathways and patient safety-netting. Alongside this, working with private provider, InHealth, to refine the service specification.

Great North Care Record

The Great North Care Record (GNCR) is a way of sharing health and care information between practitioners and with individuals.

GNCR digitally shares patient information from a range of health and social care providers together across the North East and North Cumbria safely and securely, helping to make care better and safer.

GNCR provides access to potentially life-saving patient information at the click of a button, such as diagnoses, allergies, medications, test results, visits and treatments. This means health and social care staff don't have to depend upon a patient's understanding when they are feeling unwell. They also do not need to spend time making a number of phone calls or reaching out to other organisations to pull together a complete view of the patient's history.

- One hundred per cent of primary care data is being shared – this covers 3.2 million patient records from 413 GP practices
- Out-of-hours providers have access
- Eight acute trusts view GNCR and six trusts contribute data to HIE (health information exchange)
- Both mental health trusts view and one shares data
- Over 200 community services are both viewing and sharing data including Child Health Information Services
- North East Ambulance Service view (crews and service centre) and share crew reports into GNCR
- Five local authorities view GNCR with two also sharing information regionwide

- Across the region, the HIE is now supporting nearly 400,000 patient encounters every month.

GNCR is the most-used Cerner HIE in the country with staff in the North East and North Cumbria with access to the system viewing shared records more than 377,000 times a month (as of May 2022) – the highest figure yet.

The next stage, the MyGNCR development, will see GNCR integrate with the NHS App by providing patients with a single digital front door to access secondary care services. It will include appointments and correspondence, which will be sent to the NHS app allowing patients to add these to their calendar and receive reminders.

For more information, please visit www.greatnorthcarerecord.org.uk.

Capacity Tracker

Our area is using Capacity Tracker, which was built by our partners at NHS North of England Commissioning Support (NECS) in partnership with NHS England, local authority representatives and care home providers.

Capacity Tracker
Insight for Care

Capacity Tracker provides a platform for care homes, in-patient community rehabilitation, substance misuse and hospice providers to make visible their vacancies and other critical information through minimum input to provide rich information across health and social care organisations, to help reduce the time taken to discharge individuals from hospital, PPE to enable rapid response from local/regional teams.

It enables care homes to make their vacancies instantly visible to all discharge teams across England in real-time and is accessible from any desktop or mobile device and is used by 99% of all care homes in England. This helps individuals make the right choice, ensuring they don't stay in hospital any longer than is necessary when discharge to their own home is not possible. The simplified process reduces stress and anxiety for the individual and their families at a time when they need care and support.

Capacity Tracker continues to evolve, thanks to the input from health and social care partners and users of the system. By having close engagement with user groups drawn from local authorities and health care commissioners, this enables the system to meet the changing and ongoing needs and priorities of its users.

Enhanced Health in Care Homes

Despite the challenges posed by the Covid-19 pandemic, the development of our integrated approach to partnership working goes from strength to strength across the Tees Valley in relation to care homes. The 'at place' Enhanced Health in Care Home (EHCH) Groups

continue to work together to support the delivery of the EHCH DES. A recent survey conducted across care homes in May 2022 continues to see positive response to the EHCH delivery in comparison to the 2021 survey with care homes citing the top 5 benefits of the scheme including, better partnership working, improved and efficient care through a named GP and weekly contact, staff also report feeling better supported.

The establishment of the Tees Valley Care Homes Collaborative has supported the development of a Tees Valley Care Homes Digital Strategy as part of the 'Care Homes Connected Programme'. The Care Homes Connected Programme aims to bring together several initiatives to enhance existing core services provided across Tees Valley adult care homes whilst making best use of digital opportunities including NHS Mail, Proxy Medication ordering and remote clinical monitoring.

In 2021/22 funding was secured via the Tees Valley Better Care Fund (BCF) resources to continue the roll out of NHS Mail across local care homes, and the development of information pathways to improve communication across the system in 2022/23 and 2023/24. As of May 2022, 20% of care homes across the Tees Valley had completed the DSPT for the 21/22 publication year, the completion rate has now risen to 89% over 3 months from April 2022 to end of July 2022.

Enhancing the healthcare of residents in care homes has been supported by the Tees Valley Medicines Optimisation care home team through improving safe use and management of medicines in care homes. The team have also supported the implementation of the NHS digital agenda in care homes by working closely with them, digital teams, GP practices and PCN pharmacy teams to support the implementation of proxy online ordering for medication such as implementation of proxy ordering. To date 37% of Care Homes have implemented proxy ordering of medications with a further 27% ready to move to implementation. It is anticipated that 100% of care homes suitable for the scheme will have proxy medication ordering in place by March 2023.

The continued review of associated BCF care home schemes will continue with recommendations scheduled for late Autumn 2022.

CCG Closedown

The Health and Care Bill received Royal Assent in Parliament on 28 April 2022, which was an important step on the journey towards establishing the statutory Integrated Care Board (ICB) on 1 July 2022.

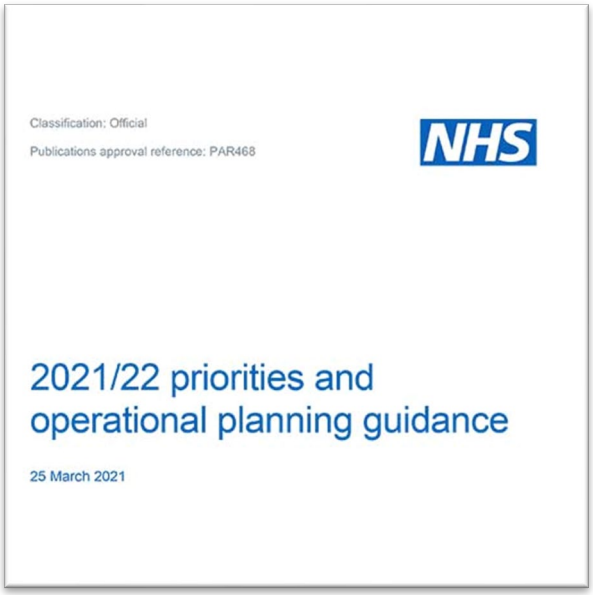
Staff throughout the CCG have been involved in various aspects of the CCG close-down and ICB development, including ensuring the safe transfer of functions via a robust due diligence process, and contributing to workstreams that are helping shape the future working of the ICB.

The Year Ahead 2022/23 Planning

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. The priorities will continue to be progressed as a North East and North Cumbria Integrated Care Board.

In addition to the locally identified priorities for our Health and Care System that are informed by the Joint Strategic Needs Assessments (JSNAs) covering our Five Local Authority areas, the 2022/23 NHS Priorities and Operational Planning Guidance was published on 24th December 2021. The guidance set out national priorities requiring local responses for the year ahead:

a. Invest in our workforce
b. Respond to Covid-19 ever more effectively
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
e. Improve timely access to primary care
f. Improve mental health services and services for people with a learning disability and/or autistic people
g. Continue to develop our approach to population health management, prevent ill health and address health inequalities
h. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
i. Make the most effective use of our resources
j. Establish ICBs and collaborative system working.



Across all these areas we will as part of the ICB maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health inequalities set out in guidance in March 2021.

Priority 1: Restore NHS services inclusively

Priority 2: Mitigate against digital exclusion

Priority 3: Ensure datasets are complete and timely

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Priority 5: Strengthen leadership and accountability.

Key Issues and Risks

Key Issues and Risks

The CCG has continued to manage a number of identified issues and risks, and, in addition to regular reviews, the CCG's risk register was fully reviewed during the final quarter of the CCG's operation to ensure that all risks were up to date with appropriate controls in place to support safe transition to the ICB. The key risk themes on the CCG's risk register related to the delivery of high-quality care across the CCG population, performance issues with regards to Constitutional standards, financial position and delivery, sustainability of Primary Care and corporate organisational risks such as information governance and security, staffing and the transition towards the new Integrated Care Board.

Although the ongoing impact of Covid-19 meant that we had some added complexities to the management of our risks, this also provided us with an increased impetus to consider different approaches and opportunities to address them so we could try to minimise the inevitable impact Covid-19 had on patients and staff. We worked hard to capitalise on the momentum of closer partnership working and innovative system approaches to tackling issues and risks and examples of some of our successes are elsewhere in the document.

At the end of the year, the CCG was actively managing 26 corporate risks. All these risks have key controls identified against them and the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate and are often subject to an action plan. Throughout the year, the CCG worked hard to ensure any concerns or issues related to the achievement of Constitutional Standards such as waiting times have been managed proactively.

The Governing Body regularly reviewed the CCG's Assurance Framework and received an assurance report on work undertaken to maintain the corporate Risk Register. The 2022/23 CCG Assurance Framework was also reviewed and details of the 14 principal risks included in the Framework can be found in the Governance Statement. The end-of-year Assurance Frameworks were presented to the Audit and Assurance Committee on 15th June 2022 and a risk update provided to the Governing Body on 30th June 2022.

NHS Long Term Plan

The NHS Long Term Plan (www.longtermplan.nhs.uk) is a plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years. The plan focuses on building an NHS fit for the future by:

- enabling everyone to get the best start in life
- helping communities to live well
- helping people to age well.

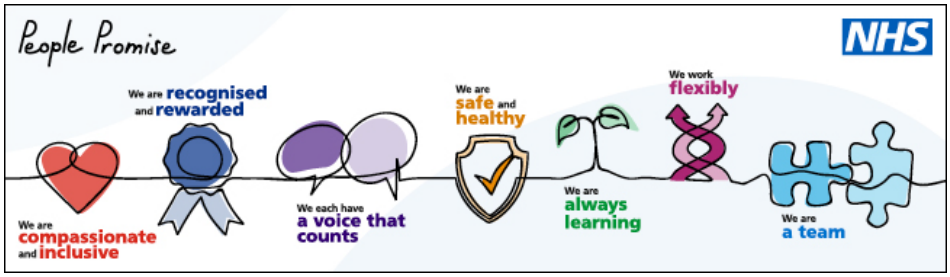
The plan was developed in partnership with frontline health and care staff, patients and their families. It will improve outcomes for major diseases, including cancer, heart disease, stroke, respiratory disease and dementia. The plan also includes measures to:

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

Supporting Our People

As NHS staff our daily focus is improving the health and wellbeing of patients, but it is vitally important that we take care of each other's health and wellbeing, as managers and as colleagues, as well as our own.

Since the People Plan was published in July 2020, the CCG continued to work through several actions that were set out by NHS England and NHS Improvement, focusing on supporting our people in conjunction with the priorities within the operational planning guidance which endeavours to make the NHS a better place to work for all staff by looking after our people, improving belonging, working differently, and growing for the future.



Hybrid Working guidance was shared to provide clarity to staff on the expectations around working from various locations, providing additional flexibility to determine the best location to work.

Health and wellbeing conversations continue to allow opportunity for a pro-active and open approach to mental health, taking into consideration preferred approaches to stress to anxiety management, building on the bespoke sessions we have delivered at staff events towards the end of 2022. Although the Better Health at Work Bronze award was achieved in late 2021/22, we have continued with a number of successful campaigns.

A Wellbeing Directory has been produced and made readily available detailing a number of support services and useful links for staff with health resources regularly shared through our

weekly staff briefings. In addition, there is an employee assistance service who are accessible 24-hours a day.

Our staff group continued to meet every 6 weeks with each department having a representative, to ensure that all staff have a voice and allowing for 'safe space' conversations. The meeting is focussed on two-way feedback for engagement. General topics of discussion are hybrid working, input into staff events, staff health and wellbeing, communications, sustainability and staff achievements/recognition. Within this forum we have continued to progress the actions in relation to the 2021 National Staff Survey.

As we moved forward to transition across to the Integrated Care Board on the 1st July 2022, individual and group consultation meetings were offered, with trade unions attendance, so that staff were assured of the process and terms and conditions regarding the transfer. An anonymous method of submitting concerns was established and a frequently asked questions document compiled, alongside regular strategic briefings from our Chief Officer. A baseline survey has since been conducted with staff that will be used to shape the new organisation and help form new values.

Celebration Event

On the last day as NHS Tees Valley Clinical Commissioning Group a staff event was held at a local community centre to celebrate our organisation's legacy and achievements. Each of our directors presented their team's proudest achievements, of which there were numerous, as so much had been accomplished as an organisation and by the predecessor CCGs (Darlington, Hartlepool and Stockton-on-Tees and South Tees CCGs).

The 'Poscars' ceremony, appropriately named and led by our CCG Chair Dr Posmyk, was followed by a range of awards to colleagues for their fantastic skills and attributes. Categories for awards ranged from Champion Problem Solver to Behind-the-Scenes Wonder.

Financial Review

Overview

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

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

The maintenance of financial control and stewardship of public funds has remained critical during the NHS response to Covid-19. All financial controls have continued to operate as normal and the robust systems of financial governance and financial management processes have allowed all financial risks to be appropriately managed during the three-month period enabling the delivery of financial targets.

Further details on the CCG's financial position can be found in the Governing Body (GB) finance reports published on the CCG's website.

This continues to be a challenging time for the NHS with significant pressures from managing the impact of the pandemic and recovery of activity backlogs. The financial performance outlined in the CCG's annual accounts is pleasing to see, reflecting the strong financial management within the organisation.

Financial targets and performance for the year

CCG financial position

For 2022/23, the CCG's performance results are set out in the table below, with further detail included in note 17 of the full annual accounts published alongside this Annual Report.

Target	Outcome	Target Met?
Maintain expenditure within 'in-year' funding allocation	In-year breakeven against an in-year funding allocation of £340.8 million	✓
Maintain running costs within separate running cost allowance	Breakeven delivered on running cost budgets	✓
Maintain capital spending within capital resource limit	No capital resource required and no capital spend in year	**N/A**
Ensure cash spending is within the cash limit set	Cash managed within available resources	✓

Expenditure not to exceed resource limits

Unlike commercial companies which make a profit or loss, CCGs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs.

The CCG financial performance is reported on an in-year basis.

The CCG's final in-year programme budget allocation for 2022/23 was £337.6 million.

As highlighted above, a separate running cost allowance is provided to all CCGs, to cover the

administrative costs of running the CCG. There was a requirement to manage administrative costs within this allowance.

Total running costs for the year amounted to £3.19 million, compared to a running cost allowance of £3.19 million.

Capital resource limit

The CCG had no capital expenditure in 2022/23 and therefore did not require any capital resource, hence this target is not applicable in the current year.

Other financial targets and disclosures

In addition to the above statutory duties, CCGs have similar responsibilities to other NHS organisations to record performance against the Better Payment Practice Code (BPPC) published by the Department of Health.

Compliance with Better Payment Practice Code

The BPPC requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in note 4.1 to the financial statements.

Performance against the target is monitored by the CCG on a monthly basis with performance maintained at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

Prompt payments Code

In addition to compliance against the BPPC, on 11 February 2014 the CCG became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- pay suppliers on time,
- give clear guidance to suppliers and resolve disputes as quickly as possible,
- encourage suppliers and customers to sign up to the code.

Setting of charges for information

The CCG has complied with HM Treasury's guidance on setting charges for information.

Pensions

Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the CCG's financial statements (notes 1.7.2 and 2.3 respectively). Further details of senior managers' pension benefits can be found in the Remuneration and Staff Report.

Audit and Assurance Committee

An Audit and Assurance Committee has operated throughout the year, chaired by the Lay Member for Governance and Audit. Details of other members of the Committee can be found within the Members Report.

External auditors

Following a procurement and selection process undertaken by the predecessor CCGs, Ernst & Young continued to be the appointed auditors to the CCG for 2022/23.

The cost of audit services can be found in note 3 of the CCG's financial statements.

Looking forward

This continues to be a particularly challenging time for both the NHS and wider health and care system. The principles of system financial envelopes will continue during 2022/23 with system allocations set at Integrated Care Board level and CCG performance considered in aggregate at system level.

The arrangements for 2022/23 have seen a reset to move allocations back towards a fair distribution of resource, leading to an additional efficiency ask across the North East and North Cumbria ICB.

From 1st July 2022, Tees Valley CCG was abolished and its functions transferred to the North East and North Cumbria Integrated Care Board (ICB). The ICB was established with the remaining amounts for the financial year, meaning its allocations will be reduced by the amount of resources the CCG have consumed.

The new ICB is committed to working with local providers and partners as part of system integration. This joint planning and working is necessary to deliver the financial efficiencies to manage short term pressures, as well as deliver longer term plans to ensure sustainable, high-quality services are available for our local population across the ICB footprint.

Performance Analysis

Performance Overview

This report reviews Tees Valley CCG's performance in quarter 1 (Q1) of 2022-23until the North East and North Cumbria Integrated Care Board (NENC ICB) was formed. Performance for the remainder of 2022-23 will be included in the NENC ICB 2022/23 annual report.

The impact of Covid-19 continues to affect all of the Trust's performance against the key standards. The following pages will highlight the areas most impacted, what the issues are and actions that have been put in place to recover the position, including both local and national initiatives.

The following pages set out Tees Valley CCG's performance against the following indicators:

- Referral to Treatment Times
- Diagnostics
- A&E
- Ambulance Response Times
- Healthcare associated infections (MRSA and Clostridium difficile)
- Mixed Sex Accommodation (MSA) Breaches
- Cancer Waiting Times.

Referral to Treatment (RTT) Performance

92% of patients should wait no longer than 18 weeks from referral for initial treatment on incomplete pathways

Tees Valley CCG had underachieved against the 18-week standard in Q1 of 2022/23. The CCG's performance in June 2022 was 72.2%, which is significantly higher than the national average performance of 62.2%. This means that as of 31st June 2022, there were 17,251 patients from Tees Valley CCG that had been waiting longer than 18 weeks for their treatment.

Tees Valley CCG's three main Providers were South Tees Hospitals NHS Foundation Trust (STHFT), North Tees and Hartlepool NHS Foundation Trust (NTHFT) and County Durham and Darlington NHS Foundation Trust (CDDFT). All three Trusts also underachieved the standard in 2022/23.

Due to the pressures of the Covid-19 pandemic on the NHS and the cancellation of all routine electives in 2020, the Trusts waiting lists had grown beyond usual levels. Although significant progress has been made by eliminating 104-week waits and reducing 78 week waits, the impact of the pandemic can still be seen in referral to treatment time performance in Q1 of 2022/23.

The elective recovery programme of work that began in 2020/21 continues into 2022/23, with the three Acute NHS Trusts and Independent Sector (IS) Providers working closely to reduce waiting lists and to allow for the Acute Trusts to prioritise more urgent procedures. To reduce the demand on secondary care services, Acute Providers implemented robust measures to ensure that a clinical triage of all referrals is made by an appropriately qualified clinician. This allows for patients to be placed in the most appropriate clinics to ensure that outpatient appointments are maximised. Specialist advice and guidance has increased the number of patients able to receive ongoing management in Primary Care.

The three Trusts, with support from the CCG, also implemented actions to reduce waiting lists, such as additional clinics and theatres sessions, patient initiated follow ups, Advice and Guidance to GPs, in-sourcing capacity, and the cleansing of waiting lists. Patients continue to be clinically prioritised, ensuring the most urgent patients are treated first.

There should be no patients waiting more than 52 weeks for treatment (Incomplete pathways only)

As of June 2022, Tees Valley CCG had 1,247 patients that had been waiting more than 52 weeks for treatment. Nationally, there were 358,220 patients waiting more than 52 weeks, which equates to a rate per 100,000 of 584 people. Tees Valley CCG's comparable rate per 100,000 is 175 people.

As outlined above, the suspension of all routine elective procedures in 2020 has significantly impacted on the CCG's performance against this standard, pre-covid-19 the number of patients that waited more than 52 weeks for any treatment was minimal and usually had exceptional circumstances if a breach occurred.

Diagnostic Performance

Less than 1% of patients should wait over 6 weeks for a diagnostic test

Tees Valley CCG underachieved the Diagnostic standard in Q1 of 2022/23. As with the RTT standard, the Covid-19 pandemic has impacted on the Diagnostic performance.
Performance in June 2022 was 22.1%, this means that as of 30th June 2022, 4,467 patients had been waiting longer than 6 weeks for a diagnostic test. The national average performance in June 2022 was 27.5%.

All three Trusts underachieved against the diagnostic standard in Q1. The majority of breaches at NTHFT were in MRI, Non-obstetric Ultrasound and Endoscopy. STHFT breaches are in Audiology Assessments, Endoscopy, MRI and Echocardiography. Although CDDFT have failed the diagnostic target, there were minimal breaches for Tees Valley CCG patients in Q1.

All modalities have demand and capacity plans in place with actions and trajectories to work towards compliance, including the use of future Community Diagnostic Hub capacity. The Trusts have also created additional capacity using overtime and weekend working to support the recovery of diagnostic performance.

A&E Performance

95% of patients should spend 4 hours or less in A&E or minor injury unit

Tees Valley CCG managed A&E performance at a Trust level, on behalf of the population of the Tees Valley.

During 2019/20, NTHFT was one of fourteen hospitals involved in a pilot of new performance measures which could lead to changes in the 4-hour emergency care standard. This meant that the Trust was exempt from reporting against the 4-hour A&E standard. Due to Covid-19, the roll out of the metric has not been finalised and NTHFT were not required to revert to reporting against the original 4-hour standard, therefore no data is available for NTHFT.

Both STHFT and CDDFT underachieved the 4-hour standard in 2022/23. In June 2022, performance at CDDFT was 70.8% and STHFT was 66.6%. Both sites' performance was below the national average of 75.1%.

The local A&E Delivery Board continues to review pressures in the system and agree plans to reduce risks. Several initiatives have been implemented to reduce patient waits in an A&E setting. These include but are not limited to:

- Same Day Emergency Care (SDEC) – ensuring that those patients who require further investigation but not an overnight admission, are catered for in a timely and effective way
- Emergency Department Staffing Model – ensuring a workforce fit for the future
- Estate expansion and reconfiguration, to create additional cubicle capacity
- Expansion of Virtual Wards
- The development of a Children and Young People's Emergency Department.

A number of initiatives have also been implemented to look at Ambulance Handover Delays, these include but are not limited to:

- NEAS provide a QI lead into the Trust 2 days per week looking at the current handover processes and making improvements such as working with crews to understand alternative pathways for patients such as admission directly into SDEC

- IMPACT Nurse – the clinical management of up to 3 patients within the ambulance handover area, which releases crews whilst ensuring patient safety by significantly reducing the risk to patients caused by ambulance delays.

- MCN Task & Finish Group – the Integrated Urgent Care Task & Finish Group has been re-purposed to look at UEC pressures, the first meeting will take place in September with the priority being Ambulance Handover Delays and handover recording.

Ambulance Response Times

Tees Valley CCG commissioned ambulance services from North East Ambulance Service NHS Foundation Trust (NEAS) and specified that they comply with operational standards. New performance measures were introduced in 2018/19 which places calls into the following categories:

Category 1 (C1) *- For calls to people with immediately life-threatening and time critical injuries and illnesses. These will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes.*

NEAS slightly underachieved the Category 1 response time in Q1 of 2022/23. The average response time across the quarter was 00:07:24, against the 7-minute target.

NEAS have achieved the Category 1 90th centile consistently so far in 2022/23, with an average response time of 00:12:50 across the quarter.

Category 2 (C2) *- For emergency calls. These will be responded to in an average time of 18 minutes and at least 9 out of 10 times before 40 minutes.*

NEAS underachieved the Category 2 response time target in 2022/23, with an average response time of 01:30:02 across the three months.

Category 3 (C3) *- For urgent calls. These types of calls will be responded to at least 9 out of 10 times before 120 minutes.*

NEAS underachieved the Category 3 response time target in 22/23, with an average response time of 05:37:34 across the three months.

Category 4 (C4) *- For less urgent calls. These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes.*

NEAS underachieved the Category 4 response in 2022/23, with an average response time across the quarter of 04:11:42.

NEAS performed well against the life-threatening response time target (C1) in Q1 of 2022/23. However, the Trust has been challenged with all other response times, with significantly longer wait times recorded against the C3 standard. The NEAS response time for the C3 target in June was 05:51:56, this is significantly quicker than the national average performance of 07:21:14 and NEAS remain one of the better performing Trusts across all standards in the country.

An increase in call numbers and patient acuity has impacted on performance across the standards, as well as staff sickness rates and Covid-19 isolation requirements. The following actions were implemented to support NEAS performance:

- Recruit additional call handlers/health advisors
- To recruit additional clinical staff focusing on the dispatch queue

- To procure third party vehicles
- The development of a quality and performance deck which has oversight of all vehicles and reviews crew movements and will liaise with hospitals in relation to handover delays / pressures to improve ambulance turnaround times

Healthcare Associated Infections (MRSA and Clostridium difficile)

Tees Valley CCG had 0 cases of MRSA in Q1 of 2022/23, against a target of 0. The CCG has had 69 cases of clostridium difficile (c.diff) in the same period, against a target of 60.

Monitoring of healthcare associated infections has continued through Clinical Quality Review Groups and the CCG Head of Quality continues to attend the Trust's Infection Control Committee.

Cancer Performance

93% of patients should be seen within 2 weeks of an urgent GP referral for suspected cancer

Tees Valley CCG underachieved the 93% target in Q1 of 2022/23. The average performance across the three months was 70.6%, this is significantly below the national average performance of 80.1% and means that of 7,513 patients, 5,307 patients were seen within 2 weeks of referral.

93% of patients should be seen within 2 weeks of an urgent referral for breast symptoms

Tees Valley CCG achieved the 93% target for 1 out of 3 months in 2022/23. The average performance across the three months was 86.4%. This means that out of 676 patients, 584 patients were seen within 2 weeks of referral. Tees Valley CCG's performance was significantly above the national average performance of 67.1%.

96% of patients should be treated within 31 days of a cancer diagnosis

Tees Valley CCG achieved the 96% target in June 2022. Average performance across the three months was 95.2%, this equates to 838 patients out of 880 being treated within 31 days of having a cancer diagnosis. Performance is above with the national average performance of 92.1%.

85% of patients should be treated within 62 days of an urgent GP referral for suspected cancer

Tees Valley CCG underachieved the 85% standard throughout in Q1 of 2022/23. The average performance for the three months was 63.2%. This means that out of 549 patients, 347 were treated within 62 days. Tees Valley CCG performance was in line with the national average performance of 62.1%.

90% of patients should be treated within 62 days of an urgent GP referral from an NHS Cancer Screening Service

Tees Valley CCG underachieved the 90% standard in Q1 of 2022/23. Due to small numbers, performance against this indicator can fluctuate monthly. Out of 77 patients that were referred via a cancer screening route, 60 were treated within 62 days from this referral. The average performance across the quarter was 77.9%, which is higher than the national average performance of 69.5%.

Challenges delivering the cancer standard continue, with issues including reduced treatment and diagnostic capacity, complex pathways that cover complex tumour groups at cancer centres. Covid-19 continues to impact cancellations and capacity. The pressures remain across most tumour pathways. The Trusts remain committed to a collaborative approach through the Cancer cell initiative, ensuring equitable access to treatment for all patients. Some initiatives include, insourcing supporting additional week and weekend lists, cancer delivery groups led by lead clinicians and specialist nurses and cancer navigator posts in all tumour groups.

Sustainable Development

Introduction

As an NHS organisation, and as a spender of public funds, the CCG had an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It requires particular attention to be paid to energy, travel, waste, procurement, water, infrastructure and buildings.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition of reducing the carbon footprint of the NHS, public health and social care system. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. As a region we are focused on preventing ill-health and improving the overall health of communities with NHS organisations, and our partners, working together to deliver our ambition to be the greenest region in England by 2030.

By demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. While we are committed to this, we have not yet issued a statement on meeting the requirements of the Public Services (Social Value) Act.

Policies

To embed sustainability within our business it is important to explain where in our process and procedures sustainability features. Across the North East and North Cumbria as part of the Integrated Care system we are working together to deliver our ambition to be the greenest region in England by 2030 and have contributed to the plan development. Across our region, NHS organisations and our partners are already working to reduce our environmental footprint from how we are reducing waste, supporting active travel, using electric vehicles, re-thinking our supply chain and switching to more sustainable products

In response to the pandemic, and with the adoption of hybrid working across the CCG, we know that we have significantly reduced our travel, use of paper resources and other office utilities. We also have a Cycle to Work scheme with cycle racks and shower facilities available at our North Ormesby Office to enable active travel.

Improve Quality

Quality Analysis

CCGs had a statutory duty to improve the quality of services provided for local people and a responsibility to ensure they commission safe, good quality and effective services that result in positive experiences for patients. The CCG did this by working with system partners to secure continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness. This was achieved through a collaborative approach, monitoring the effectiveness and safety of services and the quality of the experience by patients. We understand that securing continuous quality improvement in our commissioned services is an ongoing process and to ensure we remain sighted on all aspects of quality and are able to constructively challenge, scrutinise and assess individual providers' performance and service delivery, we have established robust relationships with providers that facilitate and support internal and external quality assurance mechanisms.

To effectively address quality issues with commissioned services and seek assurance, we systematically undertook a range of activities. These informed and shaped the CCG Quality and Safeguarding Annual Work Programmes. Allowing for the nationally driven Covid-19 related contingencies, priorities identified continued to be positively progressed through proactive collaboration with partners via ongoing monitoring, evaluation and scrutiny of these areas of work. This enabled a range of quality assurance activities to be undertaken by the CCG during Q1 2022/23, with innovative amendments to ensure Covid-19 security, and has included listening to concerns, virtual face to face contact with providers, analysis of provider data and information, and the sharing of intelligence with relevant NHS commissioners, local authority organisations, Healthwatch and regulatory bodies.

Further detail of these activities is described below:

Quality Committee

The Quality Committee successfully brought together senior representation from the five main NHS provider Trusts in the Tees Valley locality to discuss and share the main areas of quality concerns, and where appropriate safeguarding issues, being experienced by the individual Trusts and wider Tees Valley system. The meeting also provided a useful forum to aid the sharing of any identified learning.

A comprehensive quality and safeguarding report was produced for this committee to aid discussion of key areas and a subsequent report published for the Governing Body with any actions and learning that had been compiled. This report was shared publicly following the meeting to highlight the ongoing quality assurance and patient safety work the CCG was involved in.

Clinical Quality Review Groups (CQRGs)

These meetings continued during Q1 2022/23, work continued with the five main NHS provider Trusts; North Tees and Hartlepool NHS Foundation Trust (NTHFT), South Tees Hospitals NHS Foundation Trust (STHFT), County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), and North East Ambulance Service NHS Foundation Trust (NEAS), to monitor, evaluate and drive forward quality standards.

Work continued in conjunction with NHSE/I and CQC colleagues in supporting TEWV throughout their quality escalation and following their CQC visit. This work involved additional quality monitoring meetings to identify what extra support the Trust required and support the implementation of this.

Following the end of Covid-19 national restrictions, the CCG performed a number of planned Commissioner Assurance Visits during the first quarter of 2022/23, to gain assurance around patient safety and quality of care. A full programme of visits is planned during the remainder of the year to all Tees Valley commissioned services, involving a more collaborative approach, which involves working alongside providers 'Peer Review' programmes.

The national Commissioning for Quality and Innovation (CQUIN) schemes that were suspended due to the altered working arrangements arising from the Covid-19 pandemic pressures, have now been reinstated and the CCG agreed priorities with the Trusts.

Patient Safety Serious Incidents

Healthcare systems and processes can occasionally have weaknesses which may at times lead to errors, therefore it is important the NHS system is able to both promptly recognise and respond appropriately when things may not go according to plan. This flexible and responsive approach aims to ensure services and processes continue to improve. As part of this the CCG was responsible for ensuring an effective clinical governance process to review the management of incidents that occur within providers or within the CCG. During the first

quarter of 2022/23 we worked together with Trusts at the outset of several Serious Incident investigations in a supportive approach to inform the scope of the investigations.

The clinical governance process is supported by the Serious Incident Reporting and Management System (SIRMS), operated by the North of England Commissioning Support Unit (NECS) and CCG staff. The Serious Incident Framework is to be replaced by the Patient Safety Incident Report Framework (PSIRF) during 2022 and the CCG were involved in ongoing discussions with local providers to support the smooth transition to this process.

As part of the current process a monthly Serious Incident Review Panel was held, which is responsible for reviewing the final Root Cause Analysis investigation reports and associated action plans. The purpose of this was to ensure all appropriate root causes and contributory factors are identified and have appropriate actions to address them. While this panel was routinely chaired by the CCG's Director of Nursing and Quality or deputy, it benefits from a multi-agency, multi-disciplinary membership, who agree to close an incident once robust evidence-based assurance is provided that the appropriate action has been taken to safeguard patients, prevent the incident happening again, and that lessons have been learnt to ensure patients receive quality care. During the first quarter of 2022/23, the CCG successfully implemented a more collaborative approach to this process and instigated a joint CCG/Trust Serious Incident review panel, whereby Trust Quality/patient safety leads attend and input to all the incidents is discussed. This approach has facilitated shared learning across providers.

Key themes and trends were reviewed to inform learning during 2022/23. We continued to work with providers to understand the processes that require improvement and agree actions that will be taken to improve patient care. The themes and trends that inform the learning were taken forward and monitored via the CQRG meetings. From the key themes and trends identified the CCG held a number of Serious Incident panels to discuss emerging areas of concern, examples so far this year include the 'Deteriorating patient' and 'Lost to Follow up' incidents. Working collaboratively with providers, this method enabled a discussion of the work already ongoing and further actions needed to gain assurance.

Quality Surveillance Groups

The CCG was an active member of the Cumbria and North East Quality Surveillance Group (QSG) which is led and co-ordinated by NHS England. This forum brings together regulators, local authority colleagues, Healthwatch and Health Education England, as well as CCGs and other commissioners, to review quality by sharing intelligence and local knowledge to help identify early signs of service failure or poor quality. During Q1 2022/23, although there was a continuation of virtual teleconference working, a wide range of intelligence shared by the group in relation to services across acute, community, specialist mental health and learning disability, care homes and primary care services (GP practices, Dentists, Pharmacists and Optometrists). The QSG provides an opportunity to discuss concerns or risks with the quality of care delivered by providers at a local level, as well as gain an insight into regional and national quality concerns that are ongoing with providers.

NHS England Safeguarding Forum

CCG safeguarding colleagues continued to attend and share information and intelligence at the Regional Safeguarding Forum, a health commissioner sub-group of the Quality Surveillance Group which enabled focused attention on specific quality issues in relation to adult and children's services.

Safeguarding

The CCG had a close and effective working relationship with partner agencies which includes NHS and Independent Sector providers, the five Tees Valley local authorities and the Cleveland and Durham Police forces, as well as wider partner agencies such as probation. We continued to work closely and share expertise to respond to early warning indicators, and address these in a timely and efficient manner. This has been particularly important this year in light of the enhanced concerns about safeguarding risks associated with the various periods of national lockdown and an increase in domestic abuse and self-neglect.

System working with partners across our localities is undertaken via a variety of groups and topics, a selection of which are as below:

- The Cleveland Anti-Slavery Network with the key aim to increase greater local awareness/intelligence and ensure an improved multi-agency response for those affected by Human Trafficking and Modern Slavery. CCG has updated the Modern Slavery Statement and posted on the web- site.
- There has been an increase in the area of identification and reporting of Modern slavery safeguarding concerns
- The CCG was a statutory member of the following statutory partnerships / Safeguarding Boards:
    - Hartlepool and Stockton Safeguarding Children Partnership (HSSCP)
    - South of Tees Children's Safeguarding Partnership (STSCP)
    - Tees wide Safeguarding Adults Board (TSAB)
    - Darlington Integrated Children and Adults Safeguarding Partnership.

    Going forward this continues as NENC ICB.

- Local Authorities' Domestic Abuse strategic groups.
- NHS provider safeguarding meetings and subgroups to ensure the sharing of information as well as support with expertise and challenge to these groups.
- The CCG had a duty to co-operate with Multi-agency Public Protection Arrangements (MAPPA) meetings. MAPPA aims to ensure the successful management of violent and sexual offenders. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

We also worked closely with the Care Quality Commission (CQC) in relation to quality concerns about providers. The CQC links included both the NHS providers and nursing home

providers, so this involves additional close working across the health and social care economy.

Assurance in relation to provision of services, with safeguarding as an integral component is part of a comprehensive, transparent and co-designed process with providers. The routine reporting of performance metrics as part of the enhanced (NHS Standard Contract) Local Quality Requirements (LQRs) helps to promote a common understanding of the position, identify areas for improvement, and also monitor progress. Subject to review by the NENC ICB these will continue to be reviewed annually to ensure relevance and value without undue reporting burden.

The Learning Disabilities Mortality Review (LeDeR) Programme continues through the Tees multi-agency Service Improvement Group (SIG) and involves the four Tees local authorities and major health providers. This process reviews the life and death of any person with learning disabilities and shares good practice and any lessons learned that will support future improvements in care provision. Darlington LeDeR programme is discharged via the Durham SIG. Teesside have set up their own Service Improvement Group (SIG) where any themes can be identified, lessons learnt, and good practice can be disseminated. There is a region wide Quality assurance panel that meets monthly to discuss individual reviews and agree next steps, for example, the signing off, of a review or identifying an initial review that needs to be focused.

The Designated and Named Safeguarding Children professionals have continued to provide expert safeguarding advice and support across the health economy, as well as seeking assurance commissioned services are fulfilling their safeguarding responsibilities, leading, and influencing the safeguarding children agenda. This includes being a core member of multi-agency groups as well as identification of any gaps in service provision with regards to the safety of vulnerable children, child abuse, child deaths and Looked After Children. This ensures the safeguarding of children and young is rooted across the work streams. The Designated Nurse for Children in Care has lent their expert knowledge around CIC health outcomes and mandated services, to the procurement of a new service provision for health assessments

Where necessary, this work has also included support to providers to ensure implementation and embedding of improvement actions to support delivery of statutory safeguarding services and requirements. This work includes NHS primary and secondary care, as well as independent providers.

Attendance at Vulnerable, Exploitation Missing and Trafficked (VEMT) meetings has led to information being shared across multi-agency partners to ensure contextual safeguarding is embedded to detect community concerns and better safeguard children and young people, increasing the awareness for contextual safeguarding risks, ensuring a sharing and improvement approach across the location.

The team have been involved to provide assurance in completion of the Section 11 audits across the Safeguarding Children's Partnership. Statutory guidance such as ‘Making arrangements to promote the welfare of children under section 11' and the Children Act 2004 reinforces and describes the duties of health services.

The revised Working Together to Safeguard Children (2018) recognises the changing commissioning arrangements within the NHS and need for more robust arrangements to manage allegations against staff and the thresholds for serious case reviews.

The 2019 initiative around implementation of the child protection information sharing process (CP-IS), continues to deliver benefits to service cohesion when children subject to child protection plans or looked after children attend unscheduled care settings i.e. Hospital Emergency Departments.

The safeguarding team had the challenge of delivering limited primary care sessions due to Covid-19 pandemic, however the expansion of the safeguarding team for children and adult has enabled the sessions to be recommenced with good engagement from primary care, delivering support and training in the following areas for child and adult: Think Family, Adolescence issues across Teesside; links with domestic homicides; child sexual exploitation; learning from serious case reviews; modern slavery; and ICON initiative (promotion of normal crying patterns in babies). Further sessions planned will include bespoke sessions for GP based safeguarding leads and promote safeguarding awareness across all primary care staff.

Provider assurance and monitoring continues within the streams for the workplan:

- Continue to work with all colleagues to promote the safeguarding agenda
- Improve links with the whole team, in particular commissioning, as well as maintaining the positive links with primary care and all partners across Tees Valley, to ensure that safeguarding is integral and a normal addition to services specifications and contracts
- Continue to support partners in improving the safeguarding function and processes that they offer, thus attempting to reduce the number of safeguarding related incidents.
- Support the roll out of the Liberty Protection Safeguards, LPS, (affecting 16 years plus) across all commissioned services, particularly CAMHS and Adult MH. There has been a further delay to the implementation, which is currently in the consultation process.
- Continue to develop the Designated and Named professionals team by way of regular, structured meetings and work plans, and roll out of a training calendar for GPs and primary care staff.

Care Homes

Where significant safeguarding or quality of care issues are identified in a nursing care home within the Tees Valley localities, a coordinated and systematic approach to support and gain

assurance is mounted by system colleagues and agencies. In order to gain a level of assurance a visit to individual care homes has often been required which has usually been led by the Senior Adult Safeguarding Officer. Following these visits feedback is provided and the care home is expected to design and implement improvement action plans, and progress is monitored against these for assurance. This in turn is shared with all relevant partners including the provider, as well as being reported to the regional QSGs.

We also continued to work collaboratively with each Local Authority to ensure the best possible outcomes for individual residents were achieved by:

- Providing expert advice, guidance in respect of individual queries and concerns raised relating to safeguarding, quality standards and nursing care provision. Attending multiagency strategy meetings and undertaking investigations.
- Where care homes have been subject to the Teeswide Adult Safeguarding Boards Responding to and Addressing Serious Concerns protocol, the CCG has provided support and guidance to care home providers and Local Authorities and contributed to LA provider meetings through information sharing and effective liaison with Continuing Health Care (CHC) and Medication Optimisation (MO) teams.
- In addition, there has been the sharing of intelligence with the CQC and Local Authorities on a regular basis, informing CQC inspection preparation to local care homes.

Engaging People and Communities

What are our statutory responsibilities?

The NHS belongs to the people and we believe that it is essential to listen to and work with local people to shape our health services. This section of the Annual Report will share some of the ways local people and partners can and have influenced our work, and how we have considered these views and experiences when commissioning services.

Tees Valley CCG was also bound by several statutory and regulatory obligations with regards to engagement and involvement such as Section 14Z2 of the NHS Act 2006 (as amended 2012) to involve the local public in commissioning activities and the impact that engagement activity has had. Similarly, the Health and Social Care Act 2012 tells us that CCGs must show how the views of local patients, carers, public, communities, Health and Wellbeing Boards, Local Authorities "… are translated into commissioning intelligence and shared decision-making."

Supporting the involvement of patients and the public, the NHS Constitution enshrines public ownership of the NHS as a fundamental value:

The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives.

Everyone has a stake in the health of their community and an engaged and supportive public can provide a powerful mandate and resource for the CCG.

The principles of participation

We ensured the principles of participation were applied by:

1. Reaching out to people and asking them how they want to be involved, avoiding assumptions.
2. Promoting equality and diversity and encouraging and respecting different beliefs and opinions.
3. Proactively seeking participation from people who experience health inequalities and poor health outcomes.
4. Providing clear and easy to understand information and seeking to facilitate involvement by all, recognising that everyone has different needs.
5. Planning and budgeting for participation early as possible.
6. Being open, honest, and transparent in the way we work, telling people about the evidence base for decisions, and being clear about resource limitations and other relevant constraints. Where information must be kept confidential, explaining why.
7. Recognising, recording and celebrating people's contributions and providing feedback on the results of involvement; showing people how they are valued.

Our Communication and Engagement strategy which supported the delivery of patient participation is available on our website.

Engaging with local people

When we talk about engagement and engaging with local people and partners, we mean that we are seeking and providing opportunities for the "*active involvement of patients, carers, families, partners, stakeholders and anyone else who is either interested or is passionate about the work we do and the decisions we make on their behalf". (Tees Valley CCG C&E Strategy).*

The aim is to develop meaningful, diverse and continuous forms of engagement with our communities, including patients, carers and members of the public.

Communications and Engagement Strategy

Our Communication and Engagement Strategy sets out our two overarching engagement objectives:

Objective one – Embed engagement as a key organisational priority to influence the planning and development of services. To do this we embed engagement at an early stage of our plans, allowing sufficient opportunity for people to influence service change and development in line with our statutory and legal duties.

Objective two – Ensure meaningful, accessible and consistent engagement. We adopted an inclusive approach to engagement; we strived to actively involve seldom heard groups and communities to ensure they have the same opportunities for meaningful engagement, and we measured that engagement effectively to evaluate and offer feedback on how their contributions have been used to shape services.

Locally we continued to work closely with the North of England Commissioning Support Unit, neighbouring CCGs, NHS Trusts and other service providers, the Voluntary and Community Sector, the Local Medical Committee, local councillors and local Members of Parliament (MPs) to ensure that the voice of local people is heard and understood. Nationally we engaged regularly with the Department of Health and Social Care, NHS England and the Care Quality Commission.

Involvement Strategy for the NENC ICB

As we moved into greater collaborative working arrangements, NHS Tees Valley CCG has worked together with involvement leads across the new Integrated Care Board (ICB) footprint to develop stronger partnership arrangements. Through this partnership work, we have held conversations with our stakeholders to understand what has worked well for involvement, what could work better, and in an ideal world, how involvement will work once we become the North East and North Cumbria (NENC) ICB. 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 NENC ICB. This strategy was built upon conversations with our stakeholders, and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission.

Citizens' Panel engagement for the NENC ICB

The North East and North Cumbria Integrated Care Board (NENC 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 Citizens' 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 on 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.

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.

There are several ways through which people in our communities can influence the way local health services operate, which are outlined below:

Patient and Public Networks

We've worked with local patient and public networks that we have commissioned to reach and talk with people across the Tees Valley on a range of health matters. These groups bring lived experience, intelligence from local networks and support us as critical friends.

Across the Tees Valley, there are three commissioned Patient and Public Involvement (PPI) groups:

Community Health Ambassadors

This programme is delivered by Catalyst across Stockton-on-Tees and Hartlepool. Community Health Ambassadors are encouraged to provide feedback and recommendations that are solution focussed, allowing us to provide a practical response to concerns and issues; whilst also providing a real opportunity to improve patient experience when accessing health services.

Darlington Community Council

The Community Council is managed by Healthwatch Darlington and brings together people from the community, the local NHS and the voluntary sector to discuss local health services. It aims to give people a voice and an opportunity to get involved in how local services are shaped and delivered.

Healthwatch South Tees

Patient and Public Involvement in Middlesbrough and Redcar and Cleveland is supported by Healthwatch South Tees team, who support our engagement by assisting in the planning and delivering of consultations and engagement exercises, communicating key messages to local people and engaging with seldom-heard groups through their Community Champions network, who represent lots of different communities.

An example of work that our PPI groups were involved in was engagement on non-complex, age-related Adult Hearing Services, in which they assisted in drafting survey questions and planning focus groups that ask people with hearing aids for their views on their patient journey (from referral to after care). This engagement went live in May 2022 until July 2022.

Healthwatch

Healthwatch organisations in Darlington and Hartlepool have shared their reports with us after engaging with local people on a variety of subjects related to health and care. These reports provide insight into patient and public perception of local health services and help to inform us of how they can be improved, in addition to what is going well.

CCG Directors reviewed and responded to all the reports sent to us by local Healthwatch, ensuring that their feedback and recommendations were acknowledged and outlining which workstreams the reports would inform. While no reports were received from other Healthwatch organisations across the Tees Valley, we continued to engage with them regularly by providing key messages (such as bank holiday opening times for services) and meeting with them to find out about their priorities.

Healthwatch Darlington

In April, Healthwatch Darlington shared a report exploring Lesbian, Gay, Bisexual and Trans (LGBT+) experiences of healthcare, and how these experiences could impact how the LGBT+ community access healthcare services.

The report highlighted that there is not a consistent healthcare service offering for LGBT+ people, with respondents saying it depended on the healthcare professionals they encountered as to whether their experience was positive or negative. It also indicated LGBT+ people identified training and education for healthcare professionals as a priority, education on HIV awareness being increased and support for maternity services to be made more accessible with the use of inclusive language.

Recommendations made by Healthwatch Darlington included healthcare providers promoting inclusivity within their organisations, promoting awareness of HIV testing in Darlington and ensuring the use of inclusive language in maternity services.

Responding to the report, we affirmed our commitment to being an inclusive organisation, referencing the mandatory equality, diversity and inclusion training for all staff, as well as additional training undertaken, such as unconscious bias and LGBT+ awareness training.

In relation to HIV testing, we contacted Darlington Borough Council (who commission enhanced HIV testing provision) to offer support with promotion and made Healthwatch Darlington aware of the free HIV testing service operating nationally.

Regarding the use of inclusive language in maternity services, we clarified that service providers would be able to provide detailed responses, but that from a commissioning perspective, the use of inclusive language, preferred pronouns and awareness of unconscious bias were embedded into our work.

We also received a report in June 2022 which covered local people's experiences of the Covid-19 pandemic. The report featured feedback from patients between 2020 and 2022, covering the pandemic before the vaccine was available, experiences of the vaccination programme and subsequent experiences. People gave feedback on primary care, mental health support, and hospital services, as well as their experiences of the vaccination programme.

Recommendations to health organisations were focussed on ensuring good communications between services and patients regarding accessibility, consideration of digital exclusion, ensuring carers and loved ones aren't overlooked, types of appointment (face-to-face and virtual) and support required for post-Covid syndrome and for mental health.

In response, we explained our approach to co-ordinated communications with partners such as Local Authorities, GP practices and NHS Trusts and clarified that where significant changes to services may be made, we will formally consult with the public in accordance with the Health and Social Care Act 2022 and statutory guidance provided by NHS England. On the subject of digital exclusion, we clarified that we continue to work with partner organisations

across the Tees Valley (and wider region) to avoid it, and that traditional service access was not being replaced by digital access, which is expected to flourish as an alternative access route. Our response also covered our Post-Covid Syndrome campaign promoting the support available for people living with Covid-19 symptoms for twelve weeks or more and noted that the feedback in relation to mental health services would support ongoing work across the region as part of the Tees Valley Mental Health and Wellbeing Alliance.

Finally, Healthwatch Darlington sent us another report in June 2022 based on experiences of health services from people living with sensory impairments. The report covered reducing the cost of digital access to health services, consideration of accessibility when communicating with patients, adherence to the Accessibility Information Standard (AIS) and local experiences of accessing health and care services with a sensory impairment throughout the Covid-19 pandemic.

The report highlighted that there was a lack of consistency across service providers in relation to sensory impairments, as only half of respondents were comfortable with contacting services to make appointments, access information, and receive adequate support through adaptations.

Recommendations from the report included adoption of the AIS by health organisations, which we clarified was a contractual requirement (monitored by the Care Quality Commission) and promotion of its key principles, which we committed to supporting by sharing relevant information through our established communications routes, such as our newsletter, website and social media.

Healthwatch Hartlepool

In June, we responded to a Healthwatch Hartlepool report on access to GP services, which was based on the experiences of 269 local people. The key areas covered by the report were making appointments with a GP via telephone, which patients said was difficult and time consuming, and that while people accepted that restrictions introduced to GP practices during the Covid-19 pandemic were necessary, they felt that post-pandemic the return to face-to-face GP appointments was too slow and that alternative appointments (online/telephone) were a barrier to receiving the same quality of care.

Healthwatch Hartlepool made a number of recommendations in the report, stating that all GP practices in Hartlepool should review their appointment processes in terms of access, make extended access available, consult patients in a review to appointment processes, introduce text services for Deaf patients, make information available in accessible formats, reinstate face-to-face appointments as quickly as possible, increase staff awareness of the communications needs of patients (such as sensory impairment requirements) and ensure that patients are fully informed of all appointment and prescription services.

In response, we clarified that GP practices are required to review the needs of their patients (due to CQC regulation) which includes determining which health professional a patient should see (nurse practitioners, physiotherapists, social prescribing link workers etc.) to

ensure their needs are met. We also highlighted the additional access to primary care services provided in Hartlepool including the extended hours service delivered by Primary Care Networks and the improved access (evening and weekend) provision we commission, currently provided by Hartlepool and Stockton Health. It was also made clear that face-to-face appointments had continued throughout the pandemic and continued to be available alongside digital access routes.

We explained that online appointment booking had been paused throughout the pandemic (nationally) and that GP practices were awaiting NHS England guidance to confirm which types of appointments could be made available for online booking in the future. For patients to have input on proposals, we provided information on Patient Participation Groups which exist in all GP practices.

For accessibility-related recommendations, we highlighted the text messaging service currently in place in GP practices, which can be utilised to send reminders and short communications, the ability to book appointments which do not require triaging online (via the NHS App) and for patients for whom telephony is not suitable, clarifying that online consultation or attending the practice to book an appointment are the best options.

Finally, we provided information on staff training, such as the Primary Care Training Hub and GP Federation training on learning disabilities, the AIS and sensory impairments, and on the communications routes practices can use to raise awareness of services to patients, such as websites, posters in waiting rooms, telephone messages, social media, newsletters and text messaging.

Patient and Public Involvement Lay Member Updates

Michelle Thompson BEM, our Lay Member for Patient and Public Involvement (and also the non-voting PPI Lay Member for the Northern CCG Joint Committee) provided updates to the Governing Body by attending local, regional and national external meetings and events and working closely with local Healthwatch organisations who share their intelligence on the experiences of local people when accessing health services – we called this the 'word on the street.'

These real-time updates provided opportunities for the CCG to act where needed and quickly identify solutions. Some of the updates between April and June centred around:

- Availability of NHS dental services
- Provision of ear syringing (ear wax removal) services
- Access to GP services
- Waiting times for treatment
- Hospital discharge
- Long-covid / Post-covid syndrome

Full details of this feedback is available to the public, for further information please email your information request to - nencicb-tv.enquiries@nhs.net

Accessibility

We offered opportunities throughout April to June to enable local people to become involved in shaping local services. Due to the Covid-19 pandemic, face-to-face activities and events were limited, so digital opportunities such as online surveys were primarily utilised.

We recognise that digital exclusion is a significant challenge for the Tees Valley, and while working digitally does offer more opportunities to engage for some people, equally it presents barriers for others. To alleviate these barriers, we are engaging with colleagues in various sectors across the Tees Valley as part of a Digital Inclusion Subgroup, which has the core aim of addressing three factors of digital exclusion:

1. Access to data
2. Access to technology
3. Skills to use the technology.

It is anticipated that face to face public involvement events will resume in the near future, to ensure that people who prefer not to (or are unable to) engage digitally have an opportunity to share their views, ideas and experience. We are committed to ensuring that any public involvement event we hold caters for the needs of all local people and therefore provides:

- Language and British Sign Language (BSL) interpreters on request
- Hearing loops within event venues
- Wheelchair accessible venues
- Halal / vegetarian catering where possible/ required
- Papers/ agendas in accessible formats including large print on request.

Engagement Activity (You Said, We Did)

Hartfields Medical Centre

Hartfields Medical Centre is one of five practices in the McKenzie Group Practice and is located in the Hartfields Extra Care Village in Hartlepool. The practice temporarily closed in March 2020 as it was unable to provide a Covid-safe working environment for staff and patients. Following a change in the national Covid-19 infection prevention and control guidelines, requiring some minor adaptations to be made, the practice was able to re-open in January 2022.

In February 2021, McKenzie Group submitted a draft proposal to the CCG Primary Care Commissioning Committee to close Hartfields Medical Centre permanently, when the practice was requested to undertake a period of public engagement during the summer of 2021 regarding the draft proposal to permanently close Hartfields Medical Centre.

The CCG and McKenzie Group commenced a second eight-week period of public engagement on 9 May 2022. This phase two engagement looks more closely at the impact

of a possible permanent closure, whilst also beginning to explore alternatives to the branch being fully closed and fully open.

The engagement targeted patients who are most likely to be affected by potential changes to services, identified as patients registered with McKenzie Group, who attended an appointment at Hartfields Medical Centre in the two years prior to the temporary closure in March 2020 or since it reopened in January 2022. A paper survey has been sent to these identified patients, with the option of completing online.

In addition, the survey has also been made available to the wider community, regardless of whether they are registered with a McKenzie Group practice. A series of public engagement meetings are also taking place during May and June 2022 to gather additional feedback and to answer questions. Support is being provided by Healthwatch Hartlepool, including reaching out to local VCSE groups and those with protected characteristics.

A full engagement report will be produced on the feedback of the engagement activity, and this will be used to inform and support McKenzie Group to decide whether to progress a formal application to the Integrated Care Board for a branch closure, or changes to service provision from Hartfields Medical Centre; and will also support the Integrated Care Board to make an informed decision, should a formal request be received.

Any viable and sustainable scenarios that are developed may be taken forward, and any proposals for significant change will be subject to formal consultation with people who access Hartfields Medical Centre and the wider public.

Termination of Pregnancy

In May 2022, we engaged with patients who have accessed Termination of Pregnancy services to understand the gaps, barriers to access and positive elements of their experiences. This feedback was gathered to help us understand what needed to be considered for a new service model that would go out to procurement later in the year.

Engagement took place primarily via an anonymous survey which made use of sensitive language in recognition of it being potentially upsetting for service users to complete. The survey was promoted on our website and social media, with a promoted Facebook post being utilised to highlight the engagement opportunity.

In total, 226 people completed the survey, with 85 having accessed Termination of Pregnancy services from January 2021 onwards.

Professionals who refer or support service users were also engaged with to understand from their perspective how the service could be improved. Links with community leaders within Black, Asian and Minority Ethnic (BAME) communities were also made in order to explore how we could engage with people in these communities appropriately. It was suggested that in addition to the survey, we arrange a session whereby art could be the focus while gaining feedback from service users. In recognition of this, we have organised a Clay Art Engagement

Session in collaboration with Community Ventures Tees Valley, with an emotional and wellbeing practitioner, which will take place in July 2022.

All feedback will help to shape the new service specification which will commence in April 2023.

Non-complex, Age-related Adult Hearing Services

We began a period of Patient Engagement in May 2022 to review non-complex, age-related adult hearing services across the Tees Valley.

These services are provided for people usually aged over 55 years who have a hearing need that can be met by a service often delivered in their community. The current contract for Adult Hearing Services requires the provision of:

- Hearing needs assessment,
- Development of a personalised care plan,
- Provision and fitting of hearing aids, where clinically appropriate and agreed with the service user,
- Information on and signposting to any relevant communication/social support services,
- Follow-up appointment to assess whether needs have been met,
- Aftercare service for up to three years, including advice, maintenance and review at third year,
- Discharge from hearing assessment and fitting pathway,
- Provision for service user complaints and feedback to the Provider,
- Education on the management of ear wax.

An estimated 40% of people over fifty years old have hearing loss in the UK, rising to more than 70% of people over the age of seventy, according to Office for National Statistics (ONS) data from 2018. This means that patients require accessible, responsive and comprehensive adult hearing services within their communities.

Across the Tees Valley, services are commissioned using an ‘Any Qualified Provider’ model, meaning there are multiple options for patients as to where they receive their care. Across the Tees Valley, there are six providers:

- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Minor Ops
- North Tees and Hartlepool NHS Foundation Trust (NTHFT)
- Outside Clinic (domiciliary care only)
- Scrivens
- Specsavers.

To ensure that current services meet the needs of patients, we have launched a ten-week period of engagement, consisting of a patient survey, accessible online and in paper format,

and by asking our commissioned Patient and Public Involvement groups to hold focus groups in communities. The survey has been drafted with feedback from Voluntary and Community Sector organisations to ensure suitability and accessibility, and 1000 copies have been sent to the providers to be given to a random sample of their patients.

Following this engagement, a report will be published featuring an analysis of the results.

Neurodevelopmental Pathway

In May and June 2022, we engaged with Parent Carer Forums from Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees on the needs-led neurodevelopmental pathway in collaboration with Tees, Esk and Wear Valleys NHS Foundation Trust. One of the key issues we received feedback on was unsatisfactory communication between the service and parent carers, with issues such as a lack of updates on referrals and difficulty in contacting the service.

Consequently, we produced a 'You Said, We Did' document which provided a breakdown of parent carer feedback and how we were working with services to make improvements. Some examples include:

- The introduction of an automatic response email system, alerting referrers that the service has received their referral, allowing them to reassure parent carers
- A review of letters sent out to parent carers, which now contain more details and clearer guidance on next steps.
- An estimation of a waiting time for services to contact parent carers
- Information packs being sent to parent carers alongside a 'pathway tracker' to help them understand the next part of their journey.

Keeping Local People Informed

The table below provides a flavour of the news headlines we have shared in the last 3 months:

April 2022	**May 2022**
- We shared the next steps set out by Government for living with Covid-19, including the continuation of free Covid testing. - We shared with local communities that all children aged 5-11 can now receive a Covid-19 vaccination in line with the latest advice. - Ahead of both upcoming Bank Holidays, people were reminded of pharmacy opening times and to be prepared stay safe and choose the right health services for their needs.	- We shared details of how local people could feed into the review of the Termination of Pregnancy pathways to help understand gaps and barriers service users may have experienced. - A review of non-complex, age-related adult hearing services across the Tees Valley commenced with engagement. - Along with McKenzie Group we launched a survey in May to seek peoples' views on the future provision of services from Hartfields Medical Centre, based at Hartfields Extra Care Village in Hartlepool.

- Middlesbrough Vaccine Partnership received Special Award of Recognition at the Healthwatch South Tees STAR Awards 2022.	- Working alongside County Durham CCG, shared an appeal for the return of unwanted community and medical equipment during May 2022. - Due to the upcoming bank holiday, the CCG shared details of pharmacy opening times and how local people could help avoid additional pressures on NHS services. -
June 2022 - Update provided on the recent Ofsted and the Care Quality Commission joint inspection of the Darlington special educational needs and/or disabilities (SEND) service. - We sought the views of those who have accessed the NHS England and NHS Improvement My Planned Care website. - Following a surge in the levels of abuse directed to staff in primary care, we issued communications in June to remind patients to be patient. - We shared information regarding the vaccination programme which is moving to business as usual in line with other vaccination programmes as Spring boosters are coming to an end.	

Working with the Voluntary and Community Sector (VCS)

We recognise the huge benefits to be gained by working in partnership with our voluntary and community sector colleagues to benefit our shared population.

Between April and June 2022, we worked with the VCS to achieve the following:

- Ensuring the suitability of our non-complex, age-related adult hearing services engagement for people with sensory loss by liaising with Hi-Vis UK and Hartlepool Deaf Centre. These organisations provided feedback on the draft patient survey and provided information on key considerations in terms of venue hire and running focus groups with people from this community.
- Supporting the recognition of carers in local communities by attending a 'We Care You Care' task and finish group across the South Tees area, promoting case studies of the value carers provide and how they can be supported by services. This group is led by Middlesbrough Voluntary Development Agency.
- Attending Joint Sensory Support Plan meetings, led by Hartlepool Borough Council with support from VCS organisations such as Hi-Vis UK and Hartlepool Deaf Centre, to support people living with sensory loss and / or D/deafness.
- Multiple VCS organisations in the Tees Valley took part in research into a Citizen's Panel engagement model, to explore potential benefits, drawbacks and resource requirements, as well as provide feedback that would inform recommendations on an approach that would meet the needs of the ICB on an ongoing basis.

Working with Member Practices and Clinicians

Our Primary Care Commissioning Officers (PCCOs) work collaboratively with General Practice teams to provide operational support and assistance, and to promote shared learning which enables the delivery of high-quality primary care through continuous improvement.

Our member practices continued to operate with the strong clinical leadership of local GPs to commission and improve services. GPs are central to organising and coordinating patient care and their clinical leadership adds value to the commissioning process.

Primary care has experienced significant challenges during 2021/22 with continued high levels of demand for services, the requirement for staff to self-isolate, social distancing requirements, the flu vaccine and Covid-19 vaccination delivery programme and blood bottle shortages.

There have been significant pressures in Primary Care and as a result, practice staff have experienced abuse directed towards them from patients who are frustrated by some of the challenges in delivering care services. We issued patient-facing communications to make patients more aware of what is being done to support them, and that abusive behaviour will not be tolerated. We have engaged with patients and members of the public, urging them to be 'patient patients' via social media channels and media releases.

Reaching diverse, potentially excluded, and disadvantaged groups

Our Commitment

Equality, fair treatment, and social inclusion lie at the heart of the NHS England's plans to modernise the health service, as required under the Equality Act 2010.

As a CCG we committed to the following principles:

- To recruit, develop and retain a workforce that can deliver high quality services that are accessible, responsive, and appropriate to meet the diverse needs of different groups and individuals
- To be a fair employer achieving equality of opportunity of outcomes in the workplace
- To use its influence and resources as an employer to make a difference to the life opportunities and health of its local community.

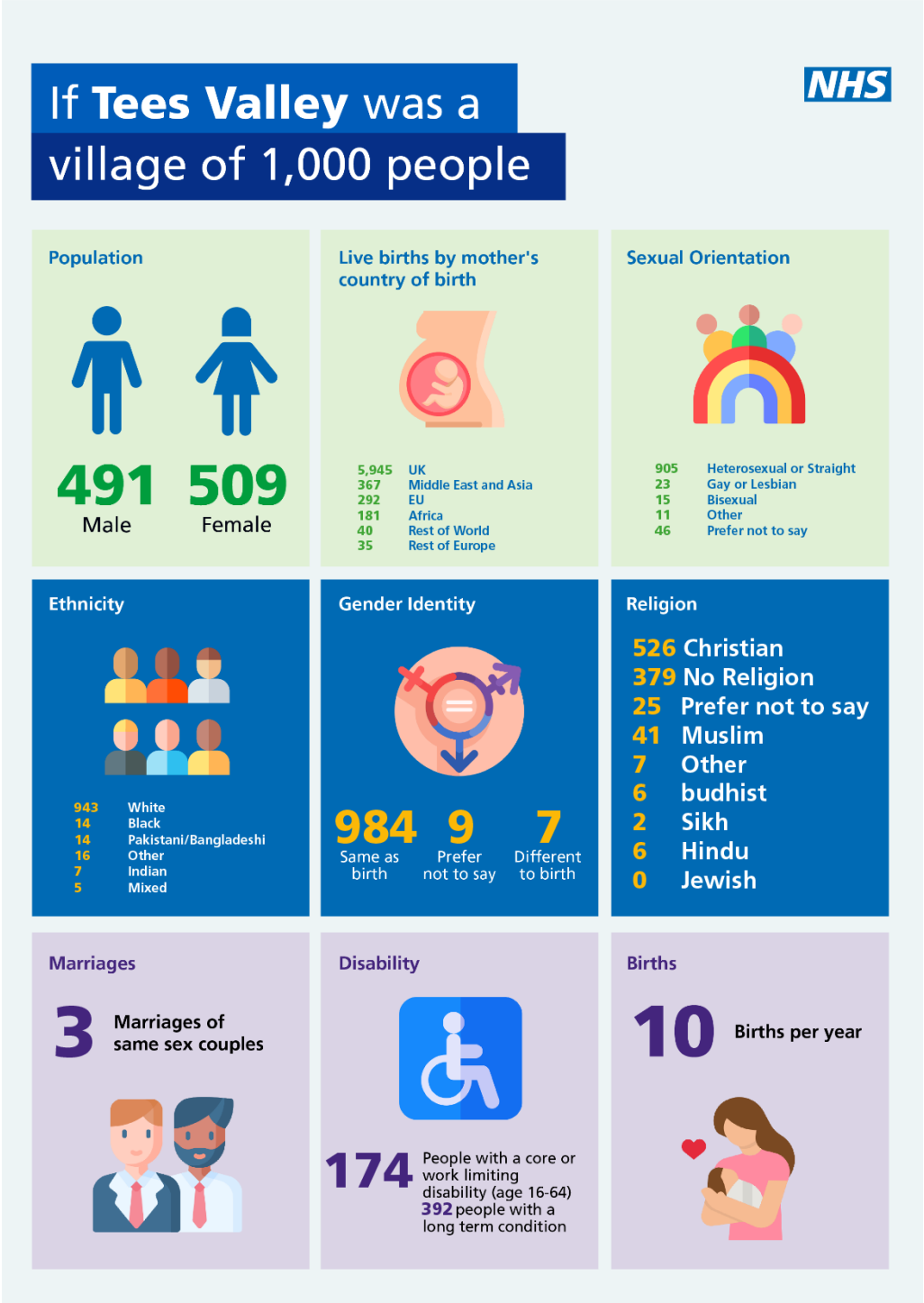
We demonstrated our commitment to taking Equality, Diversity and Human Rights (EDHR) into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work as evidenced below: Public Sector Equality Duty EDS2 helps us meet the requirements of the Public Sector Equality Duty which is set out in the Equality Act 2010.

The CCG used Equality Impact Assessments (EIAs) to inform commissioning using evidence such as health profiles, practice data and JSNA information. Seldom heard groups are identified as part of the stakeholder mapping. Each project has a stakeholder map and

communication and engagement report completed to determine implications and our Communications & Engagement Strategy outlines an understanding of the population and actions required to address the needs of our local population and tackle health inequalities in a more sustainable way.

In addition to describing our local population data by health condition, the graphic below details the local population regarding protected characteristics.

More detail can be found in the 'Reducing Health Inequality' section of this report.



Reducing Health Inequality

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

We demonstrated our commitment to tackling Equality, Diversity and Human Rights (EDHR) in everything we do; forming the golden thread throughout commissioning services, employing people, developing policies, communicating, consulting, or involving people in our work.

Public Sector Equality Duty (PSED)

As a CCG we were required under the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010, to have due regard to:

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

We were 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) is governed by and reports into the Audit and Assurance Committee and the Governing Body. The Governing Body ensured compliance with legislative, mandatory, and regulatory requirements regarding equality and diversity and inclusion, develops and delivers national and regional diversity-related initiatives within the CCG and ensures a two-way conduit for information dissemination and escalation to ensure delivery of our Strategy and objectives. The CCG also took part in regional EDI Steering Groups to ensure that it can share and learn from good practice in other organisations, including Foundation Trusts and Local Authorities.

A quarterly Governance Assurance Report was submitted to the Audit and Assurance Committee outlining relevant updates in relation to equality, diversity and inclusion.

Equality Strategy

Our Equality Strategy for 2020-2023 continued to be delivered against 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 we serve, train our people, and work together differently to deliver patient care.

The Equality Delivery System 2 - Our Equality Objectives

We continued to use the Equality Delivery System (EDS2) framework and used the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010.

We are awaiting the launch of the new EDS3 and as part of the new ICB, will work with our population, staff and stakeholders to develop a new Strategy and equality objectives.

In the meantime, we have worked hard to develop our approach to equality, diversity and inclusion and deliver against our objectives.

EDS Domain 1 – Commissioned or Provided Services
Objective - We will involve, engage and listen to people from communities to inform the work of the CCG to improve health outcomes and reduce health inequalities for the CCG's local population.
EDS Domain 2 – Workforce Development and Well-being
Objective - Ensure the organisation represents the communities it serves with staff feeling engaged, supported and valued in their workplace.
EDS Domain 3 – Inclusive Leadership
Objective - Demonstrate how the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff - Encouraging Diversity

We continued to encourage a diverse range of people to apply to and work for us as we recognise the benefits such diversity brings to the quality of our work and the nature of our organisation.

We 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 the Department for Work and Pensions (DWP), we maintained our 'Level 2 Disability Employer' status by demonstrating our commitment to employing the right people for our business and continually developing our people.

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 (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The CCG completed the Workforce Race Equality Standards (WRES) reporting on an annual basis to assess itself against the nine WRES indicators and has continued to implement the WRES action plan that was consistent across all North East and North Cumbria CCGs in readiness for the inception of the ICB in July 2022.

Equality Impact Assessments

We used our Equality Impact Assessment (EIA) Toolkit so any potential negative impact on any of the protected groups set out within the Equality Act 2010 could be identified at the start of development for a new, proposed service, policy or process.

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.

In addition to complying with the Public Sector Equality Duty, the EIA supports the culture of recognising that people are different, and our services should be inclusive to all.

The EIA is embedded into the governance process and an up-to-date EIA was required prior to approval of proposals or policies from the Governing Body or its Committees.

Accessible Information Standard

The Accessible Information Standard aims to make sure that people with a disability or sensory impairment have access to information that they can understand, and access to any communication support they might need.

We ensured compliance with the standard by taking the following actions:

- Ensuring that their commissioning and procurement processes, including contracts, tariffs, frameworks, and performance-management arrangements (including incentivisation and penalisation), with providers of health and / or adult social care reflect, enable, and support implementation and compliance with this standard.

- Seeking assurance from provider organisations of their compliance with this standard, including evidence of identifying, recording, flagging, sharing, and meeting of needs.

- Upon request, providing engagement and involvement materials in alternative formats such as braille, large-print, easy-read and other languages.

Our website lists the five things we must do as an NHS organisation to ensure people can access our information, including asking people how we can meet their information/communication needs, recording these needs, highlighting them, sharing them with other NHS an adult social care providers (with consent) and acting to ensure that people get support with accessing information if they need it and more information can be found on the NHS England website.

Website accessibility

We considered the ways in which different people access the Internet, to develop a website that is clear and simple for everybody to use.

Our website uses HTML5 and Cascading Style Sheets (CSS) conforming to World Wide Web Consortium (W3C) specification. In addition, we have also endeavoured to achieve Level AA standard of the Web Content Accessibility Guidelines to help make our online content accessible to people with additional accessibility needs. Our Accessibility Statement is available to the public, should you require further a copy please email your request to nencicb-tv.enquiries@nhs.net

Our Accessibility Statement is available to view on our website.

Health Inequalities

We are committed to reducing health inequalities, including those between patients in accessing health services for our local population.

Health across the Tees Valley is generally worse than the England average; with health inequalities between most and least deprived wards being significant. In the majority of areas, obesity in children is worse than the England average and the rate of alcohol-specific hospital stays among those under 18 is also worse than the national average. GCSE attainment is lower than average, rates of breastfeeding are lower than the national average and all localities have higher than average levels of smoking at time of delivery. In most areas, excess weight in adults and physical activity is worse than the England average. There appear to be more similarities than differences amongst the general population across the five local authority areas.

We understand our local population and local health needs working closely with local authorities and Directors of Public Health, using joint strategic needs assessments (JSNAs) and we collated additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage seldom heard groups.

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

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

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

We continued to work closely with other local NHS organisations to support the regional working addressing equality, diversity and inclusion and this has been a particularly helpful way of sharing and learning from good practice, particularly as we transitioned towards the formation of the Integrated Care Board.

Additionally, a central part of our Covid-19 recovery response was aimed at tackling health inequalities by increasing the scale and pace of NHS action. Nationally, eight urgent actions were originally identified and systems have since been asked to focus on five of these priority areas, distilled from the original eight actions. These are:

- Restore NHS services inclusively
- Mitigate against digital exclusion
- Ensure datasets are complete and timely
- Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Strengthen leadership and accountability

Building on these focus areas, systems are also asked to overlay the 'Core20PLUS5' approach which helps to define a target population cohort and identifies five focus clinical areas which require improvement. Systems are therefore asked to use the Core20PLUS5 approach when agreeing and implementing actions that meet the five priority areas.

As an ICS, North East North Cumbria also have a Health Inequalities Advisory Group in place, which aims to offer a multi-agency expert resource, utilising the skills of all partners to achieve a more systematic approach to health inequalities across the system. Regionally across the North East (NE) and North Cumbria (NC) the Deep End NENC is a network of GPs and other primary care staff that focus on meeting the needs of communities and reducing health inequalities. Further information can be found here.

In response to general planning guidance and specific guidance in relation to health inequalities including the ICS action plan, the CCG led on the development of a series of OGIM (objectives, goals, initiatives and measures) documents that set out a system response to a number of key themes/areas. The aim of these high-level documents is that they are recognised and owned by the system and all partners input into and put plans in place to deliver action against the agreed themes/areas.

OGIM development has been focussed around areas identified through the Core20PLUS5 approach alongside local place-based need and within each OGIM, the five-health inequality key priority areas are a thread through all actions identified. Tees Valley OGIMs include:

- Prevention (healthy lifestyles)
- Cancer
- Long Term Condition Management (Respiratory, CVD, Diabetes)
- Vaccination programmes
- Access
- Mental Health
- Palliative and End of Life Care
- Maternity
- Children and Young People
- Elective Recovery.

This is in addition to work led by partners that supports addressing the wider societal determinants of health including employment, housing, air pollution and transport.

We continue to monitor the health profiles and data available that detail the health challenges of our population including the Joint Strategic Needs Assessments (JSNA) and Local Authority Health Profiles.

Further information can be found at:

- Local Authority Health Profiles (use the 'Geography' function to select from Local Authority areas)
- Public Health England – Local Health (use the 'Geographical search' function to search for Local Authority areas in the Tees Valley)
- Joint Strategic Needs Assessments:
    - Darlington JSNA
    - Middlesbrough JSNA
    - Hartlepool JSNA
    - Redcar and Cleveland JSNA
    - Stockton-on-Tees JSNA

Health and Wellbeing Strategy

Contributing to the Delivery of Joint Health and Wellbeing Strategies

During April to June 2022 and the last three months as a CCG, we continued to provide updates with members of the four Health and Wellbeing Boards covering all five Local Authority areas (Darlington, Hartlepool, Stockton-on-Tees, Middlesbrough and Redcar and Cleveland), with Middlesbrough and Redcar and Cleveland working in partnership as a single 'Live Well South Tees' Board.

The Boards bring together a number of partners (the NHS, public health, adult social care and children's services, elected representatives, Local Healthwatch and in some cases Voluntary, Community and Social Enterprise (VCSE) sector organisations) to plan how to best to meet the needs of the local population and tackle local health inequalities. We actively contribute alongside a range of partners to the delivery of joint health and wellbeing strategies. We had a director aligned to each of the five local authorities and four Boards spanning the CCG's geography and where possible had CCG clinicians in attendance too as required. We have enjoyed and benefited from the continued development of these relationships as Board members.

Between April and June 2022, only the Stockton-on-Tees Health and Wellbeing Board met on three occasions. At the April meeting, members received an update relating to the implementation of the local Integrated Care System, including constitution, due diligence process and readiness to operate. The following month, members received a further presentation on the ICS covering guiding principles, details of appointments, functions and expectations.

In the year ahead, the ICS will continue partnership working and a collective approach to improving health and wellbeing and reducing inequalities through the Boards.

Accountability Report[2]

Samantha Allen

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

Accountable Officer

26th June 2023

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

Accountability Report

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

It comprises three sections:

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

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

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

Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of the CCG's governance structures and how they support the achievement of our objectives.

Members Report

This report explains the composition and organisation of our governance structure and how they supported the achievement of our objectives.

Council of Members

The Council of Members was the mechanism through which the individual member practice representatives come together for collective discussion and decision-making as a member organisation. This ensured active participation by each member practice in the functions of the CCG in accordance with its constitution, standing orders and scheme of reservation and delegation. Each practice nominated a senior clinical representative of the practice to participate in meetings.

Member Practices

At 30 June 2022, the CCG was made up of the following 80 member practices.

Locality	Primary Care Network (PCN)	Network [Practice names]	Practice Address
Darlington	Darlington PCN	Blacketts Medical Practice	63-65 Bondgate, Darlington, DL3 7JR
		Carmel Medical Practice	794 Nunnery Lane, Darlington, DL3 8SQ

Locality	Primary Care Network (PCN)	Network [Practice names]	Practice Address
		Clifton Court Medical Practice	Victoria Road, Darlington, DL1 5JN
		Denmark Street Surgery	Denmark Street, Darlington, DL3 0PD
		Moorlands Surgery	Willow Road, Darlington, DL3 9JP
		Neasham Road Surgery	186 Neasham Road, Darlington, DL1 4YL
		Orchard Court	Orchard Road, Darlington, DL3 6HZ
		Parkgate	Park Place, Darlington, DL1 5LW
		Rockliffe Court Surgery	Hurworth Place, Darlington, DL2 2DS
		St Georges Medical Practice	Yarm Road, Middleton St George, Darlington, DL2 1BY
		Whinfield Surgery	Whinbush Way, Darlington, DL1 3RT
Hartlepool	Hartlepool Health	Headland Medical Centre	2 Grove Street, The Headland, Hartlepool, TS24 0NZ
		McKenzie Group Practice	17 Kendal Road, Hartlepool, TS25 1QU
		Wynyard Road Practice	Wynyard Road, Hartlepool, TS25 3DQ
	Hartlepool Network	Drs Koh & Trory	Victoria Medical Centre, Victoria Road, Hartlepool, TS26 8DF
		Gladstone Surgery	Victoria Health Centre, Victoria Road, Hartlepool, TS26 8DF
		Hart Medical Surgery	1 Surgery Lane, Hartlepool, TS24 9DN
		Seaton Surgery	Station Lane, Seaton Carew, Hartlepool, TS25 1AX
		West View Millennium Surgery	West View Road, Hartlepool, TS24 9LJ
	One Life Hartlepool	Bankhouse Surgery	One Life Centre, Park Road, Hartlepool, TS24 7PW
		Chadwick Surgery	One Life Centre, Park Road, Hartlepool, TS24 7PW
		Havelock Grange Practice	One Life Centre, Park Road, Hartlepool, TS24 7PW
Middlesbrough	Central Middlesbrough	Discovery Practice	Cleveland Health Centre, 20 Cleveland Square, Middlesbrough, TS1 2NX
		Endeavour Practice	Cleveland Health Centre, 20 Cleveland Square, Middlesbrough, TS1 2NX
		Erimus Practice	Cleveland Health Centre, 20 Cleveland Square, Middlesbrough, TS1 2NX
		Martonside Medical Centre	1a Martonside Way, Middlesbrough, TS4 3BU
		Park Surgery	One Life, Linthorpe Road, Middlesbrough, TS1 3QY
		Prospect Surgery	Cleveland Health Centre, 20 Cleveland Square, Middlesbrough, TS1 2NX
		Thorntree Surgery	11 Beresford Buildings, Thorntree, Middlesbrough, TS3 9NB
	Greater Middlesbrough	Acklam Medical Centre [Previously known as Bluebell Medical Centre until 26 March 2021]	Trimdon Avenue, Middlesbrough, TS5 8SB
		Coulby Medical Practice	Cropton Way, Coulby Newham, Middlesbrough, RS8 0TL

Locality	Primary Care Network (PCN)	Network [Practice names]	Practice Address
		Crossfell Health Centre	Berwick Hills, Middlesbrough, TS3 7RL
		Hirsel Medical Practice	5 Trinity Mews, North Ormesby Health Village, Middlesbrough, TS3 6AL
		Kings Medical Practice	3 Trinity Mews, North Ormesby Health Village, Middlesbrough, TS3 6AL
		Newlands Medical Centre	Borough Road, Middlesbrough, TS1 3RX
		Parkway Medical Practice	Cropton Way, Coulby Newham, Middlesbrough, RS8 0TL
		Westbourne Medical Centre	7 Trinity Mews, North Ormesby Health Village, Middlesbrough, TS3 6AL
	Holgate	Borough Road & Nunthorpe Medical Practice	167a Borough Road, Middlesbrough, TS1 3RY
		Foundations 1	Acklam Road, Middlesbrough, TS5 5HA
		Foundations 2	7 Harris Street, Middlesbrough, TS1 5EF
		Linthorpe Surgery	378 Linthorpe Road, Middlesbrough, TS5 6HA
		The Village Medical Centre	400-404 Linthorpe Road, Middlesbrough, TS5 6HF
Redcar and Cleveland	East Cleveland	Brotton Surgery	Alford Road, Brotton, Saltburn, TS12 2FF
		Garth Surgery	Rectory Lane, Guisborough, TS14 7DJ
		Hillside Practice	Windermere Drive Skelton TS12 2TG
		Springwood Surgery	Rectory Lane Guisborough TS14 7DJ
		Woodside Surgery	High Street Loftus TS13 4HW
	Eston	Cambridge Medical Centre	10a Cambridge Road, Middlesbrough, TS5 5NN
		Eston Surgery	Low Grange Health Village Normanby Road Middlesbrough TS3 6TD
		Manor House Surgery	Braidwood Road Normanby Middlesbrough TS6 0HA
		Normanby Medical Centre	Low Grange Health Village Normanby Road Middlesbrough TS3 6TD
		South Grange Medical Centre	Trunk Road Eston Middlesbrough TS6 9QG
	Redcar Coastal	Bentley Medical Practice	Redcar PC Hospital West Dyke Road Redcar TS10 4NW
		Coatham Surgery	Coatham Health Village Coatham Road Redcar TS10 1SR
		Huntcliff Surgery	Bath Street Saltburn TS12 1BJ
		Ravenscar Surgery	Redcar PC Hospital West Dyke Road Redcar TS10 4NW
		Saltscar Surgery	22 Kirkleatham Street Redcar TS10 1UA
		The Greenhouse Surgery	Redcar PC Hospital West Dyke Road Redcar TS10 4NW
		Zetland Medical Practice	Windy Hill Lane Marske TS11 7BL
	Billingham and Norton	Dr Rasool	Abbey Health Centre Finchale Avenue Billingham TS23 2DG
		Kingsway Medical Centre	Kingsway Billingham TS23 2LS

Locality	Primary Care Network (PCN)	Network [Practice names]	Practice Address
Stockton-on-Tees		Marsh House Medical Centre	Abbey Health Centre Finchale Avenue Billingham TS23 2DG
		Melrose Medical Centre	38 Melrose Avenue Billingham Stockton TS23 2JW
		Norton Medical Centre	Billingham Road Norton TS20 2UZ
		Queenstree Practice	Farrer Street Stockton-on-Tees TS18 2AW
		Roseberry Practice	Abbey Health Centre, Finchale Avenue Billingham TS23 2DG
	Bytes PCN	Eaglescliffe Medical Practice	Sunningdale Drive Eaglescliffe Stockton-on-Tees TS16 9EA
		Park Lane Surgery	Redmarshall Street Stillington Stockton-on-Tees TS21 1JS
		Thornaby & Barwick Medical Group	Thornaby Health Centre Trenchard Avenue Stockton-on-Tees TS17 0EE
		Yarm Medical Practice	1 Worsall Road Yarm Stockton TS15 9DD
	North Stockton	Alma Street Medical Practice	Nolan Place Stockton-on-Tees TS18 2BP
		Queens Park Medical Centre	Farrer Street Stockton-on-Tees TS18 2AW
		Tennant Street Medical Practice	Tennant Street, High Newham Road, Stockton-on-Tees, TS18 2AT
	Stockton	Arrival Medical Practice	Endurance House Clarence Street Stockton-on-Tees TS18 2EP
		Densham Surgery	The Health Centre Lawson Street Stockton-on-Tees TS18 1HU
		Dovecot Surgery	The Health Centre, Lawson Street Stockton-on-Tees TS18 1HU
		Elmtree Surgery	22B Wesbury Street Thornaby TS17 6PG
		Riverside Practice	Alma Street Stockton-on-Tees TS18 2AP
		Woodbridge Medical Practice	Thornaby Health Centre Trenchard Avenue Stockton-on-Tees TS17 0EE
		Woodlands Family Medical Centre	106 Yarm Lane Stockton TS18 1YE

Composition of the Governing Body and Director Profiles

Governing Body Profiles

Mr David Gallagher, Accountable Officer

With previous experience of working with CCGs in Newcastle, Gateshead, County Durham and Darlington, David has been involved with the NHS in both clinical and strategic roles as a commissioner and provider. He has lived in the North East all his life and has extensive management experience in hospitals and commissioning, including 12 years in senior manager roles at South Tees Hospitals and a period as Primary Care Trust locality director in Darlington.

Having started his career in 1982 at Sunderland Royal Infirmary as a student radiographer, he worked in radiology in Freeman, Newcastle General, Middlesbrough General and James Cook University Hospitals before joining Northumberland Tyne and Wear Strategic Health Authority. After working as a Director at County Durham Primary Care Trust and several interim lead roles with nascent CCGs, he joined Sunderland CCG serving as Chief Officer from 2012, until March 2020 when he joined the merged Tees Valley CCG.

In Tees Valley he chairs the Tees Valley Executive Management Group and the Covid-19 planning group. On an Integrated Care System footprint, he also chairs the Armed Forces Health Network, Primary Care Strategy Group, the Estates Strategy Group and is Vice Chair of the Workforce Strategy Board. In the transition to Integrated Care Boards, he has also led the commissioning, contracting and procurement workstream and was appointed as Executive Director of Place Based Delivery (Tees Valley and Central).

Dr Boleslaw Posmyk, Governing Body Chair

Dr Posmyk qualified as a doctor in Leeds in 1981 and became a GP in Hartlepool from 1986 where he practiced until 2020. He gradually became interested in medical management via the Diabetes Local Implementation Team, and joined the Hartlepool PCT Professional Executive Committee. He then became a representative on the Hartlepool Practice Based Commissioning Group prior to becoming Chair. Dr Posmyk was elected to be the Locality GP Representative and Chair of the then Hartlepool Shadow Pathfinder Committee and became Chair of the NHS Hartlepool and Stockton-on-Tees CCG Governing Body.

He gained an understanding of more general issues affecting healthcare while working for several years on the SeQIHS (Securing Quality in Health Services) and the follow-on Better Health programmes looking at planning of healthcare in the wider Darlington, Dales, Durham and Tees areas.

He has been Chair of NHS Tees Valley CCG since the merging of the Darlington, Hartlepool and Stockton-on-Tees, and South Tees CCGs, and is staying in office until the dissolution of the CCG.

Mr Mark Pickering, Chief Finance Officer

Mark is a qualified accountant, a member of the Chartered Institute of Management Accountants (CIMA) and has a master’s degree in Applied Financial Management. He has worked in finance and performance for a variety of NHS and Local Government organisations for over 30 years. A career across various sectors including healthcare commissioning, acute secondary care, primary care, mental health and community care services.

Ms Jean Golightly, Director of Nursing and Quality

Jean started her nursing career at the North Riding Infirmary in Middlesbrough, and as a Registered Nurse, she has had a 30+ year career spanning a diversity of healthcare environments and organisations, including international experience. This has included roles

across the clinical spectrum, as well as encompassing management and operational delivery of a variety of clinical services, medical informatics, clinical governance and nursing.

Since joining the Tees based CCGs in 2013 as Executive Director of Nursing and Quality, her role has been integral to the commissioning and provision of safe, high-quality services for the Tees, and latterly Tees Valley populations. She also fulfils the statutory roles in relation to Child and Adult Safeguarding.

Jean has been appointed as Nurse Director for Tees Valley in the NENC ICB.

Dr Janet Walker, Medical Director

Dr Walker qualified as a GP in 1998 and worked locally as a GP in Teesside for over 20 years. She played an active role in Practice Based Commissioning (PBC) as Group chair, before becoming the lead for the Greater Eston Pathfinder. She was involved with the establishment of Clinical Commissioning Groups, was previously South Tees CCG Governing Body Chair and has worked with colleagues evolving into a single CCG across the Tees Valley in the role of Medical Director.

Janet has a special interest in medicines optimisation and works with the Tees Valley medicines group and the Durham and Tees area prescribing committee. She chairs the Tees Valley vaccination board and works with partners across the Tees Valley delivering the Covid-19 vaccination programme. During the pandemic she worked with CCG and GP Federation colleagues to develop and implement the award winning Covid-19 oximetry @home service.

Janet has been appointed as the Medical Director for Tees Valley in the NENC ICB.

Mrs Michelle Thompson, Lay Member Patient and Public Involvement

Michelle lost her teenage sister to cancer in 1995 and in 2003, at the age of 36, she survived thyroid cancer. Since then she has run, hiked and cycled all over the world raising money and awareness for Macmillan Cancer Support. By using her voice locally, regionally and nationally she has made a difference not only in her local community but also in the health and social care and voluntary and community sectors. She was incredibly proud to receive the British Empire Medal in 2013 for Voluntary Community and Charity Work in Darlington and County Durham. Michelle is driven by a passion to ensure that the patient, carer and public voice is not only listened to, but understood and acted upon appropriately.

Mrs Caroline Gitsham, Lay Member

Caroline has over 30 years' experience working in the Public Sector, including 15 years working at an Executive level. Caroline is passionate about customer service and making a difference and has worked with a variety of partners across her career including working in an advisory capacity to the government and other bodies. Caroline has managed a range of complex services and a number of new and innovative service offers have been developed under her leadership, many of which are award winning with tangible outcomes.

Caroline brings a different dynamic, she challenges the norm and encourages a greater focus on cultural and value alignment, outcomes monitoring and social impact. Her strengths are many; she has an extraordinary belief in people and their ability to achieve their potential. Caroline is a supportive leader, well networked, who enjoys challenges and variety.

Ms Karen Dales, Lay Member

Karen is both the Audit Committee Chair for Tees Valley CCG and the Conflicts of Interest Guardian. Karen has over 30 years' experience of working in the public sector including health, social care, local government and education. She is currently Assistant Principal: Corporate Services at Hartlepool College of Further Education.

Karen is a qualified accountant; her roles have included Finance Director, planning, policy development, performance, governance, procurement, and contract management as well as managerial responsibility for HR, data services, facilities, and IT.

Mr David Emerton, Secondary Care Specialist

David qualified as a doctor in Leeds in 1979. After experience as a junior doctor, he worked at Murgwanza Hospital in Tanzania from 1984-1991 where he was part of a team that managed all health emergencies and supported the developing community-based healthcare work. David was an Accident & Emergency Consultant at North Tees Hospital from 1993-2019. During that time, he taught regularly on life support courses for health professionals. He was Clinical Director of Accident & Emergency and subsequently Associate Medical Director for Patient Safety and Clinical Governance. He was Executive Medical Director of North Tees and Hartlepool NHS Foundation Trust from 2010 to 2016 which gave him considerable experience as a Trust Board Member and clinical leader.

David's key strengths include understanding the needs of patients who come to secondary care from the perspective of an experienced clinician and recognising the importance of patient safety and good clinical governance. David has experience working with many healthcare professionals and is committed to managing and leading services so that they improve patient care.

Mr Andie Mackay, Independent Member

Andie served as a firefighter for over 28 years, gaining strategic management experience with the County Durham and Darlington Fire and Rescue Service. Andie graduated from Teesside University in 2010 with a Masters in Business Administration (MBA) with a particular focus on transformational leadership. Andie joined Stockton Borough Council as a senior manager leading construction and facility services as part of the Community Services directorate of the council.

Dr James Nevison, Elected Healthcare Professional

Dr Nevison qualified from the University of Aberdeen in 2000 before completing further medical training in Inverness and Middlesbrough. He has been a GP in Darlington since 2006

working as a Partner in Denmark Street Surgery. He is a GP trainer in the Durham, Tees Valley GP training scheme and does regular sessions in Darlington Urgent Care Centre. He has also worked on projects such as the Responsive Integrated Assessment Care Team (RIACT) service for frail elderly patients.

Dr Hassan Tahir, Elected Healthcare Professional

Teesside born and bred; Hassan returned home after completing his medical degree in Manchester in 2009. Hassan currently works as a GP in Billingham, also working in Urgent Care and in Extended Access in Hartlepool, Stockton and Middlesbrough.

Hassan has an interest in cancer and palliative care and also has a role as Personalised Care Lead within the Northern Cancer Alliance and Clinical Advisor for MacMillan. Hassan also works with the CQC as a GP special advisor.

Ms Joanna Bushnell, Elected Healthcare Professional

Born and raised in Newcastle, Joanna studied for her degree in Pharmacy in Cardiff, qualifying in 1987 and working in various roles at the Royal Victoria Infirmary in Newcastle for many years. She then moved into primary care where she has worked for the last 16 years, initially as part of the Practice based pharmacy team with Stockton PCT, (supporting local practices manage the prescribing budget and deliver safe and effective prescribing) and then Tees PCTs, North of England Commissioning Support (where she gained some experience of the NHS commissioning landscape and challenges). For the last 3 years she has returned to a patient facing role working as a Clinical Pharmacist in 2 practices, one in Stockton and one in Darlington. She has a Masters in Therapeutics, is an Independent Prescriber and has a diploma in Leadership and Management in Health and Social Care. She is also a Clinical Mentor with the CPPE (College of Pharmacy Postgraduate Education), supporting pharmacists training to become Primary Care Clinical Pharmacists and Independent Prescribers to expand primary care capacity.

Joanna has special interests in diabetes, cardiology and care of the elderly, with a passion for supporting and empowering patients to get the best from their medicines and for collaborative working across professions and sectors to improve the quality of healthcare and wellbeing across Tees Valley.

Dr Alistair Johnston, Elected Healthcare Professional

Alistair qualified as a GP in 2017, and is currently working as a partner in Woodbridge Practice, Stockton-on-Tees having lived and trained in the region for several years. Working with a diverse demographic footprint has helped Alistair begin to understand some of the challenges faced by patients in achieving wellbeing and some of the barriers they face in accessing healthcare. Alistair is passionate about continuing to develop the provision of health and social care across our region and has interests in medical education. He is a GP Trainer and Designated Medical Prescriber/Supervisor to Non-medical Prescribers within the Practice.

Alistair's commitment to improving service provision and promoting health outcomes is highlighted by his role as Lead GP for Armed Forces Veteran Friendly Accreditation status within his practice.

Director Profiles:

Mrs Karen Hawkins, Director of Commissioning, Strategy and Delivery (Primary and Community Care)

Karen is Director of Commissioning, Strategy and Delivery with a lead responsibility for out of hospital care, including primary care. Her role spans across Tees Valley after over 25 years' experience working in the public sector with most of her career progressing in Teesside where she lives. Karen has a strong commissioning, service transformation and contracting background and has held a variety of senior positions in the NHS across primary, community and acute commissioning, including leading health service developments and transformation schemes across the area. Karen is inspired by working in partnership with others who have a similar desire to improve local health and care services for the local population.

Karen has been appointed as Director of Place for Hartlepool in the NENC ICB.

***Mr Mike Brierley, Director of Commissioning, Strategy and Delivery (Mental Health and Learning Disabilities*)**

Mike has worked at a strategic level with both the public and private sector and assignments have ranged from leading a large informatics service to implementing strategic planning frameworks and the development of organisation-wide strategic plans. He is an experienced senior programme manager and has strong leadership skills and stakeholder and relationship management experience with an ability to achieve results in complex environments. Mike's role covers the two CCGs across Tees Valley and County Durham.

Mrs Alex Sinclair, Director of Commissioning, Strategy and Delivery (Children and Young People and Maternity)

Alex, a pharmacist by profession, joined the NHS in 2001 after an early career in the private healthcare sector and academia. Alex holds masters' degrees in both clinical pharmacy and business administration (MBA) and has extensive senior level experience in strategy, operations, commissioning, programme management and business transformation along with clinical experience across a range of sectors and organisations. Alex moved into a CCG role in 2014 after holding a variety of senior NHS positions in both community and acute services across County Durham, Darlington and Teesside.

Alex has been appointed as Director of Place for Stockton-on-Tees in the NENC ICB.

Mr Craig Blair, Director of Commissioning, Strategy and Delivery (In-hospital Care)

Craig commenced his career in the NHS as a trainee at the Tees Health Authority in 1998 and later achieved a Master of Science degree in Healthcare Leadership. During his time in

the NHS Craig has gained extensive commissioning, performance management and planning experience through working in a variety of settings in the Durham and Tees Valley area including working within the former Tees Primary Care Trusts, the Strategic Health Authority, acute providers and in a joint commissioning team with one of the Tees Local Authorities. Craig has held a variety of senior positions within the local NHS across primary, community, mental health and acute care and is passionate about improving the health and healthcare for the local population.

Craig has been appointed as Director of Place for Middlesbrough and Redcar & Cleveland in the NENC ICB.

Mrs Diane Murphy, Director of Strategy and Delivery (Continuing Healthcare)

Diane joined the NHS 41 years ago and qualified as a registered nurse in 1984 and health visitor in 1991. She has held a range of senior and director level clinical and managerial posts in both acute and community settings with portfolios covering operational management, clinical governance, clinical quality, patient safety, and large-scale change and transformation. Diane also works across NHS County Durham CCG.

Committees, including Audit Committee

Audit & Assurance Committee

The Audit and Assurance Committee has operated throughout the year in order to fulfil its obligations. Members of the Committee were:

- Ms Karen Dales, Lay Member (Audit Committee Chair)
- Mrs Michelle Thompson, Lay Member
- Mrs Caroline Gitsham, Lay Member
- Mr Andie Mackay, Independent Member.

Other Committee structures are referenced fully in the Governance Statement and the Remuneration and Staff Report details members of the Remuneration Committee.

Register of Interests

All members of the Governing Body and its Committees are required to declare any interests they have in accordance with the CCG's Standards of Business Conduct and Declarations of Interest Policy. They are required to review and update their declarations of interest on an annual basis and also highlight any new interests within 28 days of them becoming apparent. The Registers of Declarations of Interest and Gifts & Hospitality are maintained throughout the year and will be kept for 6 years. The registers are made available to the public on request or via the CCG's website here.

The CCG's Conflicts of Interest Guardian was Karen Dales, Chair of the Audit and Assurance Committee.

Where interests were identified within meetings, these were declared by the individual and appropriate action is agreed, including whether the individual needs to withdraw from discussions.

To further support CCGs to raise awareness of, and manage conflicts of interest, all staff are required to complete Level 1 of the national mandatory conflicts of interest training. 100% compliance was achieved ahead of the deadline of 31st January 2022. In addition, 100% of staff that were required to complete Levels 2 and 3 did so within the timeframe.

During 2021/22 Audit One carried out an audit on the CCG's arrangements for the declaration and management of conflicts of interest and gifts and hospitality. A rating of substantial assurance was assigned and no weaknesses in control were identified.

Robust conflicts of interest arrangements continued to be in place during 2022/23 to ensure that the CCG operated with a high level of probity and transparency.

Personal data related incidents

There have been no personal data related incidents or data security breaches during the period 1 April 2022 – 30 June 2022 that required disclosure to the Information Commissioner.

Disclosure of information to auditors

Each individual who was a member of the Governing Body at the time the Members' Report is approved confirms:

- so far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and,
- that the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Modern Slavery Act

NHS Tees Valley CCG continued to fully support the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 was considered and approved at the January 2022 Governing Body meeting and is published on our website here

Emergency Preparedness, Resilience and Response

The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework requires providers and commissioners of NHS funded services to show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act 2004, NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to as EPRR.

NHS England's Core Standards for EPRR sets out the minimum standards which NHS organisations and providers of funded care must meet. In terms of these standards, NHS organisations are listed as either a category 1 or category 2 responder and on that basis are required to provide assurance against their specific standards through a self-assessment, peer review or full audit process.

The CCG was a Category 2 responder and as such, is required by NHS England to complete a self-assessment against these standards. As a Category 2 responder, we are considered as 'co-operating bodies' and the standards we are expected to comply with reflect this level of responsibility.

In line with the requirements of NHS England, we undertook a self-assessment against the core standards and demonstrated full compliance. This was reported to the CCG's Governing Body in September 2021.

The CCG continued to have a business continuity plan in place that is fully compliant with NHS England's Emergency Preparedness Framework. The plan sets out the necessary process for staff to follow in the event of a business continuity incident and includes key contacts to support this. The CCG tested the plan with all staff in April 2022 and subsequently updated the Plan to reflect learning from the testing.

Statement of Accountable Officer's Responsibilities

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

The responsibilities of the 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
- Prepare the accounts on a going concern basis, and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

Governance Statement

Introduction and context

NHS Tees Valley CCG was a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended). This establishment was the result of the merger of NHS Darlington CCG, NHS Hartlepool and Stockton-on-Tees CCG and NHS South Tees CCG; all of which were established by NHS England on 1 April 2013 and dissolved on 31 March 2020.

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

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG has a Constitution based on the NHS England's revised Model Template. The Constitution was reviewed against the revised Model Template as part of the 2019/20 merger

approval process to establish Tees Valley CCG. This was done in collaboration with NHS England to ensure the Constitution was legally compliant and took into account relevant legislation and guidance. The Constitution has not required any additional updates since that time.

The review of the Constitution confirmed that it complies with the elements of the self-certification checklist, including:

- specifying the arrangements made by the CCG for the discharge of its functions
- specifying the arrangements made by the CCG for the discharge of the functions of the Governing Body
- the procedures to be followed by the CCG in making decisions
- the arrangements it has made to secure that individuals to whom health services are being, or may be, provided pursuant to its commissioning arrangements are involved
- arrangements made by the CCG for discharging its duties in respect of registers of interest and management of conflicts of interest
- arrangements made by the CCG for ensuring that there is transparency about the decisions of the group and the manner in which they are made.

Throughout 1 April to 30 June 2022, the CCG has continued to operate with a governance structure that reflects guidance and best practice, including Governing Body, Audit & Assurance Committee, Remuneration Committee and Primary Care Commissioning Committee. In addition, the CCG has an Executive Committee and a Quality Committee. Terms of Reference have been agreed and reviewed for each of these Committees to support the organisation in the delivery of effective governance.

Council of Members

The Council of Members comprises a senior clinical representative of each member practice and ensures that the Group's activities retain a clear clinical focus with member engagement. Meetings have taken place virtually due to the pandemic.

The main areas covered by the Council of Members during this period include:

- System and service pressures
- Learning disabilities update, including local demography and care needs, learning disability Annual Health Check and information relating to Learning Disabilities Mortality Review (LeDeR)
- Updates relating to the formation of the Integrated Care Board, including arrangements for continued clinical leadership, safe transition of CCG duties
- Presentation of the CCG's Annual Report for 2021/22.

The Council of Members delegate approval of a range of functions to the Governing Body. Membership of the Council of Members consists of the senior healthcare professional nominated by each member practice to act on its behalf in dealings with the CCG and to represent that member practice at meetings of the Council of Members.

Governing Body

A record of attendance of the Governing Body Members at the Governing Body and sub-Committees is provided below.

Figure 1: Governing Body and Committee Meetings Attendance Record

Name and Title	Governing Body (3 meetings) Executive members are also in attendance	Audit & Assurance Committee (2 meetings) CCG officers and audit colleagues are also in attendance	Primary Care Commissioning Committee (2 meetings) Executive members are also members of the Committee	Remuneration Committee (0 meetings) CCG officers and HR colleagues are invited in attendance as required	Quality Committee (1 meeting) Trust representatives, Executive GPs and Directors are also members of the Committee	Executive Committee (4 meetings) Executive GPs are also members of the Committee
Mr David Gallagher, Chief Officer	3		1		0	2
Dr Boleslaw Posmyk, Clinical Chair	3					
Mr Mark Pickering, Chief Finance Officer	3		0		1	3
Ms Jean Golightly, Director of Nursing and Quality	2		1		1	3
Dr Janet Walker, Medical Director	2				0	2
Mrs Caroline Gitsham, Lay Member	3	2	2			
Ms Karen Dales, Lay Member	3	2				
Mrs Michelle Thompson, Lay Member	2	2	1			

Name and Title	Governing Body (3 meetings) Executive members are also in attendance	Audit & Assurance Committee (2 meetings) CCG officers and audit colleagues are also in attendance	Primary Care Commissioning Committee (2 meetings) Executive members are also members of the Committee	Remuneration Committee (0 meetings) CCG officers and HR colleagues are invited in attendance as required	Quality Committee (1 meeting) Trust representatives, Executive GPs and Directors are also members of the Committee	Executive Committee (4 meetings) Executive GPs are also members of the Committee
Mr David Emerton, Secondary Care Specialist	3		2		1	
Mr Andie Mackay, Independent Member	3	2			1	
Dr Hassan Tahir, Elected Healthcare Professional	1					
Dr James Nevison, Elected Healthcare Professional	3					
Dr Alistair Johnston, Elected Healthcare Professional	0					
Ms Joanna Bushnell, Elected Healthcare Professional	3					

Governing Body

During 1 April to 30 June 2022, the CCG's Governing Body met on 3 occasions 'in public'. Due to the restrictions associated with Coronavirus, all three meetings were held with the ability for the public to attend via the virtual format. All papers continued to be made available on the CCG's website prior to the meeting and questions from the public continued to be invited. Recordings of the meetings were also made available on YouTube via the CCG's website.

'In Committee meetings' were also held on 2 occasions to discuss work in progress and items of a confidential nature prior to public disclosure.

An annual cycle of business continued to be in place, which enables the Governing Body to discharge the duties conferred upon it. Where appropriate, matters were delegated to a Committee or individual and this is outlined within the CCG's Scheme of Reservation and Delegation. The arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the CCG.

Key areas of discussion have included:

- Mental health, autism and learning disability partnership reports
- Learning disabilities mortality review (LeDeR) Local Area Annual Report 2021/22
- Patient and public involvement update reports
- Annual Complaints Report
- Ockenden Review for maternity services
- Quality and Safeguarding reports
- Tees Valley Community Diagnostics Centre plans
- Staff Survey outcome and action plan
- Primary Care network year-end report
- Updates on the development and transition to the ICB, including the ICB's draft Constitution and supporting documents and Due Diligence reporting.
- Finance reports
- Performance and performance recovery reports
- Governance Assurance and Risk Reports
- CCG Annual Report and Accounts
- Regular updates from the Chief Officer and Governing Body Chair
- Updates from the CCG's Council of Members and localities
- Research and Evidence Annual Report
- Annual Report from the Northern CCG Joint Committee
- Regular Assurance reports from Governing Body Committees.

The Governing Body also received confirmed minutes from each of its Committees to enable it to consider the work and effectiveness of the respective Committee and to receive assurance relating to delivery of their terms of reference. To ensure transparency at the earliest stage, the Governing Body also received an outline report from Committees held prior to their formal approved minutes being available.

The Governing Body was committed to ensuring that sufficient time is devoted to allowing members to discuss key strategic issues as well as being able to reflect on its own performance and ensure that arrangements are in place to allow for further development and improvement. As part of this, we held one Governing Body Development Session, which covered the development of the Integrated Care Board (ICB), including its draft Constitution, and mandatory training.

Established Committees
The Governing Body's Committees have authority under the Scheme of Delegation to establish sub-committees or sub-groups to enable them to fulfil their role. Each of the Governing Body Committees has detailed terms of reference. Each Committee is authorised by the Governing Body to pursue any activity within their terms of reference and within the scheme of reservation and delegation.

Remuneration Committee
The Remuneration Committee was a statutory Committee established to advise/ recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The Committee also recommends to the Governing Body the remuneration for the role of Chair, remuneration and terms of service of Governing Body Elected Healthcare Professionals and others not on Agenda for Change terms and conditions. It also reviews any business cases for early retirement and redundancy. Full details of the membership of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record*. The Committee's terms of reference are referenced within the CCG's Constitution and are available on the CCG's website.

Although, the Committee has not been formally convened in the first 3 months of 2022/23, the Chief Officer engaged with Committee members on a proposal regarding a recommendation around the Very Senior Manager (VSM) Pay Award. It was recommended that in the absence of the required performance rating framework no award was made to those roles subject to VSM. This proposal was supported by Committee members and was subsequently ratified by the Governing Body.

Audit & Assurance Committee
Full details of the membership and attendance of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record*.

The Audit & Assurance Committee supports the Governing Body in its duty of ensuring the CCG has made appropriate arrangements to ensure functions are exercised effectively, efficiently and economically and that all relevant principles of good governance are adhered to.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the Committee provides the CCG with an independent and objective review of systems of internal control, risk and governance processes and arrangements and compliance with laws, guidance and regulations governing the NHS.
The Committee Chair is a lay member of the Governing Body and has no executive powers, other than those specifically delegated in its terms of reference. The Committee's terms of reference are referenced within the CCG's Constitution and are available on the CCG's website.

The Committee's terms of reference are reviewed annually, and the cycle of business includes a review of the process relating to the CCG Governing Body Assurance Framework and corporate risk register as well as considering the work of both internal audit (including counter fraud) and external audit. The Committee also considers assurances provided by the Commissioning Support Unit in relation to the CCG's governance responsibilities (including equality and diversity, health and safety, business continuity, corporate governance, information governance and mandatory training).

Membership is outlined in the members' report section of the annual report.

Significantly during the year through its cycle of business, the Audit Committee has received the following assurances or updates:

- Internal Audit Progress Report
- Draft Head of Internal Audit Opinion
- Provisional and Annual External Audit Results Report for year ended 31 March 2022
- Internal Audit Annual Report including Head of Internal Audit Opinion for year ending 31 March 2022
- Assurances over outsourced services for 2021/22
- Counter Fraud progress report
- Approval of External Audit fees
- Head of Internal Audit Opinion at draft and final stages
- Tees Valley CCG Annual Accounts for 2021/22 at draft and final stages, post audit
- Tees Valley CCG Annual Report for 2021/22 at draft and final stages
- ICB Transition due diligence progress report and final report
- Governance Assurance Report, including update on Equality, Diversity and Inclusion
- Review of the Risk Register and Assurance Framework
- Single Tender Action report – Community Diagnostic Hub
- Mental Health Investment Standard Audit
- Audit & Assurance Committee Annual Report for 2021/22.

Executive Committee

The Executive Committee is a Committee of the Governing Body that operates as a strategic forum for discussion, decision-making and assurance of the operational management of the CCG in support of the Governing Body and its Committees. The CCG Governing Body has delegated authority to the Executive Committee to provide an oversight role for managing and developing the CCG. The Committee has approved Terms of Reference and the duties of the Executive Committee are driven by the priorities of the CCG and are flexible in response to new and emerging priorities.

Details of the membership and attendance of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record* and the Members Report. The

Committee's terms of reference are available on the CCG's website as part of the Governance Handbook.

The Committee met on 4 occasions formally in the period 1 April to 30 June 2022. The work programme of the Committee is guided by a forward plan programme. The programme enables the Committee to carry out its key objectives necessary to support its assurances and in a timely manner.

The Committee took a robust approach to the management of declarations of interest and processes are in place to ensure that conflicted members do not inappropriately receive papers or take part in discussions or decisions where it would be contrary to the CCG's Standards of Business Conduct Policy.

Significantly during the year through its cycle of business, the Committee considered the following issues:

Decisions Made

- GP Advanced Care Practitioners Protocol – South Tees Hospitals NHS Foundation Trust clinical imaging
- Human Resource Policies
- Staff Survey – review of 2020/21 action plan and 2021/22 Staff Survey Results and action plan
- Home Oxygen Assessment and review Service options appraisal
- Respiratory primary care support programme
- Tees Valley Special Educational Needs and Disabilities Information Advice and Support Service Health Facilitator Model
- Medication Call Pathway Report
- Hospital discharge and community support
- Improving the strategic approach to learning disability and autism through personalised commissioning
- Support to meet the health needs for children with special educational needs and disabilities
- Getting advice and getting help' – Children and Young peoples Mental Health and Wellbeing service market engagement analysis report and procurement timetable
- Business Continuity Plan
- Tees Community Equipment Service
- Tees Valley Integrated Urgent Care delivery Case for Change
- Cancer Transformation Update, including proposals relating to FIT testing (Faecal Immunochemical Testing)
- Primary care diagnostics – spirometry.

Areas Discussed

- Financial position and updates relating to QIPP (quality, innovation, productivity and prevention)
- Personalised outpatients plan
- Updates relating to the transition to the Integrated Care Board
- Quality and safeguarding update
- HR update for Q4 of 2021/22
- Communications and engagement updates
- Better Care Fund 2021/22 Year end summary and plans for 2022/23
- Primary care local enhanced service payments
- Continuing healthcare update
- Termination of Pregnancy service procurement
- Speech and language therapy
- Cancer transformation updates relating to faster diagnosis framework, national targeted lung health check and specialist gynaecology/oncology services.

Quality Committee

This Committee was established to provide a greater level of collaborative scrutiny and assurances to the Governing Body of effective management in relation to quality issues. A key feature is the inclusion in the membership of main provider director-level representatives from across the Tees Valley footprint. This has facilitated a collaborative approach to addressing shared challenges and ensuring coherent and consistent messages and understanding.

The Committee's cycle of business includes overseeing that commissioned services are being delivered in a high quality and safe manner within the context of finance and performance indicators and understanding actions underway where the quality of service falls short of expectations. In addition, the Committee also focusses on clinical effectiveness and patient experience.

Details of the membership and attendance of the Committee is included at *Figure 1: Governing Body and Committee Meetings Attendance Record* and the Members Report. The Committee's terms of reference are available on the CCG's website.

The Committee met once during the period 1 April to 30 June 2022 and considered:

- Ockenden report relating to maternity services. Final report and NHS England response letter
- Focussed updates from providers with emphasis on:
    - Serious incidents
    - Never events
    - Quality and patient safety improvement plans
- Quality and safeguarding report
- Quarterly CCG complaints report

- CCG Child death cases
- CCG Locality and providers: integrated Care Partnership Infection, Prevention and Control performance data
- NHS Provider Open STEIS Patient Serious Incident report
- Safeguarding Partnership newsletters
- North East and North Cumbria Screening and Immunisation Bulletins
- CCG finance report
- CCG performance update.

Primary Care Commissioning Committee

The Committee had a primary purpose of commissioning primary medical services for the people of Tees Valley under a Delegation Agreement from NHS England. There were 2 meetings held virtually in public due to Covid-19 restrictions – members of the public continued to be able to attend via the virtual platform or submit questions in advance of the meeting. Meetings were recorded and made available on YouTube via the CCG's website. Healthwatch, the Local Authority and the Local Medical Committee were invited to attend all meetings.

The role of the Committee was to carry out the functions relating to the commissioning of primary medical services under Section 13Z of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England. During 1 April to 30 June 2022 this included the following activities:

- GP Practice informal list closure Standard Operating Procedure
- Primary Care Commissioning Committee Annual Report for 2021/22
- 2022/23 General Practice Contract update
- Primary care budget update
- Primary care risk overview
- Covid-19 response – primary care update (including improved access, extended hours, vaccination updates
- CQC Breach Reports for Woodside Surgery, Coatham Surgery and Prospect Surgery
- GP Practice Core Hours closure request – June 2022 update
- Primary care budgets 2021/22, Month 12
- Primary Care Networks – end of year report for 2021/22
- Primary Care Network Development audit report
- Digital Update report
- Winter Access Fund – update on expenditure
- Pharmacy applications summary report.

In performing its role, the Committee exercised its management of the delegated functions in accordance with the Agreement entered between NHS England and the CCG, which sits alongside the delegation and terms of reference. The terms of reference have been reviewed during the year and are available on the CCG’s website.

The Southern Individual Funding Request Panel

The Funding Panel, which was a collaboration between CCGs and is accountable to the CCG's Governing Body, considers all Individual Funding Requests and decides whether to support individual requests based on the information provided with the request to the Panel. Requests are assessed for access to treatment within the commissioning authority of the CCG, and minutes of the Panel are provided to the Governing Body.

Joint Committees

Joint Committee of the County Durham CCG, Tees Valley CCG and North Yorkshire CCG.

This Committee replaced the previously established Joint Committee of the Southern Collaborative. It aimed to provide an effective mechanism for the purpose of making decisions normally delegated to the member CCGs' Governing Bodies, where those decisions must be made together to ensure a consistent and efficient approach to the commissioning and reconfiguration of services that meet the needs of the populations served by the member CCGs.

There was no requirement for the Joint Committee to meet during this three month period.

Northern CCG Joint Committee

In common with all CCGs in the region, the CCG was a member of the Northern CCG Joint Committee, membership includes:

- NHS County Durham CCG
- NHS Newcastle Gateshead CCG
- NHS North Cumbria CCG
- NHS Northumberland CCG
- NHS North Tyneside CCG
- NHS South Tyneside CCG
- NHS Sunderland CCG
- NHS Tees Valley CCG
- NHS North Yorkshire CCG.

The Committee met on 3 occasions during 1 April to 30 June 2022 and minutes were shared with the Governing Body. The Committee discussed the following areas:

- Transition to become an Integrated Care Board
- Helping general practice overcome the barriers to decarbonization
- Non-surgical clinical oncology workforce challenges and
- Performance, Improvement and Transformation ICS workstream – Draft Integrated performance dashboard.

UK Corporate Governance Code

Although NHS Bodies are not required to comply with the UK Code of Corporate Governance, the CCG takes a robust approach to its application of good governance principles and continuous improvement. Throughout 1 April to 30 June 2022 our work has included holding dedicated development sessions with the Governing Body as well as regular staff meetings that have also incorporated elements of governance to ensure an embedded approach.

The guidance contained within the Code enables assessment of Governing Body effectiveness against the criteria of leadership, effectiveness, accountability, remuneration and relations with stakeholders. The Governing Body continued to take into account the outcomes from the 2021 reviews of its operation to ensure that it operated effectively and transparently.

Discharge of Statutory Functions

During establishment of the CCG, the arrangements put in place to govern the organisation were developed with extensive expert input from NHSE to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for the Council of Members and Governing Body decisions and scheme of delegation. The Constitution has continued to be confirmed as appropriate by NHS England throughout the existence of the CCG.

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

Responsibility for each duty and power has been clearly allocated to a lead Director.

CCG closedown

To enable the safe and effective transfer of duties and functions from the CCG to the incoming Integrated Care Board (ICB), a comprehensive programme of due diligence was established that expanded on the NHS England suggested template.

Given the scale and importance of the due diligence required, the Accountable Officers across the CCGs in the North East and North Cumbria agreed to a co-ordinated approach that would support information sharing and learning whilst also minimising duplication where appropriate. This was partly achieved through the identification of information available via central reporting (through the Commissioning Support Unit) and information that was held locally. This approach also supported the nascent ICB's ability to declare its 'readiness to operate'. NHSE issued the Staff and Property Transfer schemes that enacted the transfer from the CCG to the ICB at midnight on 30 June 2022 in readiness for the ICB's establishment on 1 July 2022.

Joint Coordinated Approach

A CCG Closedown Due Diligence Sub-Group was established with agreed assurance reporting, risk oversight and escalation arrangements in place. Assurances and risks/mitigations are also provided to the ICB Programme Board, ICB Workstream meetings, CCG Committee arrangements and NHSE. The approach has included regular input from Internal Audit who have provided valuable objective insights into the process and robustness of discussions and findings.

The formal Due Diligence report from the CCG to the Chief Executive of the incoming ICB on 30 June 2022 provided information on progress made against each of the due diligence closedown activities, information on areas of risk or concern as well as a summary of outstanding actions that would continue to be managed post 1 July 2022.

As part of the NHS England stipulated ICB establishment timeline, all NENC CCGs provided formal assurance of CCG closedown due diligence activities to the ICB Chief Executive on 30th June 2022.

Risk management arrangements and effectiveness

As the CCG responded to new challenges and the continually changing demands of the local health economy, so did the system of risk management and internal control. The CCG continued to work closely with peer CCGs and subject experts to ensure that a holistic approach is taken to risk processes.

The risk management framework provided a number of ways in which we identify and mitigate risks. The CCG had an established corporate policy set which informs our knowledge and guides our actions and behaviours. These policies ensure we conducted our business appropriately, comply with legal requirements and protect our patients and staff from avoidable harm.

The CCG continued to work with the Risk Management Policy in place across CCGs in the North East and North Cumbria. The Policy was compliant with good practice and legislation and sets out our organisation-wide approach to managing risk at all levels within the CCG. Our aims were:

- ensure that risks to the achievement of the CCG's objectives are understood and effectively managed
- ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed
- assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately
- protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and, if possible, elimination
- to maintain a risk management framework to assure the Governing Body that strategic and operational risks are being effectively managed

- to ensure that risk management is a cohesive element of the internal control systems within the CCG's corporate governance framework
- to ensure that risk management is an integral part of the CCG culture and its operating systems, and
- to ensure that the CCG meets its statutory obligations including those relating to health and safety and data protection.

Risk Scoring

The transition towards the establishment of the Integrated Care Board resulted in closer working and the agreement of a more standardised approach to the assessment and scoring of risks in CCGs. In addition, work was undertaken to benchmark risks to give a clearer picture of the overall risk profile, priorities, and hotspots in the region.

Capacity to Handle Risk

Strong leadership and an effective governance structure were vital elements of the CCG's capacity to handle risk. The governance arrangements met the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established and is maintained.

The CCG had clear lines of accountability with defined responsibilities and objectives relating to all aspects of risk reporting and management.

The Accountable Officer had overall responsibility for ensuring the implementation of an effective Risk Management Policy, systems and controls; this is delegated to the Chief Finance Officer as the nominated lead for co-ordination of corporate services and risk management throughout the CCG and had responsibility for ensuring the implementation of the risk management policy and framework.

The CCG's directors were responsible for the management of strategic and operational risk in their specific areas, including ensuring that all risks are assessed appropriately, in a timely manner and actions are taken to mitigate against the risk.

Good risk management encourages organisations to take well-managed risks that allow safe development, growth and change. However, as it is impossible to eliminate all risks, it is inevitable that there is a need to live with a degree of risk and it is the Governing Body's role to determine the balance of risk it is willing to take in meeting its objectives – the risk appetite.

The CCG's risk appetite in terms of escalation to the Governing Body Assurance Framework was agreed by the Governing Body and continued to be in place. As with all organisations, there is a level of risk inherent within healthcare commissioning. Risks that are regarded as normal business are managed at an operational level and are not escalated onto the Strategic Risk Register unless it is considered that the risk could adversely impact upon the CCG's ability to deliver its strategic aims and statutory duties. If the CCG's assessment of a risk

indicates that it is becoming more likely to have a significant impact, then it is also included on the CCG's Assurance Framework that is considered by the Governing Body.

The operation of the CCG's Quality Committee at a Tees Valley ICP level including provider executive membership also allowed the CCG to consider and manage quality and safety related risks in a more rigorous way.

In addition, the CCG contracted with the Commissioning Support Unit for provision of expert risk management advice and training as well as facilitating the sharing of good practice.

Risk Assessment

Risk was identified in accordance with the CCG's Risk Management Policy and risk management was embedded in the organisation via a number of mechanisms.

In day-to-day operations, all new projects are required to incorporate an Equality Impact Assessment and Data Protection Impact Assessment to determine whether there are any areas of potential risk relating to equality or data protection. These assessments are reviewed by subject matter experts and areas requiring further consideration are followed-up.

There are comprehensive processes in place to prevent, deter, identify and respond to risks of fraud and corruption, including effective management of conflicts of interest. These are actively overseen by the Audit & Assurance Committee.

There was an established process in place within the CCG that includes the review of the risk register and the assessment of the effectiveness of the identified controls.

Corporate risks are reviewed at four levels within the CCG. The first level is during the day-to-day operations of the CCG, where staff work within the policies of the CCG. Risks were identified within departments and the CCG management team and escalated as required. The CCG Head of Governance liaises with all risk owners to discuss and assess risks at this level.

The second level was a full review of the risk register with the CCG's Executive Committee. This review allows Executive GPs, directors and senior CCG officers the opportunity to consider the range and severity of the risks the CCG is assessing. This is an important step in the consideration of risks as it gives the opportunity for a broader discussion on the risks, controls and actions as well as a form of peer review to highlight related risks or potential impact on other areas. Risks with a residual score of 12 or above are automatically included in the Assurance Framework. This is supplemented by each risk being aligned to a Committee of the Governing Body depending on their overall theme; specific risk register reports are provided to the Committees on a regular basis.

The third level was the oversight of the process undertaken by the Audit and Assurance Committee. The fourth level of review is at the Governing Body where the Governing Body Assurance Framework and/or changes to the Risk Register are considered.

Furthermore, all staff were encouraged to report incidents and near-misses via the incident

reporting system which identifies the risks that have already (or nearly) occurred from incidents or near misses. Notifications of entries on this system are escalated to subject experts, governance leads and relevant Directors.

As at the end of the year, the CCG was actively managing 26 corporate risks, 14 of which feature on the Governing Body Assurance Framework. All these risks have key controls identified against them and also the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate.

None of the risks have been assessed as impacting upon the CCG's licence or governance, risk management and internal control processes.

Principal corporate risks

The table below gives an overview of the risks with a residual score over 12 or above that the Governing Body consider to be the most significant at its final review on 30 June 2022. Wide-ranging mitigating controls and assurances are in place for all risks and these are monitored by the relevant Committee, and these have been provided to the incoming Integrated Care Board to ensure they continue to be actively managed and monitored.

Principal Risks
Primary care related risks
Should a GP Practice receive a CQC rating of 'requires improvement' or 'inadequate' that resulted in a subsequent list dispersal/Practice closure potentially impacting upon accessibility and continuity of care for patients, there would be a reputational risk to the CCG.
Sustainability of primary Care - Risk that primary care is unable to provide long term, sustainable and reliable quality care services to patients. Caused by workforce pressures, increased patient demand, failure of - or challenges to – Primary Care Networks' ability to meet transformation agenda, infrastructure and technology limitations.
Quality and safeguarding related risks
There is a risk that high quality, safe services are not being delivered for the CCG population by providers.
Impact on quality of, and access to, services and any potential impact on wider health economy as local NHS organisations tackle financial challenges.
Non-compliance with antibiotic prescribing controls and routine infection prevention and control principles, may lead to antimicrobial resistance and increased incidence of health care associated infection (HCAI) which will have a negative impact upon outcomes and system resilience.
The Tees metrics for rates of Looked After Children indicate that our Tees Local Authorities are significantly in excess of the national England rate. This places an additional demand upon the current combined roles of Designated Nurse for Safeguarding Children and Looked After Children. In addition, the statutory regulator, CQC, is increasingly expecting these roles to be separate. These factors present a risk

Principal Risks
to the CCG of reputational damage as well as risks to the ability to fulfil its statutory responsibilities.
Insufficient Designated Doctor for Looked After Children capacity for the current numbers and rates of LAC across the Tees Local Authorities resulting in an inability to fully meet the CCG's statutory duties and a lack of strategic clinical leadership for this area.
As a result of the difficulties in identifying suitable placements for patients with complex learning disabilities, the CCG continues to be unable to achieve the target for the mandated reduction in learning disability in-patient bed capacity.
If the Butterwick Hospice is unable to meet the requirements of the CQC Inspection Conditions, the Hospice could close, resulting in: no provision in the Tees Valley area for children over the age of 6 who require end of life care and very limited provision in the Tees Valley area for children over the age of 6 who have complex health conditions and require short break care (or respite), with no provision in some locality areas and no provision for those who have particular medical conditions.
A lack of available midwives could result in a risk to mother and baby safety, possible impact of increased admissions to neonatal care, instances of being unable to offer patient choice and an impact on timely access to appropriate levels of care, resulting in the CCG failing in its statutory duties.
Corporate and performance risks
Excess demand on available capacity could result in the CCG being unable to meet Constitutional standards, thereby meaning the CCG is at risk of being subject to regulatory action or loss of autonomy.
Risk of non-delivery of in-year required financial position including the 1% cumulative business rules
There is potential for the coronavirus outbreak to interrupt the business of the CCG, either due to increased staff sickness or potential disruption to supply chain. This could risk the CCG's ability to deliver its statutory duties.
As a result of requirements of Responsible Commissioner Guidance, there is a risk of an Increase in cost of individual packages of care causing a significant cost pressure to the CCG.

Other sources of assurance

Internal Control Framework

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

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

effectiveness. The system of internal control has been in place in the CCG for April – June 2022.

Internal control was driven by our policies and procedures and embedded in our programme of mandatory staff training.

A significant feature of our organisational structure continued to be the large proportion of the administrative function of the CCG that is provided via a contract with a commissioning support unit (North of England Commissioning Support Unit). Our policies and procedures are designed to reflect this organisational arrangement, as well as the service monitoring with the North of England Commissioning Support Unit. The commissioning support unit works with NHS Shared Business Services who provide the transaction processing services and financial ledger facilities for NHS England and all CCGs.

The CCG worked closely with the commissioning support unit to ensure tight budgetary control, where the CCG gained a good understanding of debtors and creditors to facilitate accurate cash-flow forecasting and to ensure the NHS Shared Business Services financial ledger is accurate to enable NHS England to carry out their reporting requirements. The CCG achieved this through regular dialogue between the CSU and the CCG's Chief Finance Officer, monthly reconciliation sign-off controls by the CCG and the production of clear, concise, and accurate reporting.

In addition, the CCG worked with NHS England primary care financial team in relation to primary care financial transactions. The CCG receives primary care financial transaction reports on a monthly basis.

The CCG contracted with other support service providers and their sub-contractors. The CCG's payroll services were provided by Northumbria Healthcare NHS Foundation Trust using the electronic staff record service provided by McKesson UK.

Due to the nature of the shorter reporting period for the closure of CCG accounts at 30th 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.

Conflicts of interest management

The mandatory audit of conflicts of interest management was undertaken in 2021/22 by the CCG's internal auditors (AuditOne) in line with the published audit framework. The scope of the Internal Audit on Conflicts of Interest was to test against governance arrangements, including that:

- Policies/procedures comply with legal requirements and statutory guidance; appropriate number of lay members and a conflicts of interest guardian is/are appointed; and required training has been provided
- Declarations of interests and gifts and hospitality, including that: declarations are being made and recorded in accordance with legal requirements and statutory guidance
- Registers of interests, gifts and hospitality and procurement decisions, including that: each of these registers are maintained and published in accordance with legal requirements and statutory guidance
- Decision making processes and contract monitoring, including that: there are mechanisms for the management of conflicts within meetings, when making procurement decisions and in relation to contract management; and
- Reporting concerns and identifying and managing breaches/ non-compliance, including that: processes are in place for managing breaches and for the publications of anonymised details of breaches on the CCG's website.

The outcome of the audit was substantial assurance; no lapses in control were identified and there were no recommendations. 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

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

Processes were in place to raise any data quality issues with providers on a monthly basis, feedback from these challenges is utilised to alter any processing routines as required. The CCG utilises contract levers where necessary to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners. Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

Significant validation steps are in place in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

The CCG relied on the commissioning support unit to process other types of personal data, for example Human Resources or some patient data in order to fulfil its functions. NECS complies with the data quality requirements of the Data Security and Protection Toolkit and has procedures in place to ensure the quality of the data.

There have been no concerns raised by the Governing Body in relation to data quality.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security Protection Toolkit (DSPT) 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

The CCG placed high importance on ensuring there were robust information governance systems and processes in place to help protect patient and corporate information. The CCG established an information governance management framework comprising an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, an Information Governance Handbook for staff and information risk management and incident management processes, which are compliant with current guidance and DSPT requirements.

The North of England Commissioning Support Unit (NECS) as the CCG's provider of IT services has a range of controls in place to ensure data security. Control objectives include physical access, logical access, segregation of duties, data transmissions, data centre environmental controls, IT processing, data integrity and backups, change management procedures, network security measures, data migration, problem and incident resolution, system recovery and disaster recovery pans.

The CCG's Incident Reporting and Management Framework for the reporting of data security and protection incidents to the Information Commissioner outlinedd the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. There have been no Information Governance ICO reportable breaches during 1 April to 30 June 2022.

The Data Security and Protection Toolkit is provided by NHS Digital to support performance monitoring of progress on information governance in the NHS. The CCG published a compliant DSP Toolkit in June 2022; due to the impending dissolution of CCGs an internal audit of the Toolkit was not required.

The Information Governance agenda was discussed at the Audit & Assurance Committee and any specific day to day issues and IG risk oversight would be raised at the Executive Committee. The CCG appointed a Caldicott Guardian (Dr Janet Walker, Medical Director) and Senior Information Risk Owner (Craig Blair, Director of Commissioning, Strategy and Delivery). These roles were supported by the CCG's Head of Governance, Head of Corporate Services and the Data Protection Officer.

The CCG complies with its statutory duty to respond to requests for information. During the period 1 April to 30 June 2022, the CCG received 42 requests under the Freedom of Information Act 2000 and 6 subject access requests under the Data Protection Act 2018. All the requests were responded to within the statutory timescales.

Business Critical Models

The CCG is aware of the quality assurance requirements in respect of business-critical models contained within the recommendations in the Macpherson report and I consider that appropriate arrangements are in place to provide sufficient quality assurance.

Third party assurances

The majority of commissioning support services are procured from the CSU, including risk and governance expertise, together with the management of the majority of internal control systems and processes, for example in relation to finance systems and controls.

A service auditor reporting process has continued to provide assurance over the effectiveness of controls and processes within the CSU. A report has been received to cover the year to 31 March 2022. Due to the nature of the shorter reporting period for the closure of CCG accounts at 30th 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, a bridging letter has been provided to give assurance on the continued effectiveness of controls. In addition, CCG internal controls have continued to operate throughout this period

The CCG also had additional systems of control and review mechanisms internally over the work performed by the CSU which provide additional assurance that there have been no significant internal control issues which have impacted on the CCG.

In addition to using the CSU, the CCG also outsourced certain other systems and services to third party providers. The national Integrated Single Financial Environment (ISFE) and procurement systems are provided by NHS Shared Business Services and the national Electronic Staff Records (ESR) system is provided by McKesson. There are also various other outsourced services and systems relating to primary care services, including the Exeter System provided by NHS Digital and systems operated by Capita who provide the services of all primary care support teams.

Assurance over the relevant control environments in place for these systems has been gained from independent auditor reports for the year ended 31 March 2022, in accordance with ISAE3402. Due to the nature of the shorter reporting period for the closure of CCG accounts at 30th June 2022, a bridging letter has been provided to give assurance on the continued effectiveness of controls. No significant control deficiencies have been identified from these auditor reports which cause a concern for the CCG.

Payroll services were also received from a third-party provider in Northumbria Healthcare NHS Foundation Trust. The CCG's own system of internal controls provides assurance over the operation of payroll, this includes the Scheme of Reservation and Delegation and prime financial policies which govern and set levels of authorisation, together with subsequent monthly payroll reviews. Again, no significant issues have been identified from the review of payroll information during the year, with substantial assurance being provided from internal audit review of the payroll services.

Control Issues

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

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

The CCG had well developed systems and processes in place for managing its resources. The Executive Committee has continuously monitored the financial position of the CCG throughout the year and highlighted risks to the Governing Body regarding the effective and efficient use of resources.

- As part of the planning process, a range of benchmarking tools are used including the commissioning for value packs and CCG outcomes benchmarking support packs published by NHS England. These tools provide comparative information on the CCG's spend and resulting outcomes, allowing the effectiveness of CCG spending to be assessed and incorporated into strategic plans and budgets. This benchmarking is a key element for all commissioning processes to help determine value for money for new services and pathways.

- Central management costs, known as the CCG's running cost allowance was £3,192k for the period 1 April – 30 June 2022. The CCG operated within the running cost allowance during the period.

- Previously received Internal Audit reports have been provided in relation to 'contract and performance management', 'key financial controls' and 'CHC contract management'. The reports cover financial and strategic planning; financial management and reporting; and contract and performance monitoring. A level of substantial assurance has been received and the areas of good practice remain in place.

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

- The NHS England annual assessment for 2021/22 was conducted as a narrative-based assessment, focussing on the operational priorities for 2021/22 and how well CCGs discharged their statutory duties A rating was not published, but the following positive feedback was received from NHSE:

  "Quality of care, access and outcomes
  The CCG has demonstrated that they have effective systems and processes in place to draw upon data from a number of sources to support oversight and improvement of high-quality care and experience for their population. The CCG has

demonstrated the ability to identify clear priorities with an emphasis on utilising patient experience and engagement to improve both access and outcomes.

Preventing ill health and reducing inequalities
The CCG has demonstrated significant strength of working at "place" with Local Authority and partners on the broader determinants of health. There has been a particular focus on health inequality exacerbated by Covid-19, with evidence of interventions that have been put in place to ensure that services recover without worsening health inequalities and ideally improving them.

Leadership
The CCG has demonstrated significant agility in responding to the pandemic, putting in place command and control arrangements, working collaboratively with local partners and across the ICS, to ensure safe and effective care for patients. The CCG has engaged with Covid-19 Cells at all relevant levels; ICS, NEY region and at National level.
The CCG has demonstrated progress with streamlining of commissioning at Place, working with Local Authority colleagues, as well as at ICP/ICS level where there are examples of collaborative commissioning arrangements across CCGs.

Finance and use of resources
The CCG has demonstrated improved financial performance and governance, delivering in excess of their planned surplus and contributing to the offset of system deficits. The CCG has delivered the mental health investment standard.

Involve and consult with the public
The CCG has demonstrated that they have effective systems and processes to engage, involve and consult with the public. While face to face activities continue to have been hampered by Covid-19 restrictions, there were many innovative examples of how engagement with the local population has continued, using digital methods / forums. It is important to recognise the excellent collaborative work with Partners, CVS and Healthwatch."

Delegation of functions

This is covered under third party assurances section.

Counter fraud arrangements

Counter fraud activity plays a key part in determining risks to the organisation's financial viability and probity.

The CCG adheres to NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. A comprehensive counter fraud service, including an accredited Counter Fraud Specialist, is commissioned through our internal auditors (AuditOne) to undertake counter fraud work proportionate to identified risks.

The CCG's counter fraud work plan generally runs from 1 April 2021 to 31 March 2022. This period was extended to take into account the upcoming formation of the North East and North Cumbria Integrated Care Board on 1 July 2022. This extension ensured that the CCG continued to receive Counter Fraud Services as well as updates at the Audit and Assurance Committee.

The CCG continued to operate in line with the Counter Fraud and Bribery Policy, which clearly articulates NHS requirements and expectations for the management of fraud, bribery and corruption in government organisations, including the NHS Standard Contract

Counter-fraud requirements and regulations have been specifically discussed during the year to cement their knowledge and understanding of counter-fraud arrangements, with all employees also required to complete e-learning training. In addition, notifications and briefings regarding actual and potential fraud are circulated to key staff to ensure counter-fraud vigilance is maintained and enable payment systems to be reviewed for emerging risks.

The CCG’s Chief Finance Officer continued to be the Executive lead for counter-fraud matters. The Deputy Chief Finance Officer was the Counter-Fraud champion for the CCG. Any issue relating to tackling fraud, bribery and corruption is supported by the Chief Finance Officer who in accordance with the Counter-Fraud Policy would report such incidents to the Audit & Assurance Committee.

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 Clinical Commissioning Group, 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:

The purpose of my Head of Internal Audit Opinion is to contribute to the assurances available for Tees Valley CCG which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Governance Statement.

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 was presented to both the Audit and Assurance Committee and the Governing Body. The Governing Body Assurance Framework was last presented to the Audit and Assurance Committee on 15th June 2022 and to the Governing Body on 25th 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 and Assurance Committee oversee the risk management agenda and report to the Governing Body. They provide

Opinion Area	Commentary
	assurance to the Governing Body on the systems and processes by which the organisation leads, directs and controls its functions in order to achieve its strategic objectives
Transition Programme	AuditOne continued to have involvement during the transition period through: • Attendance at two weekly ICS steering group meetings and liaison with NECS who provided project support. • Attendance at a checkpoint meeting with lead officers at the CCG (14th February) and a further, more formal check and challenge session covering Tees Valley and County Durham CCGs which was held on 5 th May. Through attendance and receipt of supporting papers, it was observed that risks and issues were being reported through the project groups supported by NECS. No concerns were raised around completion of the activities required to sign off on due diligence process. • It could be confirmed that the CCG provided regular updates on CCG Closedown Due Diligence process to both the Audit and Assurance Committee and the Governing Body. At its meeting on 25th May 2022, the Governing Body recommended that the Accountable Officer write to the ICB Chief Executive Designate confirming that a robust Due Diligence process has been undertaken and highlight any risks and a further update on 30th June 2022 confirmed that a formal letter of assurance had been provided to the ICB Chief Executive on 31st May 2022.
Brought forward Internal Audit assurance	The Head of Internal Audit Opinion given for the year ended 31st March 2022 gave a level of assurance of 'substantial'. There were no material issues identified to be brought forward for consideration in this opinion statement
Response to Internal Audit recommendations	The implementation of internal audit recommendations is a key indicator of the organisation's engagement with ourselves and the importance it places on the recommendations we have made and have been agreed to be implemented. The Audit and Assurance Committee receives updates on the progress of agreed actions for all high and medium issues raised, but it does not require updates in relation to low priority issues, so these are not subject follow-up by AuditOne. At 30th June 2022, there were no outstanding audit recommendations. 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
Director of Audit, AuditOne
Date: 23 September 2022

Recommendation and assurance definitions

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

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

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

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

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

- The Governing Body
- The Audit and Assurance Committee
- The Executive Committee
- The Quality Committee
- Internal Audit
- External Audit
- Outcome of the due diligence exercise.

The Audit and Assurance Committee plays a key role in providing assurance to the Governing Body on the effectiveness of the systems of internal control and governance arrangements operated by the CCG. As part of this, the work of both internal and external audit and other sources of assurance are considered. No significant internal control issues have been identified from the work of the Audit and Assurance Committee.

Similarly, no significant governance or internal control issues have been identified through Governing Body, Quality Committee, Executive Committee or any other assurance process which impact upon my review of the effectiveness of the system of internal control.

As described within the third-party assurances section above, external assurances have been obtained over all significant outsourced services, including commissioning support services from NECS. No significant issues have been identified which impact upon the CCG or this review.

The Head of Internal Audit opinion is set out above. This contributes to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the CCG's system of internal control. The Head of Internal Audit opinion provides substantial assurance that there is a generally sound system of internal control.

Conclusion

No significant internal control issues have been identified.

Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers and describes some of the arrangements and policies we have in place to support our staff.

Remuneration report

Remuneration Committee

The Remuneration Committee was established to advise the Governing Body about pay, other benefits and terms of employment for senior employees of the CCG and people who provide services to the CCG. This includes any potential severance payments for relevant senior staff.

The Committee is established in accordance with the CCG's constitution, standing orders and scheme of delegation. The Committee was made up as follows for the period ended 30 June 2022:

M Thompson	Lay Member and Chair of Remuneration Committee
C Gitsham	Lay Member
Dr B Posmyk	Chair of Governing Body
A Mackay	Independent Member
D Emerton	Secondary Care Specialist

The Remuneration Committee provides recommendations to the Governing Body on pay and remuneration for senior employees of the CCG and people who provide services to the CCG.

The Accountable Officer, Chief Finance Officer and HR advisor provide advice and guidance to the Committee as required in relation to pay rates and terms and conditions for relevant staff, although they are specifically excluded from any discussions in relation to their own pay rates and terms and conditions.

Policy on the remuneration of senior managers

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

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health and Social Care.

Contracts of employment in relation to the majority of senior managers employed by the CCG are permanent in nature and subject to between three and six months' notice of termination by either party. The Elected Health Care Professionals are usually employed on a fixed term

of 36 months, the most recently appointed have been given a fixed term of 12 months given the ICS direction of travel. From 1 April 2020, Lay Members and the Secondary Care Specialist have been appointed for a period of two and three years for Tees Valley CCG.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the *NHS Pension Scheme Regulations* for those who are members of the scheme. No awards have been made during the year to past senior managers.

Remuneration of Senior Managers

For the purpose of this remuneration report, the CCG has considered the definition of 'senior managers' within the 2022/23 CCG Annual Reporting Guidance and the Government Financial Reporting Manual and considers that the Governing Body members represent the senior managers of the CCG.

Details of the relevant salaries and allowances for all of the senior managers of the CCG can be found in the tables below, both for 2022/23 (3 months ended 30 June 2022) and also relevant comparative figures for 2021/22 (12 months ended 31 March 2022).

The following disclosures within the Remuneration and Staff Report are subject to audit by the CCG's external auditors:

- the table of salaries and allowances of senior officers on page 121 to 122 and related narrative notes on subsequent pages;
- the table of pension benefits of senior managers on pages 126 to 128
- the analysis of staff numbers on page 129 and
- the table of pay multiples and related narrative notes on page 124.

Important Note regarding 'All Pension Related Benefits' stated in the tables below:

Please note the amount included here is the annual increase in pension entitlement expected **over twenty years**. This value has been determined in accordance with the HMRC method of calculation, in accordance with guidance from NHS England. Employee pension contributions made in 2022/23 have been deducted from the total. Pension related benefits shown in the table below relate to the NHS pension scheme members only**. The figure shown is not intended to reflect annual remuneration received by the individual during the financial year.**

NHS Tees Valley CCG senior officers' salaries and allowances – 2022/23 (3 months for the period ended 30 June 2022):

Name	Title	2022/23 (3 months for the period ended 30 June 2022)						
		Annual equivalent salary (Bands of £5,000)	Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£000	£	£000	£000	£000	£000
D Gallagher	Accountable Officer	140 – 145	35 - 40	-	-	-	-	35 - 40
M Pickering	Chief Finance Officer	105 – 110	25 - 30	200	-	-	-	25 - 30
J Golightly	Director of Nursing and Quality	105 – 110	25 - 30	-	-	-	-	25 - 30
D Murphy	Director of Commissioning, Strategy and Delivery	30 – 35	5 - 10	-	-	-	-	5 - 10
K Hawkins	Director of Commissioning, Strategy and Delivery	105 – 110	25 - 30	300	-	-	-	25 - 30
C Blair	Director of Commissioning, Strategy and Delivery	105 – 110	25 - 30	400	-	-	-	25 - 30
A Sinclair	Director of Commissioning, Strategy and Delivery	105 – 110	25 - 30	300	-	-	-	25 - 30
M Brierley	Director of Commissioning, Strategy and Delivery	50 – 55	10 - 15	200	-	-	52.5 - 55	65 - 70
Dr J Walker	Medical Director	125 – 130	30 - 35	-	-	-	-	30 - 35
D Emerton	Secondary Care Specialist	15 – 20	0 - 5	-	-	-	-	0 - 5
Dr B Posmyk	Chair of Governing Body	45 – 50	10 - 15	-	-	-	-	10 - 15
K Dales	Lay Member (Audit and Governance)	15 – 20	0 - 5	-	-	-	-	0 - 5
C Gitsham	Lay Member	15 – 20	0 - 5	-	-	-	-	0 - 5
M Thompson	Lay Member	15 – 20	0 - 5	-	-	-	-	0 - 5
A Mackay	Independent Member	15 – 20	0 - 5	-	-	-	-	0 - 5
Dr H Tahir	Elected Healthcare Professional	5 – 10	0 - 5	-	-	-	-	0 - 5
Dr J Nevison	Elected Healthcare Professional	5 - 10	0 - 5	-	-	-	-	0 - 5
Dr A Johnston	Elected Healthcare Professional	5 - 10	0 - 5	-	-	-	-	0 - 5
J Bushnell	Elected Healthcare Professional	0 - 5	0 - 5	-	-	-	-	0 - 5

There were two senior officers who received a salary in excess of the prime minister's salary of £150,000 in 2022/23 on a pro rata basis. The pro rata basis represents the full time salary for individuals who work part time. The salary reflects the clinical nature of their roles,and has been benchmarked against other equivalent general practice earnings.

NHS Tees Valley CCG senior officers' salaries and allowances - 2021/22 (12 months) (Comparative figures):

Name	Title	2021/22					
		Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (Bands of £5,000)	Long-term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (Bands of £2,500)	Total (Bands of £5,000)
		£000	£	£000	£000	£000	£000
D Gallagher	Accountable Officer	140 - 145	2,400	-	-	102.5 - 105	250 - 255
M Pickering	Chief Finance Officer	105 - 110	400	-	-	40 – 42.5	150 - 155
J Golightly	Director of Nursing and Quality	105 – 110	-	-	-	40 – 42.5	145 - 150
D Murphy	Director of Commissioning, Strategy and Delivery	30 – 35	-	-	-	-	30 – 35
K Hawkins	Director of Commissioning, Strategy and Delivery	105 – 110	600	-	-	25 – 27.5	135 – 140
C Blair	Director of Commissioning, Strategy and Delivery	100 – 105	900	-	-	32.5 – 35	135 – 140
A Sinclair	Director of Commissioning, Strategy and Delivery	100 – 105	700	-	-	37.5 – 40	140 - 145
M Brierley	Director of Commissioning, Strategy and Delivery	50 – 55	300	-	-	12.5 - 15	65 - 70
Dr J Walker	Medical Director	135 – 140	-	-	-	35 – 37.5	170 - 175
D Emerton	Secondary Care Specialist	15 – 20	-	-	-	-	15 – 20
Dr B Posmyk	Chair of Governing Body	45 – 50	-	-	-	-	45 – 50
K Dales	Lay Member (Audit and Governance)	15 – 20	-	-	-	-	15 – 20
C Gitsham	Lay Member	15 – 20	-	-	-	-	15 – 20
M Thompson	Lay Member	15 – 20	-	-	-	-	15 – 20
A Mackay	Independent Member	15 – 20	-	-	-	-	15 – 20
Dr H Tahir	Elected Healthcare Professional	5 – 10	-	-	-	-	5 – 10
Dr J Nevison	Elected Healthcare Professional	5 – 10	-	-	-	-	5 - 10
Dr J Hollingsworth	Elected Healthcare Professional (to 30 September 2021)	0 - 5	-	-	-	-	0 - 5
Dr A Johnston	Elected Healthcare Professional	5 - 10	-	-	-	-	5 – 10
J Bushnell	Elected Healthcare Professional	0 - 5	-	-	-	-	0 - 5

There were two senior officers who received a salary in excess of the prime minister's salary of £150,000 in 2021/22 on a pro rata basis. The pro rata basis represents the full time salary for individuals who work part time. The salary reflects the clinical nature of their roles, and has been benchmarked against other equivalent general practice earnings.

Notes:

The expense payments (taxable) included in the tables above all relate to car allowance and lease car benefits.

No performance related benefits have been agreed for any senior officers.

All pension related benefits disclosed in this report relate to 'officer employment' only, i.e. for any general practitioners, the figures exclude any benefits derived from practitioner employment. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the scheme could provide.

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

All senior officer remuneration is processed through the CCG's payroll with the exception of the Director of Commissioning, Strategy and Delivery who is recharged from County Durham CCG as part of the shared management arrangements below.

Shared Management Arrangements

For the 3 months of 2022/23, the following senior officers operated in a shared management role across both Tees Valley CCG and County Durham CCG, with costs split equally across the two CCGs:

M Brierley	Director of Commissioning, Strategy and Delivery
D Murphy	Director of Commissioning, Strategy and Delivery

The remuneration shown above for these posts represents only the share that relates to the Tees Valley CCG role. The total remuneration earned by these individuals for all work across the relevant CCGs in 2022/23 is shown below:

Name	Title	2022/23 (3 months ended 30th June 2022)		
		Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Total (Bands of £5,000) £000
M Brierley	Director of Commissioning, Strategy and Delivery	25 - 30	300	25 - 30
D Murphy	Director of Commissioning, Strategy and Delivery	15 - 20	-	15 - 20

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director in the CCG in the financial year 2022/23 was £140-145k (2021/22: £145-150k) this is the annualised remuneration and excludes any pension benefits. The relationship to the remuneration of the organisation's workforce is disclosed in the table below:

	25th percentile Total remuneration ratio		Median Total remuneration ratio		75th percentile Total remuneration ratio	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Band of Highest Paid Director's Total Remuneration (£'000)	140 - 145	145 - 150	140 - 145	145 - 150	140 - 145	145 - 150
Total remuneration £	32,306	34,149	54,764	63,862	116,001	126,277
Ratio	4.41	4.32	2.60	2.31	1.23	1.17

There has been no performance pay or bonuses paid to senior officers or employees during 2022/23 (2021/22: none).

There has been a negative 3.39% percentage change from the previous financial year in respect of the highest paid director due to no expense benefits received in 2022/23 (2021/22: no change).

The average percentage change from the previous financial year in respect of employees of the entity is a negative 4.24% due to 4 additional permanent staff with a lower skill mix in 2022/23 (2021/22: 0.93% increase).

In 2022/23, no employees (2021/22: none) received remuneration in excess of that of the highest paid director. Full time equivalent remuneration for employees ranged from £15,154 to £169,176 (2021/22: £15,154 to £169,176).

For the purposes of identifying the highest paid director for this disclosure, it is the cost to the CCG of an individual that is considered, rather than the total of that individual's remuneration.

The remuneration of £15,154 relates to the CCG's lay members and secondary care clinician who receive an annual remuneration for a time-commitment below the CCG's normal contractual hours. As this represents the annual remuneration for the full required

time-commitment, this is considered to represent the full time equivalent remuneration for that role although it relates to a time-commitment significantly below the CCG's normal contractual hours.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on page 121.

NHS Tees Valley CCG senior officers' pension benefits 2022/23:

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500)	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 30 June 2022 (bands of £5,000)	Lump Sum at aged 60 related to accrued pension at 30 June 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
D Gallagher Accountable Officer	-	-	65 – 70	165 – 170	1,555	-	1,490	-
Dr J Walker Medical Director	-	-	20 – 25	25 – 30	383	-	383	-
M Pickering Chief Finance Officer	-	-	40 - 45	85 - 90	758	-	611	-
J Golightly Director of Nursing and Quality	-	-	25 – 30	75 - 80	683	-	534	-
K Hawkins Director of Commissioning, Strategy and Delivery	-	-	25 – 30	45 - 50	452	-	463	-
C Blair Director of Commissioning, Strategy and Delivery	-	-	25 – 30	45 – 50	428	-	416	-
A Sinclair Director of Commissioning, Strategy and Delivery	0 – 2.5	-	25 – 30	45 - 50	478	-	496	-
M Brierley Director of Commissioning, Strategy and Delivery	5 – 7.5	7.5 - 10	35 - 40	60 – 65	567	103	690	-
Dr J Nevison Elected Healthcare Professional	-	-	15 - 20	30 - 35	200	2	208	-

NHS Tees Valley CCG senior officers' pension benefits 2021/22 (comparative figures):

Name and Title	Real increase / (reduction) in pension at age 60 (bands of £2,500)	Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Lump Sum at aged 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in cash equivalent transfer value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
D Gallagher Accountable Officer	5 - 7.5	7.5 - 10	65 - 70	175 - 180	1,402	126	1,555	-
Dr J Walker Medical Director	2.5 - 5	0 – 2.5	20 - 25	25 - 30	338	23	383	-
M Pickering Chief Finance Officer	2.5 - 5	0 – 2.5	40 – 45	85 - 90	699	41	758	-
J Golightly Director of Nursing and Quality	2.5 - 5	0 – 2.5	25 - 30	75 - 80	619	46	683	-
K Hawkins Director of Commissioning, Strategy and Delivery	0 – 2.5	-	25 - 30	45 - 50	418	19	452	-
C Blair Director of Commissioning, Strategy and Delivery	0 – 2.5	0 – 2.5	25 - 30	50 - 55	392	21	428	-
A Sinclair Director of Commissioning, Strategy and Delivery	0 – 2.5	0 – 2.5	25 – 30	45 - 50	431	33	478	-
M Brierley Director of Commissioning, Strategy and Delivery	0 – 2.5	0 – 2.5	30 - 35	50 - 55	524	27	567	-
Dr B Posmyk Chair of Governing Body	-	-	-	-	-	-	-	1
D Murphy Director of Commissioning, Strategy and Delivery	-	-	-	-	-	-	-	1
Dr J Nevison Elected Healthcare Professional	-	0 – 2.5	15 - 20	30 - 35	194	3	200	-

The table above includes only those senior managers who are members of the NHS pension scheme where the CCG made contributions to the scheme as an employer during the year.

The figures included above are provided by the NHS Business Services Authority on an annual basis and reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the CCG. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme.

The real increase figures shown above relate only to the period each individual was in post as a senior officer, for 2022/23 this is the 3 months to the 30th June 2022.

Cash Equivalent Transfer Values

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

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

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

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

Real Increase in Cash Equivalent Transfer Values

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

Staff report

Numbers of senior managers

Details of staffing costs for the year and the average number of employees can be found in notes 2.1 and 2.2 of the financial statements, respectively.

The CCG's senior officers are listed in the remuneration report. Two of the senior officers are on very senior manager bandings, six senior officers are on agenda for change band 9 and the remaining senior officers are either paid on a sessional basis or are non-executive members and hence have no agenda for change banding.

Staff Composition

The CCG staff gender profile is given in the table below. This reflects our gender representation on the Governing Body and other CCG staff.

	Female	Male
Governing Body	6	8
Employees	64	28

These figures are as at 30 June 2022 and reflect the number of employees rather than full time equivalent figures.

The CCG can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, and being entitled to equal pay.

The CCG has 59 whole time equivalent employees under contract of service and an annual staff turnover percentage of 11.05% (which includes fixed term employees supporting with a number of projects).

Staff Sickness Absence

The table below provides staff sickness absence data for the 3 months ended 30 June 2022, showing the total number of full time equivalent (FTE) staff days lost to sickness absence and the total number of FTE years available, based on the total number of FTE staff members within the CCG. This equates to an average number of days' sickness per FTE member of staff of 3:

	2022 3 months to 30 June 2022 Number of days	2021 12 months to 31 March 2022 Number of days
Total number of days lost to sickness absence	188.9	332.0
Total staff years	63.1	60.1
Average number of working days lost to sickness absence	**3.0**	**5.5**

Staff Policies

Our commitment to our responsibilities relating to the Public Sector Equality Duty (PSED) which is set out in s149 of the Equality Act 2010 is described in the reducing Health Inequality Section of this report.

The CCG is committed to giving full and fair consideration to all applications for employment received including those received from disabled persons, having regard to their particular aptitudes and abilities.

To support the human resource function the CCG has a suite of HR policies, implementation of which is supported by Human Resource Team within North of England Commissioning Support. They cover the full range of HR issues including recruitment, training and career development.

All appropriate support would be provided to any employee who might become a disabled person during the period when they were employed by the CCG.

The CCG participates in the Workforce Race Equality Standard (WRES) which aims to support the closing of any gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and improve BME representation at the Board level of the organisation. Tees Valley CCG is committed to being an inclusive employer and commissioner and we recognise that there is currently underrepresentation of the communities that we serve within our workforce. The WRES action plan can be found here.

Other employee matters

We continue to participate in the regional HR Partnership Forum coordinated by our commissioning support unit. Trade Union representatives jointly chair the group where HR policies are agreed, and general HR issues discussed. Towards the end of the period, the focus has been regarding the safe transfer of staff to the Integrated Care Board.

Staff Engagement

Earlier in the year we received the results of the independent survey we commissioned coordinator Picker to run a National Staff Survey to seek the views of all staff in scope and provide an analysis of the results. A local action plan was produced and progressed to enhance the staff experience of working for the organisation.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities. Tees Valley CCG does not have any union representatives.

Disabled employees

The CCG was a local employer, with a responsibility to the people who work extremely hard for us. The CCG has successfully been re-accredited as a Disability Confident Employer. The symbol, awarded by Job centre Plus, demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

Our Equality Report sets out details of our policy in relation to disabled employees, and the Remuneration and Staff Report details arrangements for managing staff policies and highlight the CCG's commitment to giving full and fair consideration to all applications for employment received including those received from disabled persons, having regard to their particular aptitudes and abilities.

Sickness absence data

Staff sickness absence is managed in line with our HR policy on absence management. We continue to benefit from low levels of sickness absence and are committed to promoting health and wellbeing for our staff. Days lost to sickness are shown earlier in the Staff Report.

Health and safety

The CCG had legal obligations under the Health and Safety at Work Act 1974 and subsequent regulations to ensure the health, safety and welfare of our employees and those visiting our premises.

To ensure compliance with health and safety, fire and security we have a Health, Safety and Wellbeing Strategy, which sets out our framework for health and safety within the organisation including annual health and safety audits to ensure compliance with all relevant legislation and policies and procedures that are in place and detail organisational and individual responsibilities.

Throughout the pandemic we have continued to work closely with Health and Safety Colleagues whilst adhering to Health and Safety Executive (HSE) and Government Guidance.

The CCG was compliant with legal and statutory obligations under the Health and Safety at Work Act 1974 and subsequent regulations. Our Strategy also reflects our commitment to the overall wellbeing of our staff and how we intend to continue to be a caring and responsible employer.

Expenditure on Consultancy

Details of expenditure on consultancy services can be found in note 3 of the financial statements. For the period ended 30th June 2022, there has been no spend on consultancy services (2021/22: none). Expenditure on agency staff is shown in note 2.1 of the financial statements.

Off-Payroll Engagements

There have been no off-payroll engagements during the year of greater than £245 per day and lasting longer than 6 months.

Exit Packages

No exit packages have been agreed in the 3 month period ended 30th June 2022 (2021/22: none).

Parliamentary Accountability and Audit Report

Tees Valley CCG is not required to produce a Parliamentary Accountability and Audit Report. Where relevant, disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements.

An audit report is also included in this Annual Report at page 158.

Financial statements

NHS Tees Valley CCG Financial Statements for the period ended 30 June 2022

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The Primary Statements:

NHS Tees Valley CCG - Annual Accounts for the period to the 30 June 2022

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

	Note	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Administration costs and programme expenditure			
Gross employee benefits	2.1	1,019	3,938
Purchase of goods and services	3	339,673	1,497,809
Depreciation and impairment charges	3	24	-
Other operating costs	3	100	126
Total operating expenditure		**340,816**	**1,501,873**
Finance costs	5	1	-
Net operating costs for the financial period		**340,817**	**1,501,873**
Total comprehensive net expenditure for the period		**340,817**	**1,501,873**

NHS Tees Valley CCG - Annual Accounts for the period to the 30 June 2022

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £000	31 March 2022 £000
Non-current assets:			
Right of use assets	6	318	-
Total non-current assets		318	-
Current assets			
Trade and other receivables	7	3,860	3,901
Cash and cash equivalents	8	-	124
Total current assets		**3,860**	**4,025**
Total assets		**4,178**	**4,025**
Current liabilities			
Trade and other payables	9	(70,578)	(88,557)
Lease liabilities	6	(97)	-
Borrowings	10	(1,252)	-
Total current liabilities		**(71,927)**	**(88,557)**
Total assets less total current liabilities		**(67,749)**	**(84,532)**
Non-current liabilities			
Lease liabilities	6	(221)	-
Total non-current liabilities		**(221)**	**-**
Assets less Liabilities		**(67,970)**	**(84,532)**
Financed by taxpayers' equity			
General fund		(67,970)	(84,532)
Total taxpayers' equity		**(67,970)**	**(84,532)**

The notes on pages 139 to 157 of the Annual Report form part of this statement.

The financial statements on pages 135 to 157 of the Annual Report were approved and authorised for issue by the Board on 22 June 2023 and signed on its behalf by:

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

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

NHS Tees Valley CCG - Annual Accounts for the period to the 30 June 2022

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

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the 3 months to the 30 June 2022:		
Balance at 1 April 2022	(84,532)	(84,532)
Changes in CCG taxpayers' equity for the 3 months to the 30 June 2022		
Net operating costs for the financial period	(340,817)	(340,817)
Net recognised CCG expenditure for the financial period	**(340,817)**	**(340,817)**
Net funding	357,379	357,379
Balance at 30 June 2022	**(67,970)**	**(67,970)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2021/22:		
Balance at 1 April 2021	(72,095)	(72,095)
Changes in CCG taxpayers' equity for 2021/22		
Net operating costs for the financial year	(1,501,873)	(1,501,873)
Net recognised CCG expenditure for the financial year	**(1,501,873)**	**(1,501,873)**
Net funding	1,489,436	1,489,436
Balance at 31 March 2022	**(84,532)**	**(84,532)**

Statement of Cash Flows for the period ended 30 June 2022

	Note	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Cash flows from operating activities			
Net operating costs for the financial period		(340,817)	(1,501,873)
Depreciation and amortisation	6	24	-
Interest on lease liabilities	5	1	
Decrease / (increase) in trade and other receivables	7	41	(624)
(Decrease) / increase in trade and other payables	9	(17,979)	13,000
Net cash outflow from operating activities		**(358,730)**	**(1,489,497)**
Net cash outflow before financing		**(358,730)**	**(1,489,497)**
Cash flows from financing activities			
Net funding received		357,379	1,489,436
Repayment of lease liabilities	6	(25)	-
Net cash inflow from financing activities		**357,354**	**1,489,436**
Net (decrease) / increase in cash and cash equivalents	8	**(1,376)**	**(61)**
Cash and cash equivalents at the beginning of the financial period		124	185
Cash and cash equivalents (including bank overdrafts) at the end of the financial period		**(1,252)**	**124**

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis. 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.

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, CCGs were abolished and the functions, assets and liabilities of NHS Tees Valley CCG transferred to the North East and North Cumbria Integrated Care Board (NENC ICB) from the 1 July 2022.

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.

In April 2022, NHS England and NHS Improvement (NHSE/I) published the final planning guidance and related system financial envelopes set at Integrated Care Board (ICB) level for 2022/23. This confirms CCGs will receive an allocation from 1 April 2022 and ICBs will be established with the remaining amounts for the financial year. This means the aggregate full year ICB allocations will be reduced by the amount of resources the CCG has consumed. Financial plans have been developed for 2022/23, both at CCG and ICB level, which demonstrate sufficient funding is expected for the continued commissioning of relevant health services. CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the North East and North Cumbria Integrated Care Board, rather than NHS Tees Valley CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, are not considered to impact on going concern. Our considerations cover the period through to 30 June 2024, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, there is a reasonable expectation that the successor NENC ICB will have adequate resources to continue in operational existence until at least 30 June 2024. For this reason, we continue to adopt the going concern basis in preparing these financial statements.

1.2 Accounting Convention

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.3 Movement of Assets within the Department of Health and Social Care Group

As public sector bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 business combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 *Critical Judgements in Applying Accounting Policies*

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

• determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

• the estimate of potential future liabilities in respect of continuing healthcare services; and
• the estimate of prescribing expenditure for the final two months of the period based on actual charges received from the Prescription Pricing Division.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the standard have been employed. These are as follows:
• as per paragraph 121 of the standard the CCG will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less;
• the CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the standard where the right to consideration corresponds directly with the value of the performance completed to date.

The main source of funding for the CCG is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

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

1.7 Employee Benefits

1.7.1 *Short-term Employee Benefits*

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.8 Other Expenses

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

Expenses and liabilities in respect of grants are recognised when the CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.9 Leases

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

1.9.1 The CCG as Lessee

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.10 Cash & Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.

1.11 Clinical Negligence Costs

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

1.12 Non-clinical Risk Pooling

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

1.13 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.14 Financial Assets

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income;
- Financial assets at fair value through profit and loss;

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

All CCG assets have been classified as financial assets at amortised cost.

1.14.1 *Financial Assets at Amortised cost*

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

1.14.2 *Impairment*

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

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

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

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

Notes to the financial statements (continued)

1. Accounting policies (continued)

1.15 Financial Liabilities

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

1.15.1 *Other Financial Liabilities*

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.16 Value Added Tax

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

1.17 Adoption of new standards

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

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

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

Impact Assessment

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

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the 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 £0.342m of right-of-use assets and lease liabilities of £0.342m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a nil impact to 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 and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

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

	Total £000
Operating lease commitments at 31 March 2022	365
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(18)
Operating lease commitments discounted used weighted average IBR	**347**
Less: Variable payments not included in the valuation of the lease liabilities	(5)
Lease liability at 1 April 2022	**342**

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

- IFRS 17: Insurance Contracts (application from 1 January 2021) but not yet adopted by the FREM which is expected to be April 2023: early adoption is not therefore permitted.

The application of the Standards as revised would not have a material impact on the accounts for 2022/23, were they applied in that year.

Notes to the financial statements (continued)

2. Employee benefits and staff numbers

2.1 Employee benefits

3 months to 30 June 2022	Total		
	Total	Permanent Employees	Other
	£000	£000	£000
Employee benefits:			
Salaries and wages	791	761	30
Social security costs	89	89	-
Employer contributions to NHS Pension scheme	138	138	-
Apprenticeship Levy	1	1	-
Gross employee benefits expenditure	**1,019**	**989**	**30**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year.

2.1 Employee benefits prior year

12 months to 31 March 2022	Total		
	Total	Permanent Employees	Other
	£000	£000	£000
Employee benefits:			
Salaries and wages	3,104	2,970	134
Social security costs	309	309	-
Employer contributions to NHS Pension scheme	523	523	-
Apprenticeship Levy	2	2	-
Gross employee benefits expenditure	**3,938**	**3,804**	**134**

2.2 Average number of people employed

	3 months to 30 June 2022		
	Total	Permanently employed	Other
	Number	Number	Number
Total	**59**	**57**	**2**

None of the above people were engaged on capital projects.

2.2 Average number of people employed prior year

	12 months to 31 March 2022		
	Total	Permanently employed	Other
	Number	Number	Number
Total	**56**	**54**	**2**

None of the above people were engaged on capital projects.

Notes to the financial statements (continued)

2. Employee benefits and staff numbers (continued)

2.3 Pension costs

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

Both Schemes are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the Scheme is taken as equal to the contributions payable to that Scheme for the accounting period.

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

2.3.1 Accounting valuation

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

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

2.3.2 Full actuarial (funding) valuation

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

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

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

3. Operating expenses

	3 months to 30 June 2022 Total £000	12 months to 31 March 2022 Total £000
Purchase of goods and services		
Services from other CCGs and NHS England	3,685	13,164
Services from foundation trusts	213,789	964,016
Services from other NHS trusts	234	2
Purchase of healthcare from non-NHS bodies	63,188	264,429
Prescribing costs	29,006	124,143
Pharmaceutical services	5	10
General ophthalmic services	7	19
GPMS/APMS and PCTMS	27,033	121,557
Supplies and services – clinical	676	2,690
Supplies and services – general	242	606
Establishment	82	451
Premises	1,408	5,479
Audit fees	115	115
Other professional fees	109	649
Legal fees	86	461
Education and training	8	18
Total purchase of goods and services	**339,673**	**1,497,809**
Depreciation and impairment charges		
Depreciation	24	-
Total depreciation and impairment charges	**24**	**-**
Other operating expenditure		
Chair and Non Executive Members	32	126
Clinical negligence	1	6
Expected credit loss on receivables	67	(6)
Total other operating expenditure	**100**	**126**
Total operating expenses	**339,797**	**1,497,935**

Included within Other professional fees is £15,153 paid for Internal Audit Services for the 3 months to the 30 June 2022 (2021/22: £46,122).

Limitation of auditor's liability:

The CCG's contract for external audit services provides for a limitation of the auditor's liability of £2,000,000 (2021/22: £2,000,000).

4.1 Better Payment Practice Code

Measure of compliance	3 months to 30 June 2022 Number	3 months to 30 June 2022 £000	12 months to 31 March 2022 Number	12 months to 31 March 2022 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	9,611	101,094	33,868	377,785
Total Non-NHS Trade Invoices paid within target	9,572	100,224	33,680	374,959
Percentage of Non-NHS Trade invoices paid within target	**99.59%**	**99.14%**	**99.44%**	**99.25%**
NHS Payables				
Total NHS Trade invoices paid in the year	122	224,611	910	975,603
Total NHS Trade invoices paid within target	121	224,608	902	975,073
Percentage of NHS Trade invoices paid within target	**99.18%**	**100.00%**	**99.12%**	**99.95%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

5. Finance costs

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Interest		
Interest on lease liabilities	1	-
Total interest	**1**	**-**
Total finance costs	**1**	**-**

Notes to the financial statements (continued)

6. Leases

6.1 Right of use assets

	3 months to 30 June 2022 Buildings £000	3 months to 30 June 2022 Total £000
Cost or valuation at 1 April 2022	-	-
IFRS 16 Transition Adjustment	342	342
Cost/Valuation at 30 June 2022	**342**	**342**
Depreciation 1 April 2022	-	-
Charged during the period	(24)	(24)
Depreciation at 30 June 2022	**(24)**	**(24)**
Net Book Value at 30 June 2022	**318**	**318**

6.2 Lease liabilities

	3 months to 30 June 2022 £000
Lease liabilities at 1 April 2022	-
IFRS 16 Transition Adjustment	342
Interest expense relating to lease liabilities	1
Repayment of lease liabilities (including interest)	(25)
Lease liabilities at 30 June 2022	**318**

6.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30 June 2022 £000
Within one year	(99)
Between one and five years	(224)
Balance at 30 June 2022	**(323)**
Effect of discounting	5
Included in:	
Current lease liabilities	(97)
Non-current lease liabilities	(221)
Balance at 30 June 2022	**(318)**

6.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	3 months to 30 June 2022 £000
Depreciation expense on right-of-use assets	24
Interest expense on lease liabilities	1

6.5 Amounts recognised in Statement of Cashflows

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

Notes to the financial statements (continued)

7. Trade and other receivables

	Current 30 June 2022 £000	Non-current 30 June 2022 £000	Current 31 March 2022 £000	Non-current 31 March 2022 £000
NHS receivables: Revenue	842	-	1,408	-
NHS prepayments	57	-	-	-
NHS accrued income	11	-	-	-
Non-NHS and Other Whole of Government Accounts (WGA) receivables: Revenue	976	-	1,387	-
Non-NHS and Other WGA prepayments	1,908	-	1,052	-
Expected credit loss allowance-receivables	(253)	-	(186)	-
VAT	319	-	240	-
Total trade and other receivables	**3,860**	**-**	**3,901**	**-**
Total current and non current	**3,860**		**3,901**	

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

7.1 Receivables past their due date but not impaired

	30 June 2022 £000	31 March 2022 £000
By up to three months	185	78
By three to six months	4	-
Total	**189**	**78**

£189k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The CCG did not hold any collateral against receivables outstanding at 30 June 2022 (31 March 2022: none).

7.2 Expected credit losses on financial assets

The CCG has expected credit losses on trade and other receivables of £253k at 30 June 2022 (31 March 2022: £186k).

The CCG has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the CCG considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

Notes to the financial statements (continued)

8. Cash and cash equivalents

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Balance at 1 April	124	185
Net change in year	(1,376)	(61)
Balance at 30 June	**(1,252)**	**124**
Made up of:		
Cash with the Government Banking Service	0	124
Cash and cash equivalents as in Statement of Financial Position	**0**	**124**
Bank overdraft: Government Banking Service	(1,252)	0
Total bank overdrafts	**(1,252)**	**0**
Balance at 30 June	**(1,252)**	**124**

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

The CCG completed a BACS payments run on 30 June 2022 which was due to clear the bank account 4 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 £1,252k. 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 below.

9. Trade and other payables

	Current 30 June 2022 £000	Non-current 30 June 2022 £000	Current 31 March 2022 £000	Non-current 31 March 2022 £000
NHS payables: revenue	517	-	7,993	-
NHS accruals	1,180	-	40	-
Non-NHS and Other Whole of Government Accounts (WGA) payables: Revenue	2,069	-	5,601	-
Non-NHS and Other WGA accruals	64,968	-	72,694	-
Social security costs	55	-	50	-
Tax	50	-	51	-
Other payables	1,739	-	2,128	-
Total trade and other payables	**70,578**	**-**	**88,557**	**-**
Total current and non-current	**70,578**		**88,557**	

At 30 June 2022, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2022: none)

Other payables include £918k in respect of outstanding pension contributions at 30 June 2022 (31 March 2022: £928k).

10. Borrowings

	Current 30 June 2022 £000	Non-current 30 June 2022 £000	Current 31 March 2022 £000	Non-current 31 March 2022 £000
Bank Overdrafts				
Government Banking Service	1,252	-	-	-
Total Overdrafts	**1,252**	**-**	**-**	**-**
Total current and non-current	**1,252**		**-**	

10.1 Repayment of Principal falling due

	DHSC £000	Other £000	DHSC £000	Other £000
Within one year	-	1,252	-	-
Total	**-**	**1,252**	**-**	**-**

Notes to the financial statements (continued)

11. Commitments

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

12. Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As the CCG is financed through Parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG's internal auditors.

12.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

12.1.3 Credit risk

Because the majority of the CCG's revenue comes from Parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

12.1.5 Financial Instruments

As the cash requirements of the CCG are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the CCG's expected purchase and usage requirements and the CCG is therefore exposed to little credit, liquidity or market risk.

Notes to the financial statements (continued)

12. Financial instruments (continued)

12.2 Financial assets

	Financial Assets measured at amortised cost 30 June 2022 £000	Total 30 June 2022 £000	Financial Assets measured at amortised cost 31 March 2022 £000	Total 31 March 2022 £000
Trade and other receivables:				
· NHSE bodies	580	580	1,345	1,345
· Other DHSC group bodies	327	327	264	264
· External bodies	669	669	1,186	1,186
Cash and cash equivalents	-	-	124	124
Total Financial assets	**1,576**	**1,576**	**2,919**	**2,919**

12.3 Financial liabilities

	Other 30 June 2022 £000	Total 30 June 2022 £000	Other 31 March 2022 £000	Total 31 March 2022 £000
Overdraft with external bodies	1,252		0	0
Trade and other payables:				
· NHSE bodies	517	517	1,499	1,499
· Other DHSC group bodies	1,958	1,958	7,478	7,478
· External bodies	68,316	68,316	79,479	79,479
Total Financial liabilities	**72,043**	**72,043**	**88,456**	**88,456**

13. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG's Governing Body, considered to be the 'chief operating decision maker' of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

14. Pooled budgets

The CCG entered into a pooled budget in relation to the loan of community equipment with:

- Middlesbrough Council
- Stockton-on-Tees Borough Council
- Hartlepool Borough Council
- Redcar and Cleveland Borough Council

The pool for Tees Community Equipment Services is hosted by Middlesbrough Council. Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the loan of community equipment. The memorandum account for the pooled budget is:

	3 months to 30 June 2022 £000	12 months to 31 March 2022 £000
Income	459	1,878
Expenditure	(473)	(1,866)
Net Underspend / Overspend (-)	**(14)**	**12**

The CCG entered into a pooled budget arrangement with Darlington Borough Council, Hartelpool Borough Council, Stockton-on-Tees Borough Council, Redcar and Cleveland Borough Council and Middlesbrough Council in respect of the Better Care Fund, with effect from 1 April 2015, through a section 75 agreement.

The CCG contribution to the pooled budget with the five local authorities analysed further below, was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund. The Better Care Fund provides a vehicle for furthering integration between health and social care to support the transformation that is required to address the sustainability in the system. This contribution to the Better Care Fund is recognised within the financial statements as CCG expenditure.

CCG Contribution to pooled budget	3 months to 30 June 2022 £000	2021/22 £000
Darlington Borough Council	2,284	9,098
Hartlepool Borough Council	2,123	8,456
Stockton-on-Tees Borough Council	4,159	16,568
Middlesbrough Council	3,362	13,393
Redcar and Cleveland Borough Council	3,245	12,927

Notes to the financial statements (continued)

15. Related party transactions

During the 3 month period to the 30 June 2022, the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

CCG Governing Body	Role	Dates	Related Party	Expenditure with Related Party £000	Income received from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
D Gallagher	Accountable Officer	01/04/2022 - 30/06/2022	Academic Health Science Network for the North East & North Cumbria Ltd	72	-	124	(33)
M Pickering	Chief Finance Officer	01/04/2022 - 30/06/2022	Tees Esk & Wear Valleys NHS Foundation Trust	29,827	-	-	-
M Pickering	Chief Finance Officer	01/04/2022 - 30/06/2022	County Durham & Darlington NHS Foundation Trust	20,850	-	11	-
D Murphy	Director of Commissioning, Strategy and Delivery	01/04/2022 - 30/06/2022	NHS County Durham CCG	313	-	22	-
M Brierley	Director of Commissioning, Strategy and Delivery	01/04/2022 - 30/06/2022	NHS County Durham CCG	313	-	22	-
Dr B Posmyk	Chair of Governing Body	01/04/2022 - 30/06/2022	Havelock Grange Practice	556	-	81	(6)
Dr B Posmyk	Chair of Governing Body	01/04/2022 - 30/06/2022	Rockcliffe Court Surgery	274	-	39	(8)
M Thompson	Lay Member	01/04/2022 - 30/06/2022	Healthwatch Darlington Ltd	5	-	-	-
A Mackay	Independent Member	01/04/2022 - 30/06/2022	Stockton-on-Tees Borough Council	9,176	-	8,518	-
Dr H Tahir	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Marsh House Medical Centre	270	-	25	(14)
Dr H Tahir	Elected Healthcare Professional	01/04/2022 - 30/06/2022	ELM Alliance	1,072	-	18	(100)
Dr H Tahir	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Hartlepool & Stockton Health Ltd	2,014	-	138	-
Dr J Nevison	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Denmark Street Surgery	471	-	31	(16)
Dr J Nevison	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Primary Healthcare Darlington Ltd	717	-	195	(8)
Dr A Johnston	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Woodbridge Practice	561	-	40	(115)
J Bushnell	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Tenant Street Medical Practice	629	-	7	(15)
J Bushnell	Elected Healthcare Professional	01/04/2022 - 30/06/2022	Whinfield Medical Practice	379	-	34	(10)

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

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

- NHS England (including North of England Commissioning Support Unit);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution;
- NHS Business Services Authority; and,
- NHS Property Services; and,
- Community Health Partnership.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Darlington Borough Council, Stockton Borough Council, Hartlepool Borough Council, Middlesbrough Council and Redcar and Cleveland Council.

Notes to the financial statements (continued)

15. Related party transactions prior year

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

CCG Governing Body	Role	Dates	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
D Gallagher	Accountable Officer	01/04/2021 - 31/03/2022	Academic Health Science Network for the North East & North Cumbria Ltd	328	-	187	-
M Pickering	Chief Finance Officer	01/04/2021 - 31/03/2022	Tees Esk & Wear Valleys NHS Foundation Trust	123,130	-	187	-
M Pickering	Chief Finance Officer	01/04/2021 - 31/03/2022	County Durham & Darlington NHS Foundation Trust	83,830	-	2,199	-
D Murphy	Director of Commissioning, Strategy and Delivery	01/04/2021 - 31/03/2022	NHS County Durham CCG	946	(60)	176	-
M Brierley	Director of Commissioning, Strategy and Delivery	01/04/2021 - 31/03/2022	NHS County Durham CCG	946	(60)	176	-
Dr J Walker	Medical Director	01/04/2021 - 31/03/2022	Manor House Surgery				
Dr J Walker	Medical Director	01/04/2021 - 31/03/2022	ELM Alliance				
Dr B Posmyk	Chair of Governing Body	01/04/2021 - 31/03/2022	Havelock Grange Practice	2,644	-	325	-
Dr B Posmyk	Chair of Governing Body	01/04/2021 - 31/03/2022	Rockcliffe Court Surgery	1,077	-	89	-
M Thompson	Lay Member	01/04/2021 - 31/03/2022	Healthwatch Darlington Ltd	5	-	-	-
A Mackay	Independent Member	01/04/2021 - 31/03/2022	Stockton-on-Tees Borough Council	29,353	(151)	7,371	(20)
Dr H Tahir	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Marsh House Medical Centre	1,208	-	103	-
Dr H Tahir	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Primary Healthcare Darlington Ltd	1,942	-	227	-
Dr H Tahir	Elected Healthcare Professional	01/04/2021 - 31/03/2022	ELM Alliance	3,766	-	5	-
Dr H Tahir	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Hartlepool & Stockton Health Ltd	5,377	-	387	-
Dr J Nevison	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Denmark Street Surgery	1,740	-	169	-
Dr J Nevison	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Denmark Street Pharmacy	1	-	-	-
Dr J Nevison	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Primary Healthcare Darlington Ltd	1,942	-	227	-
Dr J Hollingsworth	Elected Healthcare Professional	01/04/2021 - 30/09/2021	Linthorpe Surgery	3,483	-	345	(77)
Dr J Hollingsworth	Elected Healthcare Professional	01/04/2021 - 30/09/2021	ELM Alliance	3,766	-	5	-
Dr J Hollingsworth	Elected Healthcare Professional	01/04/2021 - 30/09/2021	South Tees Hospital NHS Foundation Trust	384,623	(8)	823	-
Dr A Johnston	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Woodbridge Practice	2,346	-	178	(76)
J Bushnell	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Tenant Street Medical Practice	2,740	-	223	-
J Bushnell	Elected Healthcare Professional	01/04/2021 - 31/03/2022	Whinfield Medical Practice	1,605	-	126	-

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England (including North of England Commissioning Support Unit);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution;
- NHS Business Services Authority; and,
- NHS Property Services.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Darlington Borough Council, Stockton Borough Council, Hartlepool Borough Council, Middlesbrough Council and Redcar and Cleveland Council.

Notes to the financial statements (continued)

16. Events after the end of the reporting period

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

17. Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).

The CCG's performance against those duties was as follows:

	3 months to 30 June 2022 Target £000	3 months to 30 June 2022 Performance £000	12 months to 31 March 2022 Target £000	12 months to 31 March 2022 Performance £000
Expenditure not to exceed income	340,817	340,817	1,508,322	1,501,872
Revenue resource use does not exceed the amount specified in Directions	340,817	340,817	1,508,322	1,501,872
Revenue administration resource use does not exceed the amount specified in Directions	3,192	3,192	13,081	12,335

CCG financial performance is reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure. For the 3 month period to the 30 June 2022, the CCGs performance was matched with an equal amount of resource.

The CCG received no capital resource during 2021/22 and incurred no capital expenditure.

Performance against the revenue expenditure duties is further analysed below:

	3 months to 30 June 2022 Programme Resource £000	3 months to 30 June 2022 Administration Resource £000	3 months to 30 June 2022 Total £000
Revenue resource	337,625	3,192	**340,817**
Net operating cost for the financial year	337,625	3,192	**340,817**
Underspend / (overspend) against revenue resource	**-**	**-**	**-**

The CCG has delivered a breakeven position in 2022/23.

	12 months to 31 March 2022 Programme Resource £000	12 months to 31 March 2022 Administration Resource £000	12 months to 31 March 2022 Total £000
Revenue resource	1,495,241	13,081	**1,508,322**
Net operating cost for the financial year	1,489,537	12,335	**1,501,872**
(Overspend) / underspend against revenue resource	**5,704**	**746**	**6,450**

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

Opinion

We have audited the financial statements of NHS Tees Valley Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 17, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Tees Valley Clinical Commissioning Group as at 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

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

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 16 - Events After the End of the Reporting Period, which describes the Clinical Commissioning Group's transition into the North East and North Cumbria Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's, or the successor body's, ability to continue as a going concern for a period through to 30 June 2024, being 12 months beyond the date of authorisation of these financial statements.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or

conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2022 to 2023; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the three-month period ended 30 June 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 88-89, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal

control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility for the audit of the financial statements

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

• We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

• We understood how NHS Tees Valley Clinical Commissioning Group is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit, those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our reading of the CCG's minutes, review of the CCG's Constitution and Governance Handbook and enquiry of employees to confirm the CCG's policies. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

• We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. Based on our risk assessment procedures, we identified manipulation of reported financial performance through improper recognition of year end non-NHS accruals and management override of controls to be our fraud risks.

• Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management, the head of internal audit and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

• We addressed our fraud risk related to improper recognition of year end non-NHS accruals by substantively testing all material non-NHS accrual balances and a sample of smaller value non-NHS accrual balances, considering the appropriateness of management judgements and assumptions and the relevance and reliability of information used to inform each accrual.

• We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in January 2023 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the three-month period ended 30 June 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

Certificate

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

Use of our report

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

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