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Performance report

Performance overview
This section includes a statement from the clinical chair and chief officer, information about our CCG including our vision, and the areas we have focused on in 2018/19. All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Statement from the clinical chair and chief officer
Welcome to the NHS North Tyneside Clinical Commissioning Group (CCG) annual report for 2018/19.

We are responsible for commissioning (planning and buying) the majority of health services for people across North Tyneside. As a clinically-led organisation, we are in a unique position to understand the needs of our patients, which helps us to deliver high quality services for the 219,954 service users in our borough.

As the CCG moves towards a more stable financial position, we have taken the opportunity during 2018/19 to review our local service priorities over and above the nationally mandated priorities. These priorities include ways of working and how we wish to develop both as a CCG and in relation to the services we commission on behalf of the patients and public of North Tyneside.

Our key achievements over the year include:

- Establishment of the Future Care Board

Future Care is North Tyneside’s Transformation Programme which encompasses the majority of the CCG’s work. Future Care requires all of the partners in the health and social care system to come together to make the identified changes. During 2018/19, we established the Future Care Programme Board, bringing together the key stakeholders who will be influential in developing the services which fall within the Programme.

- Opening of the North Tyneside Urgent Treatment Centre

We successfully completed procurement of a new integrated urgent care service. We listened to patient and public feedback from the consultation and engagement exercises which we undertook and heard that people wanted urgent care services in one place and North Tyneside General Hospital was the preferred location.

The new service, dealing with minor injuries and minor ailments, commenced on 1 October 2018 and offers a GP-led healthcare 24 hours a day, 7 days a week. The new service allows patients to book appointments 24/7, via the NHS 111 service, as well as having the option to
walk-in between 8.00am and midnight. There is also a GP out of hours service, which will offer advice and help, including home visits and which is accessed by calling NHS 111.

- Increased investment in mental health provision

During 2018/20, the CCG, with partners, implemented a number of initiatives and invested in services where appropriate to improve their quality and access.

For children and young people, we worked very closely with North Tyneside Council and with charitable organisations to better understand how to engage with young people and children. This resulted in new services being commissioned, increased investment in existing services, and development of closer ways of working between schools and mental health professionals.

We also commissioned new adult mental health crisis services as a result of engagement exercises with patients, committed investment to re-establish the Mental Health Recovery College in North Tyneside and increased investment into the North Tyneside Talking Therapies service so that it could expand its remit to help more people with Long Term Conditions.

We were delighted to achieve a rating of outstanding for mental health services in North Tyneside from the national Improving and Assessment Framework. Mental health will continue to be a priority for the CCG moving forward into 2019/20.

- Development of Primary Care Localities, preparing the way for Primary Care Networks

The CCG is proud of its work with primary care during 2018/19. There are four Primary Care Localities operating within the North Tyneside footprint, led by North Tyneside GPs. The Primary Care Localities have been working to strengthen and redesign primary care services in North Tyneside. This has involved staff coming together from a range of services to determine what is needed locally and how care can be provided closer to patients’ homes.

From this work, several initiatives have been implemented during 2018/19, including extension of the Falls prevention service, enhancing health in care homes and development of respiratory services. To assist GP Practices with this work, the CCG made funding available to Practices to enable them to develop those, and other initiatives. This work has paved the way for development of Primary Care Networks in 2019/20, as aligned to the NHS Long Term Plan.

Much of what has been achieved, as described above and throughout this Annual Report, has been because of the relationships and partnership working with key stakeholders and organisations. We would like to thank those organisations and people who have been involved in helping us to continue to improve health services for the people of North Tyneside.

Finally, we would like to take this opportunity to offer our congratulations to Dr Mark Westwood, a GP at the Village Green Surgery in Wallsend, who has won a top national award for his work on the Great North Care Record.

Dr Westwood has worked tirelessly on the project and has been incredibly influential in encouraging GPs across the North East to sign up to the Great North Care Record, so that GP
records can be shared across urgent, emergency, out of hours and mental health services to help improve care for patients.

Dr Richard Scott  
Clinical Chair

Date: 21 May 2019

Mark Adams  
Accountable Officer

Date: 21 May 2019
About NHS North Tyneside Clinical Commissioning Group

NHS North Tyneside CCG has overall responsibility for the development and planning of healthcare services for the borough, covering a population of 219,954 (based on the 2018 NHS England allocations).

All 27 GP practices in North Tyneside are members of the CCG, supported by healthcare professionals and managers. The practices are close to patients and are well placed to develop local health services to make them more responsible to the needs of the people of North Tyneside.

The NHS is facing a continuing period of unprecedented challenges. For North Tyneside Clinical Commissioning Group these challenges include:

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

North Tyneside CCG is dedicated to providing the best possible patient care to our community. We place the needs of our patients at the heart of every decision, which means we are constantly looking for ways to improve healthcare and health outcomes for the borough.

Our strategic principles are:

- High quality care that is safe, effective and focused on patient experience
- Services coordinated around the needs and preferences of our patients, carers and their families
- Transformation in the delivery of health and wellbeing services provided jointly with the local authority, other public sector organisations and the private and voluntary sector
- Best value for taxpayers’ money and using resources responsibly and fairly
- Right services in the right place delivering the right outcomes

The CCG has the quality of patient provision at its heart and constantly seeks to ensure that, through the work with our partners, we continue to improve the quality of services for the patients in North Tyneside.
Contracting & Finance Summary 2018/19

The NHS Operational and Contracting Guidance for 2017 to 2019 was published in September 2016 and refreshed in February 2018. This guidance explains how the NHS is expected to discharge its contractual responsibilities with service providers and how it will plan to work with partners to improve the quality of services as well as people’s health and wellbeing.

Because two-year contracts had already been entered into during 2017/18 and CCG operational plans written accordingly, the 2018/19 guidance required CCGs to provide a refresh of the existing operational plan.

CCGs were directed to take into account the priorities identified in the national guidance which focused on ‘must do’s’, including protection of investment in mental health, cancer services and primary care and also to continue to develop system-wide plans to describe how commissioners and providers will collaborate to improve service and manage budgets.

Our approach in North Tyneside was to review the 2017/18 & 2018/19 plan to provide the updates required by the national guidance but also to use the opportunity to update on other areas of progress.

We published our updated plan in April 2018. In it we describe how the CCG will continue to work to achieve the nationally identified nine ‘must do’s’, as well as other pathway and quality changes and developments. Much of the work already started in North Tyneside is to address the key priorities of the national planning guidance and key strategic documents such as the NHS Five Year Forward View, Mental Health Forward View and the GP Forward View.

The CCG has a financial objective to meet its financial duties and support delivery of other corporate objectives. Over the last four years, the CCG has successfully implemented its financial recovery plan, delivering savings of around £45m. This work has put the CCG in recurrent financial balance and it is making good progress in repaying the deficit it accumulated. The deficit peaked at £19.3m and is £5.9m at the start of 2019/20. The CCG has also improved its underlying financial position.

Delivery of our financial targets is important because it will allow the CCG to commission high quality care for patients on a sustainable basis and the financial plan supports providers and our key quality developments. Looking forward, the improved financial position allows the CCG to begin implementation of the NHS Long Term Plan.
Our vision, plans and priorities

Our vision is:

“Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of resources”

We strive to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed. Our strategic priority themes for changing the health care system are:

- Keeping healthy, self-care
- Caring for people locally
- Hospital when it is appropriate

Our strategic vision is supported by ambitious plans to change the way that care is delivered by 2020. Figure 1 below gives a pictorial representation of the CCG’s commissioning priorities which echoes our vision.

Figure 1: Commissioning priorities
We are already progressing the development of a local approach towards integrated services for older people and reshaping primary care to meet future demand. Improving and developing the integration of health and social care is also an important cross cutting priority for both the CCG and local authority.

Many of our plans are based on the Future Care Programme, which brings together existing strands of work to deliver sustainable care closer to home, with hospital by exception.

We are very conscious of the various national standards and performance requirements and always strive to achieve high quality care. We have set ambitions for achievement of the NHS Constitution Performance standards which includes achievement of current mental health standards, progress in achieving the cancer standards and also how the CCG continues to work with the Northumberland & North Tyneside Local A&E Delivery Board to achieve the A&E standards.

We have continued to oversee quality improvements via support for the various quality systems and processes in place to provide assurance that requirements are being met.

Our local plans have been reviewed to ensure they align to sustainability and transformation partnerships and the emerging Integrated Care System for the North East and North Cumbria. Our plan includes how the CCG will work in collaboration with our partner organisations to help deliver our vision for healthcare in North Tyneside.

Key issues and risks

We identified a number of key risks to the achievement of our corporate objectives during 2018/19. The following risks were closed throughout the year following effective management:

- Risk of unexpected and unacceptable decline in quality of services due to a focus on the Financial Recovery Plan
- Risk of delayed mobilisation of the urgent care contract leading to a failure to respond effectively to local healthcare needs
- Failure to mobilise 111 Clinical Advisory Service (CAS) service

The CCG continues to manage the following corporate risks into 2019/20:

- Delayed transfer of primary care records and/or medical supplies
- Intermediate Care - delayed discharges and/or patients not realising their potential for rehabilitation
- Delayed ambulance handovers
- Contingency arrangements in the event of a no deal EU exit are not in place
- Inconsistency with the quality and timeliness of electronic discharge summaries (EDSs) from hospitals to GP practices and community teams
- The prescribing of contraindicated medications
- Untested new service delivery models
- Undetermined capacity in primary care

Strategic risks i.e. those which may undermine the CCG’s ability to meet its statutory duties remain on the Risk Assurance Framework permanently to provide assurance that the risks are being effectively managed. The Accountability section of this report explains how the CCG manages risk.

**Performance summary**

We have used two main sources of influence to help us determine our priorities: the requirements of the national planning and contracting guidance and also the invaluable feedback we have received from various public engagement and involvement exercises.

In addition, the CCG considers the risks and areas of uncertainty identified on its Risk Assurance Framework and ensures that performance in these areas is closely monitored, e.g. maternity services and cancer 62 day waits. Where possible and appropriate, we use national data sets as our KPIs to help us monitor and improve performance as well as locally determined KPIs.

Future Care is the banner under which most of our transformation programmes are undertaken. We have established a Future Care Board which includes representation from all of the statutory sector health organisations, local authority, voluntary sector, HealthWatch and patient and carer representatives. This group provides oversight and governance to this programme.

Future Care encompasses four themed work streams:

- Primary Care Home
- Urgent and emergency care
- Planned care, long term condition management and NHS RightCare
- Children and young people

We describe Future Care in more detail later in this document.

The national planning guidance identified three main priorities for CCGs to focus on in 2018/19:

- Cancer provision
- Mental health services
- Primary care services, specifically GP services
For cancer provision, we had developed a three year cancer plan, with six priority areas of focus identified. Work has already begun on each of these priority areas, which we describe in more detail in the Performance Analysis section of this report.

We do still need to make improvements in some areas of cancer services, working with our partners to do so. The cancer 62 day wait target, whereby patients should begin to receive treatment within 62 days of referral from their GP for suspected cancer, continues to be challenging, as it is for many areas nationally.

We are also involved in the regional work being undertaken during 2018/19 to shape and influence the design of tumour specific pathways and address challenges in the system. This includes establishing a lung cancer case finding steering group aiming to improve earlier detection of lung cancer. We are also addressing challenges in the breast cancer symptomatic service to relieve workforce pressures in the diagnostic areas.

We have also invested in local services to develop follow up pathways for patients with breast, colorectal and prostate cancer and to increase the number of people receiving a health needs assessment.

We have invested considerably in mental health services in North Tyneside in 2018/19, for both children and young people’s services and adult services. The focus on this expenditure is to improve access to services and, where possible and appropriate, offer alternatives to statutory service provision.

We were delighted to learn that the CCG has achieved a rating of “outstanding” for the mental health provision in North Tyneside for 2018/19, based on achievement of the nationally set mental health quality targets, as well as meeting the required financial investment in mental health provision called the Mental Health Investment Standard.

For primary care, we continued to implement the Primary Care Strategy which had been co-produced by the CCG, the Local Medical Committee (LMC) and Tynehealth, the GP Federation in North Tyneside. We also continued to fund a significant number of extra GP appointments in evenings and weekends to make it easier for people to access a GP appointment at a time more convenient to them. We have begun work with our GP Localities in North Tyneside to implement the national guidance on creation of Primary Care Networks.

Urgent care was also a local priority in 2018/19. We had previously undertaken a detailed engagement exercise to understand what people in North Tyneside wanted and we followed this up with another engagement exercise in 2017. From this, we successfully completed procurement of a new Integrated Urgent Care Service which opened at North Tyneside General Hospital in October 2018.

This means that patients can book an appointment 24/7 as well as having the option to walk-in to the Urgent Care treatment Centre between 8:00am and midnight. Patients can book into the centre through the NHS 111 service and can also access the GP out of hours service offering advice and help, including home visits.

We have also been, and continue to be, involved in regional work which has helped the region to record some of England’s best A&E performance records. The national performance targets
do show that we still have improvements to make, mainly around ambulance response times, and we will continue to work collectively with the North East and North Cumbria Urgent and Emergency Care Network as well as local providers and services to achieve the improvements needed.

We also recognise the importance of the learning disabilities transformation programme. This is aimed at ensuring that people with complex learning disabilities can be appropriately and safely supported closer to home and receive out of hospital care. The CCG continues to work with other CCGs and local authorities to develop a complex case framework that will ensure community based pathways are robust, fit for purpose and meet individual needs.

In relation to carers services, a number of priorities for North Tyneside have been identified and are described in the North Tyneside Commitment to Carers Plan. During 2018/19, we wrote a specific action plan for young carers across the health economy and worked with North Tyneside public health colleagues on a health needs assessment on the carer population in North Tyneside. We will use this assessment to help inform future planning and commissioning.

Quality of services is always a key priority for the CCG. To this end, we have in place robust structures and systems to ensure that the services we commission are of high quality and are safe for patients and staff. The CCG was represented on the relevant Quality Review Groups which are in place for all foundation trusts and local private hospital providers. These provide a focus on assurance relating to the clinical quality of commissioned services. The CCG also continued with its schedule of quality assurance visits, in partnership with the local authority, to all independent nursing homes in North Tyneside.

In 2018/19, we met all of the national performance standards on clinical areas. In terms of the Improvement and Assessment Framework annual assessment, we received a rating of “outstanding” for both mental health and diabetes services, a "good" rating for cancer, dementia and learning disabilities services but received “requires improvement” for maternity services.

As Accountable Officer I consider that overall the CCG has performed well during 2018/19. We continue to strive to make further improvements and emphasis on improving quality will continue into 2019/20.
Performance analysis

North Tyneside health and wellbeing overview

North Tyneside is one of the least deprived boroughs in the region and there is generally an improving picture of health and wellbeing.

Life expectancy has been increasing at all ages across the borough, which is very good news. The reasons are changes in infant mortality, improvements in medical treatments, improved standards of living such as good nutrition, cleaner air, fewer people smoking and generally better public health.

For those born 2012-2016 the life expectancy for both men and women has plateaued.

Figure 2: Life expectancy in North Tyneside

Healthy life expectancy has not increased at the same rate as life expectancy, leaving large numbers of people living the later stages of their lives in poor health, often with multiple long term conditions.

A woman can expect to live 62.1 years in good health at birth in North Tyneside (2014/16). This is similar to the England average (63.9 years), and higher than the North East average (60.6 years). Full life expectancy at birth in North Tyneside for women is 82.4 years (2014/16).
A man can expect to live 61.9 years in good health at birth in North Tyneside (2014/19. This is similar to the England average (63.3 years) and higher than the North East average (59.7 years). Full life expectancy at birth in North Tyneside for men is 77.9 years (2014/16).

Figure 3: Healthy life expectancy in North Tyneside

Relative deprivation in North Tyneside is improving. In the 2010 North Tyneside was ranked 113 out of 326 authorities (higher is better) in the Index of Multiple Deprivation (IMD). In the 2015 IMD, North Tyneside was ranked 130. However there are wide inequalities across the borough, with persistent pockets of deprivation particularly in the wards of Riverside and Chirton.

The gap in life expectancy between the most and least deprived areas within the borough is 11 years, and this gap has remained static during the last decade. Men in our most deprived wards live on average 11.7 years less than those residing in our least deprived wards and for women the corresponding figure is 10.6 years less.

Figure 4: Life expectancy gap
Premature mortality

- Cancer, cardiovascular disease (CVD) and respiratory disease are the leading causes of premature death in North Tyneside. Age standardised mortality rates for all three diseases are higher than the England rate.
- Cancer remains the most significant cause of premature mortality in North Tyneside with 888 deaths in 2015-17.
- Although CVD mortality has declined faster than cancer; there were still 461 premature deaths in 2015-17.
- COPD is one of the major respiratory diseases and smoking is a major cause of COPD. There were 214 deaths in 2015-17.
- People are also dying from liver disease at a younger age compared to the national average. Deaths due to liver disease are heavily influenced by both alcohol and obesity. In North Tyneside there were 135 deaths in 2015-17.
- Social factors, lifestyle choices and late presentation, diagnosis and treatment contribute to the premature mortality, however much of this premature mortality is preventable. The figure below highlights that there were 1,432 deaths in North Tyneside that were considered as preventable.

Figure 5: Preventable mortality in North Tyneside

In the period 2015-17 there were 1,432 deaths deemed to have been preventable deaths. The largest cause of these was cancer followed by cardiovascular disease, respiratory disease then liver disease.

Produced by Policy, Performance & Research
Lifestyle and behaviour

- Major risk factors for poor health include unhealthy diets, smoking, drinking too much alcohol and physical inactivity
- Just under two thirds (62.2%) of adults in North Tyneside are overweight or obese (2016/17)
- There are increasing numbers of people who have type 2 diabetes: there are 12,848 individuals in North Tyneside with type 2 diabetes (7.2%) and there is a further 2,147 (1.4%) individuals who have not been diagnosed
- It is estimated that 11.6% of adults have non-diabetic hyperglycaemia and thus represent an opportunity to prevent from developing type 2 diabetes
- The numbers of adults smoking in North Tyneside has significantly declined over the last decade to an all-time low of 16.5% (2017). However, there is variation in North Tyneside: 30% of adults in the most deprived areas of North Tyneside smoke compared to only 8% in our least deprived areas
- Alcohol related admissions to hospital are higher in North Tyneside compared to the national average. In 2016/17 there were over 1,700 people admitted to hospital for specific alcohol reasons
- 23.5% of the population is drinking at levels that risk damaging health
- 27.2% of adults are doing less than 30 minutes of exercise per week (2016/17)

Children and young people

- 17% of children are living in poverty. There is a persistent gap in educational attainment between disadvantaged children and other children in the borough
- The rate of obese children doubles between five year olds and 10 year olds. One in 10 children are obese aged 4-5, and one in five by aged 10. There is a clear relationship between deprivation and obesity
- 10.5% of 15 year olds are regular smokers (this is similar to the England average)

An ageing population

- North Tyneside’s population is getting older
- There are growing numbers of people with multiple long term conditions and frailty
- More than one in 10 of the adult population has a caring responsibility
- An estimated 14% of people over 65 years old are caring for someone
- There are just under 15,000 older people over the age of 65 who live alone
- The number of people aged over 75 living alone is predicted to rise by 41.9% by 2030
Reducing health inequality

Health inequalities have been defined as “Differences in health status or in the distribution of health determinants between different population groups”. Addressing health inequalities is crucial in tackling key challenges including preventing premature mortality, improving recovery from illness and enhancing quality of life for people with long term conditions.

We have regard to the need to reduce inequalities between patients in accessing health services for our local population.

In summary, the challenges within North Tyneside include:

- Ageing population with increasing needs
- Health inequalities between localities
- Increasing over reliance on hospital-based services
- Increasing high cost drugs and cost of new medical technologies
- Minimal growth in financial allocations and funding shift to social and primary care

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

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

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders.

We aim to ensure that comments and feedback from our local communities are captured and, where possible, give local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.
Health and wellbeing strategy

We work in close partnership with North Tyneside Council and actively support the development and delivery of the joint health and wellbeing strategies.

The CCG’s plans are aligned with the objectives and priorities of the strategy. The Local Authority Director of Public Health is in attendance at the CCG Governing Body and provides updates to the Committee as well as supporting the CCG with public health advice and support through the ‘Core Offer’.

Dr Richard Scott, CCG Clinical Chair from 1 April 2018, is a member of the North Tyneside Health and Wellbeing Board from this date.

The Health and Wellbeing Board (HWBB) Work Plan 2018-2020 was co-produced, following a refresh of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment. It resulted in a number of key priority areas being identified. The CCG’s refreshed Commissioning Priority Areas document has cross referenced those HWBB priority areas, clearly demonstrating the close synergy between the two sets of priorities.

The CCG has consulted with representatives of the Health and Wellbeing Board who have confirmed the CCG's contribution to the delivery of the joint Health and Wellbeing Strategy.

Our Operating Plan for 2018/19 includes detail of our health and wellbeing priorities. The document highlights the population changes expected over the next five years. It also describes how these population changes will impact on how services need to be provided to ensure that the CCG and partners meet local need and address both health and inequalities challenges.

In addition to regular attendance at the Health & Wellbeing Board throughout 2018-19, the CCG has led or been directly involved in the following Health & Wellbeing Board agenda items:

- Sustainability and Transformation Plan/emerging Integrated Care System (ICS)
- Pharmaceutical Needs Assessment and new pharmaceutical regulations
- North Tyneside Children and Young People’s Mental Health and Wellbeing and Emotional Wellbeing Strategy 2016-2021
- Adult and Older People Mental Health Strategies
- North Tyneside commitment to carers – meeting statutory duties
- Treating tobacco dependency and achieving a smoke-free generation in North Tyneside by 2025
- The CCG is also the regional lead for the National Diabetes Prevention Programme.
- Urgent care
- Better Care Fund
- Health, wellbeing and social care commissioning intentions 2018/19
- Refresh of the Joint Strategic Needs Assessment (JSNA)
Financial performance

Key financial performance indicators 2018/19

North Tyneside CCG has met the statutory requirement to ensure expenditure in a financial year does not exceed its allocated resource. In 2018/19, the CCG achieved an in-year surplus of £6.2m, reducing the brought forward 2017/18 deficit from £12.2m to £5.9m as at 31 March 2019.

Financial performance targets are reported in the notes of the annual accounts. Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). North Tyneside CCG’s performance against those duties was as follows:

Table 1: Financial performance targets

<table>
<thead>
<tr>
<th>Target</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>Achieved</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>Achieved</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>Achieved</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

In addition to the commissioning budget, the CCG had an initial annual running costs budget of £4.7m in 2018/19. This was spent on CCG staff and associated costs and on services from North of England Commissioning Support (NECS). The CCG operated small office premises in North Shields leased from NHS Property Services in 2018/19.

Financial outturn in 2018/19

The CCG 2018/19 annual accounts are provided in full as part of the annual report. During the year, the CCG commissioned healthcare services to the value of £346.6m and incurred expenditure of £4.4m in respect of running costs. The overall closing position of the CCG was an in-year surplus of £6.2m.
Table 2: CCG 2018/19 expenditure

<table>
<thead>
<tr>
<th>Service</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute health services</td>
<td>191.2</td>
</tr>
<tr>
<td>Mental health services</td>
<td>26.8</td>
</tr>
<tr>
<td>Community health services</td>
<td>37.9</td>
</tr>
<tr>
<td>Continuing health care</td>
<td>17.9</td>
</tr>
<tr>
<td>Prescribing</td>
<td>33.4</td>
</tr>
<tr>
<td>Primary care</td>
<td>35.6</td>
</tr>
<tr>
<td>Other programme costs</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Total programme (commissioning) costs</strong></td>
<td>346.6</td>
</tr>
<tr>
<td><strong>Total running costs</strong></td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Total expenditure for 2018/19</strong></td>
<td>351.0</td>
</tr>
</tbody>
</table>

The majority of the CCG’s expenditure was spent with NHS organisations, purchasing healthcare for the benefit of North Tyneside residents. Funds were also used to purchase healthcare from non-NHS bodies, as indicated in the accounts.

There were no reported incidents of fraud, bribery or corruption during 2018-19.

Table 3: CCG 2018/19 acute expenditure

<table>
<thead>
<tr>
<th>Trust</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumbria Healthcare NHS Trust</td>
<td>115.1</td>
</tr>
<tr>
<td>Newcastle upon Tyne NHS Trust</td>
<td>64.5</td>
</tr>
<tr>
<td>North East Ambulance Service NHS Trust</td>
<td>6.8</td>
</tr>
<tr>
<td>Other NHS Acute Services</td>
<td>2.6</td>
</tr>
<tr>
<td>Other Non NHS Acute Services</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Total 18/19 Acute Services Expenditure</strong></td>
<td>191.2</td>
</tr>
</tbody>
</table>

**Better Payment Practice Code**

The Better Payment Practice Code requires all CCGs to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. North Tyneside CCG has met the requirements of the code, as reported in the annual accounts and indicated in notes to the accounts.
Financial plans for 2019/20

The CCG allocation for 2019/20 is £374.1m as follows:

Table 4: CCG financial allocation

<table>
<thead>
<tr>
<th>£000’s</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
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<td>Programme Baseline Allocation</td>
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<tr>
<td>Primary Care Co-commissioning</td>
<td>28.9</td>
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<tr>
<td>Running Cost Allocation</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>374.1</strong></td>
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Current plans identify that the CCG will spend £370.6m in 2019/20 (£366.1m commissioned services and £4.5m administration) which will generate an in-year surplus of £3.5m. This is the level of surplus specified by NHS England.

We are required to recover our brought forward deficit. The planned surplus for 2019/20 will be used to reduce the brought forward deficit of £5.9m. An efficiency savings programme of £6.5m has been developed in 2019/20 and will need to be delivered in full to achieve the planned outturn.

Respect for human rights

The CCG is committed to equality, diversity and human rights (EDHR) in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

Social matters

The CCG takes its social responsibilities seriously. During 2018/19 the CCG has approved the introduction of a VCS scheme for a grant scheme which will enable the voluntary and community sector (VCS) to apply for grants which support the delivery of CCG objectives.

The CCG has also worked with Barnardos to develop an apprenticeship scheme to encourage young people into the workplace.

The CCG has also encouraged apprenticeships from the ‘Project Choice’ scheme for people with autism and learning disabilities. This has resulted in a post being made permanent within the CCG following successful completion of the apprenticeship.
The CCG also routinely includes a question on social value when it is undertaking procurements and bidders are evaluated as to their response to this question.

**Sustainable development**

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 us to pay particular attention to energy, travel, waste, procurement, water, infrastructure and buildings.

As a commissioner of healthcare services and as an employer, the CCG recognises the need to minimise our impact on the environment. Use of technical solutions for meetings (i.e. video/teleconferencing and webinars) are promoted to reduce travel across, which in turn reduces the CCG’S carbon footprint.

**Carbon footprint**

The CCG is supported by NHS Property Services to ensure plans to reduce the carbon footprint are in line with the recommendations of the Sustainability Development Unit of NHS England.

**Travel**

We can improve local air quality and improve the health of our community by promoting active travel to our staff. The CCG supports it staff through a cycle to work scheme.

**Programmes of work**

In this section, we describe the main programmes of work which we undertook during 2018/19, taking into account our vision, and priorities, as well as using the information contained in the North Tyneside Health & Well-being Overview section above to inform our work.

Where there are national performance standards or constitutional standards to a particular programme, we have detailed how we rated against that standard as at the end of 2018/19 and provided some analysis to explain this rating.
Future Care

Future Care is North Tyneside’s Transformation Programme, the principles of which are:

- Delivering Population Health and Wellbeing
- Delivering high quality, coordinated care
- Improving quality of life and experience of services
- Supporting and empowering staff
- Providing effective stewardship of resources.

A central component of Future Care is development of a new model of community and primary care provision to support a move in resources from acute to primary and community services, as well as working in four localities across North Tyneside to support local delivery where appropriate.

Future Care requires all of the partners in the health and social care system to come together to make the identified changes.

The multiagency Future Care Board involves all of the NHS Foundation Trusts working in North Tyneside, the ambulance service, TyneHealth GP Federation, North Tyneside Local Authority, Public Health, GP practice representatives, VODA, HealthWatch, patient representatives, the independent sector and the CCG itself. This group provides oversight and governance to this programme and was established during 2018/19.

The programme of work has the following themed work streams which will focus on achievement of agreed outcomes:

- Primary Care Home
- Urgent and emergency care
- Planned care, long term condition management and NHS RightCare
- Children and young people

It should be noted that mental health has been included in each of the four work streams, rather than as a stand-alone work stream.

There are a number of prioritised projects under each work stream as well as a number of system cross cutting enablers/risks (each with their own work plan) which include

- IT
- Workforce
- Communication and engagement
- Parity of esteem
- Safeguarding
- Better Care Fund
**Primary Care Home**

We began laying the ground work for local Primary Care Home in 2018/19. Primary Care Home (PCH) is an innovative approach to strengthening and redesigning primary care in line with the ambitions set out in the NHS Long Term Plan (2019).

Developed by the National Association of Primary Care (NAPC), the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

PCH identifies those services which would benefit most from being provided at a locality level, either by moving care closer to the patient, enriching clinical teams, or because the current model is simply no longer sustainable.

Staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients’ homes.

The following initiatives fall within the auspices of Primary Care Home in North Tyneside

- A range of events have been held during 2018/19 to help to shape and design the model for Primary Care Home in North Tyneside
- The service pathways for end of life care were reviewed during 2018/19
- For the Care Plus/Care Point and falls services, IT systems were improved, the referral pathway redesigned and the falls pilot was extended
- Following an older person’s pathway mapping exercise, the intermediate care service pathway was analysed and redesigned during 2018/19. The next phase of provision of intermediate care services is now underway.
- A number of quality measures were put in place, enhancing health in care homes. Additionally, more staffing is being recruited at locality level to provide more input and resource into care homes

**GP extended access**

During 2017/18, we worked with the GP Federation and GP practices in North Tyneside to implement a system to provide more GP appointments every month. During 2018/19, we continued to fund a significant number of extra GP appointments across afternoons, early evenings and weekends.

The scheme means that it will be easier for patients to arrange appointments with a GP, particularly for those people who find it difficult to attend during the day. The service is provided by local GPs and offers appointments within a number of existing GP surgeries across the area.
**Urgent care**

**Integrated urgent care service**

We successfully completed procurement of a new integrated urgent care service. The new service commenced on 1 October 2018 and offers a GP-led healthcare 24 hours a day, 7 days a week.

The new urgent care centre is based at North Tyneside General Hospital (Rake Lane), in line with the overall preference expressed by patients during the consultation process in 2017. The new service deals with minor injuries and minor ailments and is separate from A&E, which provides emergency care for life-threatening conditions.

The new service replaced the previous urgent care centres at Battle Hill and North Tyneside General Hospital and differs from the previous provision as it not only brings all urgent care services in one place but also allows patients to book appointments 24/7 as well as having the option to walk-in between 8.00am and midnight.

The new urgent care centre integrates with the 111 service. The 111 service can book appointments directly into the urgent care centre. The service incorporates a GP out of hours service, which will offer advice and help, including home visits, between midnight and 8am.

**North East and North Cumbria Urgent and Emergency Care Network**

North Tyneside CCG is an active part of the North East and North Cumbria Urgent and Emergency Care Network which brings together over 30 organisations to improve the quality, safety and equity of access to services.

Established through the ‘New Models of Care’ (vanguards) programme, the network has led on a range of innovations which have helped the region to record some of England’s best A&E performance figures and road-tested a series of changes to improve and ease the pressure on services. These include extra clinical support for 999 and 111, the ‘flight deck’ demand monitoring system, and ‘Respond’ mental health training.

This vital work is continuing through an ambitious three-year strategy to reduce hospital admissions and A&E attendances, make better use of GPs and pharmacists, and help patients improve their own health.

Through the network, the region’s hospitals work together as a single, well-coordinated system, monitoring demand, sharing information in real time, and supporting each other through busy periods. This means emergency responses are better coordinated and the risk of queueing ambulances and unnecessarily long waits in A&E is reduced.
This whole system approach includes:

**GP ring back scheme** allows ambulance clinicians to have direct contact with the patient’s own GP practice helping to address ambulance delays and improve patient care and experience. An initial pilot across Durham, Dales Easington and Sedgefield CCG began mid-November 2018 and evaluation in January 2019, to ensure an effective regional roll out and implementation of any required changes.

It is expected that there will be reductions in time on scene and conveyances to hospital, while increasing care closer to home and providing a better patient experience.

**New NHS 111 online service** went live in July 2018 and provides a digital option for patients accessing urgent care in the North East and North Cumbria.

Patients are able to receive self-care advice via their smart phone, tablet or computer, be signposted to pharmacy and optician services, be referred to GP services and receive telephone call-backs from clinicians when appropriate.

**Free NHS falls training for care home staff** is a one-day training course, specially designed for care homes in the region and is helping staff give the best possible support to residents who suffer falls. The course is delivered by the North East Ambulance Service NHS Foundation Trust, with funding from NHS England and support from the North East and North Cumbria Urgent and Emergency Care Network.

**Winter funding for 2018/19 allocated by NHS England** for schemes to deliver against the UECN strategy were agreed for a small number of priority schemes. These are:

- **Consultant connect system** – offering phone advice & guidance allowing GPs to contact local physical and mental health specialists directly and immediately
- **Point of care testing for norovirus and flu** – to enable point of care testing for flu and norovirus in emergency departments
- **Regional communications campaign** – regional messages aimed at educating patients about NHS services, encouraging the most appropriate NHS service to be chosen and the use of self-care
- **Specialist cardiology transport** – provide a dedicated cardiology transport vehicle to Freeman Hospital between November 2018 and end of March 2019
The UEC-RAIDR app shows where providers across the system are experiencing pressure, offering real-time information on Operational Pressure Escalation Levels (OPEL) ratings, ambulance activity, patients present, bed availability and emergency department waiting times. Including:

- An ambulance view showing the overall position with vehicles at each site and en route to hospitals
- Hospital escalation action plans will be available for use within hospitals to inform system partners of actions as they are taken
- General practice and pharmacies will be able to flag when they are experiencing a surge.

Urgent treatment centres standardisation to a core set of standards means that it will be much clearer and less confusing to patients about what centres offer in terms of opening times, the types of staff present and what diagnostics may be available.

Flight deck portal allows hospitals to share real-time information about bed capacity and escalation levels - is now a key part of the region's approach to surge management. Hospitals in the North East and North Cumbria work closely together as a single managed system, monitoring levels of demand from hour to hour and supporting each other through busy periods.

Respond is a pioneering initiative, bringing together the full range of professionals involved in mental health crisis care to learn together using a simulated scenario with audio and video clips. Over 400 professionals in the North East have already completed Respond training, which is accredited by the Continuous Professional Development certification service, so professionals can earn credits for their learning.

Digital care means thousands of patients are benefiting from better, safer care, thanks to a new system supported by the network. In the past, different parts of the NHS have had their own paper records and exchanged information using letters, telephone and fax. As a result, important information held by GPs, such as medications prescribed and test results – was not easily available to other healthcare professionals at the point of care. Now, in the North East region, 100% of the regions 340 GP practices have agreed to share patient records with emergency doctors, nurses and paramedics, using the Medical Interoperability Gateway (MIG) system.

The MIG offers secure, real-time access to a summary of GP-held records so clinical decisions are made using the most up-to-date information, such as diagnoses, medications, details of hospitals admissions and treatments.

Over 40,000 patient records are successfully accessed each month, resulting in safer, faster, more effective care, with less time wasted getting hold of medical records, or answering questions more than once.

Rolling out the MIG is an important first step towards the long-term vision for a Great North Care Record.
Direct GP bookings through NHS 111 with 96% of GP surgeries in the North East committed to accepting appointments through NHS 111, putting the region in the forefront of change within the NHS nationally. This equates to 328 of the region’s 340 GP practices who are committed to the scheme, patients are already benefiting from the convenience of a streamlined service, knowing that one call will get them the care they need.

Since the service was launched in June 2016, more than 42,000 appointments have been booked electronically through NHS 111, helping the NHS to direct patients to the right service and reducing the risk of individual patients disregarding clinical advice by turning up at A&E after being referred to their GP by call handlers.

As the first region to implement GP bookings through NHS 111 on this scale, the North East and North Cumbria is now advising NHS England about how to include direct bookings in national GP contracts in future.

Emergency Care Improvement Programme (ECIP) team has helped two of the region’s hospital trusts to analyse complex issues around patient flow and capacity.

ECIP, which offers intensive clinically-led help to urgent and emergency care systems around quality, safety and patient flow, has worked with Northumbria Healthcare NHS Foundation Trust and County Durham and Darlington Foundation Trust to help them address issues around ambulance handover delays and improve against the 95% emergency department standard.

The Directory of Services (DoS) is a web-based directory with real-time information about services. Several on-going initiatives means that the information is constantly improving so it can better guide NHS 111 and 999 referrals and reduce the pressure on emergency departments.

NHS child health app helps parents who lack confidence to deal with common childhood illnesses as well as reducing the pressure on services. Children account for a high proportion of A&E attendances in the North East, but around 60% under-fives are discharged with no treatment.

Strong demand in recent months has seen over 19,000 downloads to date, with the app being shortlisted for several national awards.

Urgent and emergency care regional campaign

The aim of the campaign is to raise awareness in the most effective way to influence people’s decisions about the best use of health services, and significantly change the use of urgent care services across the North East.

The campaign ran for 12 months, mapped against peak surge activity at key times of the year. It was integrated with national campaigns by NHS England and Public Health England to deliver planned locally tailored communications activities.

Local activities included the use of digital, media advertising and out of home activity. The campaign will continue to be used as part of surge management and delivering against the
insight developed as part of the behavioural analysis work into the views and behaviours of urgent and emergency care.

The campaign evaluation showed that:

- People remembered seeing the plasticine people ads in various places, including on Facebook, in GP practices, on the back of buses, through posters displayed in public places, in pharmacies, and on TV
- People were more likely to recognise the ads about coughs and colds, and what is in peoples first aid kits, but also recognised the ads for GP evening and weekend appointments, and the NHS child health app
- People reported changing their behaviour as a result of the ads, including: contacting their pharmacist for advice, downloading the NHS child health app, creating or updating a first aid kit, finding out about GP and pharmacy opening times and arranging an evening or weekend GP

**Winter pressures**

As part of the North East and North Cumbria Urgent and Emergency Care Network, all CCGs worked together to develop a regional winter surge management campaign to help reduce pressure on A&E services in the region. Key priorities identified included:

- Proactive support and management of the frail elderly
- Improving pathway flows though A&E for children younger than 2 years old
- Increase flu uptake
- Point of care testing for D&V and Norovirus
- Increase capacity in primary care
- Increase numbers of available discharge vehicles

In addition, the Northumberland and North Tyneside Local A&E Delivery Board implemented a whole system approach to improve resilience. Plans were implemented in A&E that included capacity management to ensure flexibility in the system to manage ‘pinch points’. The introduction of nurse navigators and clinical flow facilitators helped to ensure safe, timely transfer of patients and improve efficiencies ambulance handover times.

A regional wide campaign used ‘plasticine’ people to help to highlight good self-care, raise awareness of GP extended access, and to promote the NHS Child Health app.

**Performance measures 2018/19**

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<thead>
<tr>
<th></th>
<th>Met expected standard</th>
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<tbody>
<tr>
<td></td>
<td>Just below expected standard</td>
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</table>
All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Urgent care performance

There are five national measures relating to urgent care performance. North Tyneside CCG’s performance in 2018/19 is detailed below:

Four hour waits in A&E

The principal measure used to assess local urgent care performance is the standard that 95% of patients attending A&E will be admitted or discharged within four hours.

95.9% of patients who attended A&E were seen and treated within four hours. This is an increase from the previous year, which brings the CCG performance above the national standard.

Ambulance response times

In July 2017 NHSE published a new set of performance standards for the English ambulance services through the national Ambulance Response Programme (ARP).

It is expected that changing the performance standards (set 1974), will free up more ambulance crews to respond to emergencies, giving the opportunity to send the most appropriate response to each patient first time.

Category 1 response time

The average time an ambulance took to respond to a category 1 ambulance call was 6 minutes and 3 seconds. This is below the national standard of 7 minutes.

Category 2 response time

The average time an ambulance took to respond to a category 2 ambulance call was 18 minutes and 28 seconds. This is above the national standard of 18 minutes. The number of unscheduled care incidents has risen by 5.4% in North Tyneside which has impacted upon response times. We are working with the provider and an action plan is in place to ensure that the target is met in 2019/20.

Category 3 response time

90% of all category 3 ambulance calls were responded to within 2 hours, 45 minutes. This is above the national standard of 2 hours 0 minutes.
The number of unscheduled care incidents has risen by 5.4% in North Tyneside which has impacted upon response times. We are working with the provider and an action plan is in place to ensure that the target is met in 2019/20.

**Category 4 response time**

90% of all category 4 ambulance calls were responded to within 2 hours, 51 minutes. This is below the national standard of 3 hours 0 minutes.

**Cancer services**

The NHS England National Cancer Strategy, Achieving World-Class Cancer Outcomes, was published in 2015 by the Independent Cancer Taskforce. The taskforce looked at how cancer services are currently provided and sets out a vision for what cancer patients should expect from the health service.

Building on “Achieving World-Class Cancer Outcomes Strategy 2015-2020, we established a multi-agency steering group chaired by Dr Clare Scarlett and includes representation from acute, community, public health, primary care, North East and Cumbria Cancer Alliance and the voluntary sector. The steering group is supported by a Public Engagement Task & Finish Group who play an integral role in shaping the development of our three year cancer plan.

The plan has been developed over an 18 month period and focuses on six priority areas spanning over a three year programme of delivery. The plan covers all elements of the patient pathway starting with prevention through to improvement in mortality rates. Most importantly, the plan puts patients at the centre with the aim of ensuring patients receive the right care, at the right time, at the right place.

Work has already begun across all six priority areas. During 2018/19 a number of initiatives have been launched that will form the basis for a long term sustainable programme in cancer care.

**Achievements to date:**

**Priority 1: Spearhead a radical upgrade in prevention and public health**

- As from April 2018 Northumbria Healthcare NHS Foundation Trust became the first acute trust to achieve smoke free status
- Provision of a health improvement programme on alcohol, smoking, diet and healthy weight
- Improve cancer screening awareness in the most deprived areas of North Tyneside
- Develop an education offer for primary care that includes the delivery of Very Brief Advice with the aim of improving smoking quit rates
Priority 2: Achieve earlier diagnosis

- 90% of practices completed the National Cancer Audit
- Develop a programme of practical support in primary care in partnership with Cancer Research UK
- Implementation of new lung cancer pathway
- Provide a guidance and information support to practice nurses and GPs on the best utilisation of discharge plans and discharge summaries

Priority 3: Establish patient experience on par with clinical effectiveness and patient safety

- Establishment of an Engagement Task and Finish Working Group made up of representatives from North Tyneside CCG, Northern Cancer Alliance and Macmillan Cancer Support to take priority three of the cancer plan forward
- Engagement event for North Tyneside Cancer Steering Group members and the general public held in October 2018, which provided an opportunity to develop knowledge and skills and share ideas
- Public Engagement Task and Finish Group established consisting of service users, carers and community organisation representatives, currently co-designing the next public engagement event in March 2019.
- Key stakeholders identified along with a planned approach to communications with the aim of raising the profile of the North Tyneside Cancer Plan work across the borough

Priority 4: Transform our approach to support people living with and beyond cancer

- Appointment of Living With and Beyond Cancer Project Team to implement stratified pathways in breast, colorectal and prostate cancers
- Successful roll out of the Living With and Beyond breast cancer pathway
- Developed a recovery package for patients living with cancer including Holistic Needs Assessment and the introduction of Health and Wellbeing programmes for patients

Priority 5: Make the necessary investments required to deliver a modern high quality service

- Recruitment of Community Development Workers to raise cancer awareness across North Tyneside
- The development of Cancer Champions in Primary Care

Priority 6: Ensure commissioning provision and accountability processes are fit for purpose

- Closer collaborative working with the North East and Cumbria Cancer Alliance in the development of joint approaches such as faster access to diagnostics, workforce development etc.
Performance measures 2018/19

=G= Met expected standard

=A= Just below expected standard

All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Cancer performance

There are 11 national performance standards relating to cancer. North Tyneside CCG’s performance in 2018/19 (April 2018 – February 2019) is described below. All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

Cancer performance is a priority area for the CCG. Some of the issues are system wide and require joint working across CCG and provider boundaries in order to address issues.

Two week wait all cancers

94.9% of patients referred by their GP urgently with suspected cancer were given an outpatient appointment within two weeks. This is above the national standard of 93%. The CCG is consistently one of the top performing CCG’s in the region for this measure.

Two week wait for an urgent referral for breast symptoms

94.9% of patients who were referred urgently with breast symptoms were seen within two weeks. This is above the national standard of 93%. The CCG has remained above the national standard for the past four years and is consistently one of the top performing CCG’s in the region for this measure.

31 day treatment – all cancers

97.3% of patients who were diagnosed with cancer waited less than 31 days for their treatment to commence. This is above the national standard of 96%. Performance has remained above the national standard for the last five years.
31 day treatment - surgery

93.5% of people diagnosed with cancer and requiring surgery waited less than 31 days. This is a decrease on the previous year and does not meet the national standard of 94%. The CCG experienced a large number of breaches during the summer 2018 which contributed to the under-performance. We are working with our providers and an action plan is in place to ensure that the target is met in 2019/20.

31 day treatment - anti-cancer drugs

98.6% of patients who required drug treatment for a cancer diagnosis waited less than 31 days to receive their treatment. This is a slight increase on the previous year and above the national standard of 98%.

31 day treatment - radiotherapy

99.3% of patients who were diagnosed with cancer and required radiotherapy waited less than 31 days for their treatment to begin. This is a slight increase on the previous year and above the national standard of 94%.

Patients treated within 62 days - urgent GP referral for suspected cancer

81.4% of patients who were diagnosed with cancer following an urgent referral from their GP waited less than 62 days for their treatment to begin. This is a decline on the previous year and does not meet the national standard of 85%. The CCG is working with providers and to meet the standard for 2018/19. Both Foundation Trusts have experienced an increase in patient numbers which has contributed to under performance.

62 days screening to first treatment for cancer – screening service

93.4% of patients who were diagnosed with cancer following referral from an NHS Screening Service waited less than 62 days from that referral for treatment to commence. This is an increase on the previous year but above the national standard of 90%.

Cancers diagnosed at an early stage

53.5% of all new cases of cancer diagnosed are at stage 1 and 2. This rate is increasing year on year.
One year survival from all cancers

70.9% of adults diagnosed with cancer are still alive one year after diagnosis. This is below the England average of 72.8%. The CCG has developed a three year cancer plan, some of which targets improving early diagnosis. The work on early diagnosis will take a number of years to impact upon reported performance.

Cancer patient experience

8.9 scored out of 10 for the questions “Overall, how would you rate your care?” on a scale from 0 (very poor) to 10 (very good). The CCG is in the highest performing quartile across England.

Regional approach for cancer diagnoses

As well as North Tyneside specific work on cancer as described above, work was also undertaken on a regional basis.

We continue to work closely across all Cancer Alliance work streams as key partners in shaping and influencing the design of tumour specific pathways and addressing challenges in the system particularly in relation to access to diagnostics and workforce capacity. In this last year, the alliance has focussed on the following key priorities:

Early diagnosis

- Establishment of a lung cancer case finding steering group with the aim of improving detection of lung cancer early.
- Phased roll-out of serious, non-specific (vague) symptoms pathway.
- Increase the number of trained radiologists and newly developed education modules for trained sonographers
- Continuation of national screening programmes

Treatment and care

- Working with partners to address challenges in the breast symptomatic service due to workforce pressures in diagnostic service groups.

Living with and beyond cancer

- Investment in local services to help develop stratified follow up pathways for patients with breast, colorectal and prostate cancer and increase the number of peoples receiving a health needs assessment
Clinicians across the region have joined forces to improve how the NHS locally uses endoscopy (telescope test) to diagnose cancer of the stomach and oesophagus (gullet) by working together to improve patient safety and use resources effectively to investigate people for suspected cancer.

These cancers predominantly occur in people over the age of 50, with 50% occurring after the age of 70. Despite this, a quarter of all endoscopies are being done in people under-50 and relatively few in older people. So, despite having one of the highest rates of endoscopy in the country, it’s found that many of these cancer patients are diagnosed at an advanced stage.

It was found that there was room to change practice safely because some GPs were referring eight times fewer young people than other GPs. A comprehensive plan aims to turn this around by offering a more standardised and consistent approach across the North East and Cumbria with the aims of improving cancer diagnosis, helping people avoid unnecessary endoscopy and offering better treatment options for patients – including looking at how they eat and lifestyles factors such as excess alcohol consumption and maintain a good body weight as well as medication.

Planned care, long term conditions and NHS RightCare

Planned care

During 2018/19 North Tyneside CCG worked with Northumbria Healthcare NHS Foundation Trust to establish new Advice & Guidance services in Cardiology, Gastroenterology, Gynaecology and Haematology. These services enable GPs to have electronic discussions with local hospital consultants to seek advice on particular patients’ cases, rather than simply referring for outpatient appointments which might not be necessary. The CCG also recommissioned its Referral Management System as a Rapid Specialist Opinion service, ensuring that referrals in 13 specialties are appropriate for hospital care.

The CCG began to work with Northumbria Healthcare on the Trust’s Outpatient Project, aiming to modernise outpatient follow-up by moving to patient-initiated follow-up for some specialities and conditions, and considering alternative options for providing outpatient follow-up such as virtual appointments. This work will continue during 2019/20.

The CCG began to train GP practices in use of the new Faecal Immunochemical Test (FIT), an alternative to colonoscopies for some patients. The benefits of this should be seen in 2019/20 as fewer patients undergo colonoscopies, which, as with any invasive procedure carries some risk.

The CCG has been working with Northumbria Healthcare Foundation Trust to transform the pain management service from being doctor-led to being more psychology and physiotherapy focused. This work will continue into 2019/20, with the new ‘Living Well with Pain’ service due to launch in July 2019.
Long term conditions

Integrated health and social care is cited as a key priority in improving the quality of care delivered particularly to people who have a long term condition and for those with complex care needs.

During 2018/19, North Tyneside CCG has worked collaboratively with patients, and our partners in health, social care and the third sector in the implementation of a number of long term condition initiatives with the aim of improving outcomes and experience for people.

Each initiative is underpinned by three key drivers:

1. A population based approach to commissioning, targeting those cohorts within North Tyneside where health detriments and condition specific diseases are prominent and health outcomes are poor

2. Commissioning a range of services and interventions that provide evidence based, holistic, person-centred, integrated health and social care, and improve outcomes for patients

3. The engagement of patients and managing their own care by providing information, education and support to individuals and their carers

As well as cancer services, which we have described earlier in this Annual Report, the CCG has implemented a number of schemes and services aimed to help people manage their long term condition.

Diabetes - Healthier You: NHS Diabetes Prevention Programme

North Tyneside CCG joined the ‘Healthier You: NHS Diabetes Prevention Programme’ (NDPP), which is a partnership between NHS England, Public Health England and Diabetes UK, which aims to deliver at scale, evidence-based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. Type 2 diabetes currently costs the NHS £8.8 billion per year.

The programme aims to prevent or delay 18,000 cases of diabetes among the five-year cohort of 390,000 participants by the end of the fifth year. The programme focuses on three core goals - weight loss, dietary achievements and physical activity. People will be supported predominantly in face-to-face groups to achieve goals and make lifestyle changes and reduce their risk of developing Type 2 diabetes.

The programme became available to all GP practices in North Tyneside from October 2018.

The CCG also commissioned, during 2018/19, a DIRECT style of structured education for patients in North Tyneside who have been newly diagnosed with Type 2 diabetes. This programme is where patients do not take diabetes medication and, instead, are placed on a nutritionally balanced low calorie diet and receive intensive guidance to gradually reintroduce a normal diet tailored to individual needs. The aim is to achieve remission of diabetes.
NHS RightCare

NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS’s money go as far as possible and improving patient outcomes. As a Wave 1 NHS RightCare site, North Tyneside CCG has been submitting Evaluation Plans to NHS RightCare since October 2016. Over the past two years the CCG has undertaken a significant amount of transformation work as part of its Quality Improvement Performance and Production (QIPP) schemes and NHS RightCare has been a key part of this.

The 2018 submission offered the opportunity for the CCG to reflect on its NHS RightCare priorities and the work undertaken over the past two years, as well as consider how we would like to take the priorities forward. Following discussions it was agreed that North Tyneside CCG would submit five NHS RightCare Evaluation Plans in 2018. These are:

- Respiratory
- trauma and injury (focusing on work around falls)
- Gastroenterology
- Medicines optimisation
- Complex patients

These projects have always formed part of the previous NHS RightCare submissions but were split across several plans including previous circulation, MSK and cancer plans. The decision was taken by the CCG to align the NHS RightCare plans to the current QIPP schemes and financial reporting mechanisms to increase transparency, streamline the reporting process and reflect the wider impact upon a number of NHS RightCare areas.

Projects and financial savings that were previously submitted as part of the circulation, cancer and MSK plans are continuing and were included in the new plans, where appropriate.

The NHS RightCare work is undertaken in partnership with Northumbria Healthcare NHS Foundation Trust and several of the NHS RightCare groups are led jointly with Northumberland CCG.

Improving services for people who have a respiratory condition

North Tyneside CCG has been actively engaged in the Respiratory Right Care Programme, working alongside Northumberland CCG and Northumbria Healthcare Trust in the development of a respiratory plan which includes a number of key projects for improving the quality of care for people with long term respiratory conditions particularly in relation to COPD and asthma.

Key areas of improvement include:
• Reduce smoking prevalence – A multi-agency task and finish group has been established to develop and design a cohesive stop smoking pathway with the aim of offering a broad range of interventions based on individual patient’s needs.

• Achieve early diagnosis – Work has begun to design a community-based diagnostic service that moves spirometry out of hospital to local settings closer to home. The aim will be to reduce variation and improve accuracy by creating local specialist hubs.

• Implementation of ‘Gold standard’ COPD and asthma pathways

• Reduce exacerbations – We have commissioned a community-based pulmonary rehabilitation service and exercise programme for patients with low and medium acuity of COPD

• Supporting self-management – We have commissioned education tools and improved use of self-management plans as well as improved access to self-management applications

Atrial Fibrillation Patient Optimisation Demonstrator Programme

The CCG has joined the NHS England Atrial Fibrillation (AF) Patient Optimisation Demonstrator Programme, which aims to review all patients who have AF but are not being treated with anticoagulant medication.

The CCG is trialling a new approach where GPs work with anticoagulation specialists to review patients’ records in “virtual clinics”, i.e. without the patients being present. Then those patients who might benefit from anticoagulants have individual shared decision making conversations about the pros and cons of treatment, before agreeing on what any treatment they will have. If successful, the approach will be rolled-out nationally.

This work will continue during 2019/20. In addition, the CCG has continued to lead an NHS RightCare group on Circulation spanning North Tyneside and Northumberland which brings together hospital doctors and GPs with the aim of improving care and reducing variation.

Mental health

During 2018/19, the CCG, with partners, implemented a number of initiatives and invested in services, where appropriate, to improve the quality and access to services.

Children and young people

The Children and Adolescents Mental Health & Wellbeing Local Transformation Plan is a five year plan which is now entering its fourth year. The current plan is available on our website.

During 2018/19, mental health in education and improved involvement and engagement were the two key priorities.

We implemented new pathways during 2018/19 to enable school head teachers and special education needs coordinators (SENCOs) to refer directly into the child and adolescent mental
health service (CAMHS). Additionally, schools now have access to urgent appointments and professional telephone advice.

Building on the success of the Emotionally Healthy Schools Resource Pack which was launched in May 2017, we worked with the local authority, the Anna Freud National Centre for Children and Families and the Department for Education as part of the Schools Link Programme 2017-18. The aim was to strengthen communication and joint working arrangements between schools and mental health professionals.

Along with the Welcome Trust, the CCG funded an innovative project called MI:2K. The MI:2K project was a year-long engagement programme, run by national charity Involve and the Leaders Unlocked social enterprise. A team recruited and trained young people across the area, including at-risk groups, on how local mental health prevention, support and services can be most effective. The team also supported the young people to conduct a research project resulting in key recommendations to be taken up by the Children and Young People Mental Health and Emotional Wellbeing Strategic Group for action.

We also commissioned an online mental health counselling and wellbeing service for children and young people in North Tyneside. The service is called XenZone Kooth On-Line Counselling, and was jointly commissioned by North Tyneside Council and the CCG, funded by health funds.

The service gives local young people aged between 11 and 18 access to free online counselling. As well as offering timely access to therapy, the 18-month pilot provides anonymous, confidential and access to self-help materials, articles, moderated online forums and tools such as a mood tracker.

The CCG also provided additional funding to the CAMHS service during 2018/19 to improve access and reduce waiting lists for children and young people with ADHD and autism.

**Working age adults**

In relation to working age adults, Northumberland, Tyne and Wear NHS Foundation Trust (NTWFT) introduced new pathways and structures for community based mental health services in North Tyneside during 2016/17.

Since then, a review was undertaken of some of these new pathways lead by the CCG, focusing specifically on the pathway for people experiencing a mental health crisis aiming to ensure that people receive timely access to appropriate services to manage their needs. The review was undertaken in partnership with Healthwatch to gain patient and carer input into the pathways work and to help inform future commissioning decisions.

From this work, we have commissioned a service called Together in a Crisis, provided by Mental Health Concern, which began accepting referrals in February 2018. The service links closely with the Northumberland, Tyne & Wear Mental Health Trust’s crisis service but provides support and signposting to individuals who do not meet the access criteria for the crisis team.
We committed to continue to fund both the national Core 24 model of liaison psychiatry, based at the A&E department of The Northumbria Hospital as well as the older peoples liaison psychiatry services, based in inpatient and rehabilitation wards at North Tyneside General Hospital. We continue to closely monitoring the impact of these services and will evaluate their outcomes.

We also recognised the additional pressures on the Improving Access to Psychological Therapies service in North Tyneside, called North Tyneside Talking Therapies. The national standard for access increased during 2018/19, placing pressure on the existing workforce. At the same time, the service is required to expand its access to include people with long term conditions. The CCG therefore provided additional funding to enable this expansion and to improve waiting times for access to Step 3 therapy.

Over the year, we have also worked closely with VODA to re-establish the North Tyneside Recovery College, offering a range of courses and workshops related to mental health and wellbeing. We have provided funding for the administration of the Recovery College, providing stability to this service. During 2019/20, we will work with VODA and key stakeholders, including patients and carers, to shape the courses and workshops on offer.

**Dementia and older people**

The CCG currently has an early dementia diagnosis rate which exceeds the national target of at least two-thirds of the estimated number of people with dementia.

We continue to review national information to ensure that we continue to meet this target. We are also working with the GP localities to ensure that patients who have been diagnosed with dementia have their care plan reviewed annually. This is audited nationally and we aim to improve our rating in this area.

During 2017/18, we agreed to fund an Admiral Nurse post with Age UK North Tyneside, aiming to improve post diagnostic support for people with dementia and their carers. We have worked with Age UK North Tyneside to review the impact of this post and the CCG has agreed to continue funding this post on a recurrent basis.

We have also finalised a joint strategy with North Tyneside Council on mental health services for older people, including dementia. Following this, a joint action plan will be developed and presented to the Health & Wellbeing Board for approval. Progress against the actions will be monitored by the Health & Wellbeing Board.

**Mental Health Performance**

There are six national performance standards relating to mental health. North Tyneside CCG’s performance in 2018/19 is described below.

All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.
**Mental Health**

**Improving Access to Psychological Therapies – Recovery**

53.6% of patients which have finished treatment are moving to recovery. This is above the national standard of 50% and therefore meets the standard.

**Improving Access to Psychological Therapies – Access**

4.8% of patients accessed psychological therapies in quarter 4, 2018/19. This achieves the ‘run rate’ requirement of 4.75% in quarter 4 and therefore meets the standard.

**People with first episode of psychosis starting treatment with a NICE approved package within 2 weeks of referral**

74.5% of people experiencing first episode of psychosis waited 2 weeks or less to start treatment. This is above the national standard of 52% and therefore meets the standard.

**Mental health out of area placements**

The CCG had no out of area mental health placements during December 2018.

**Estimated diagnosis rate for people with dementia**

69.2% of people aged 65 and over are on the dementia register. This is above the England average of 67.9%.

**Dementia care planning and post-diagnostic support**

78.1% of patients diagnosed with dementia have had a care plan and have had a face to face review in the last 12 months. This is above the England average of 77.5%.

**Learning disabilities**

The local authority and North Tyneside CCG have established joint processes to enhance and/or integrate services that underpin living well in the community.

The North Tyneside Implementation Plan for people with learning disabilities and/or autism takes into account the regional and national planning assumptions and the CCG will continue to work as part of the regional Transformational Board on developing system-wide out of hospital care and allow people with complex learning disabilities to be appropriately and safely supported closer to home.
In line with the Transforming Care agenda, North Tyneside works with other CCGs and Local Authority Commissioners as part of the North Region Implementation Group. This Group is developing a complex case framework that will ensure community based pathways are robust, fit for purpose with clear ‘step up and step down’ processes.

This is to ensure the delivery of community-based care for the people with the most challenging and complex behaviours is of a high quality and meets the assessed needs of individuals. Alongside this development a review of assessment and treatment beds is underway across the North Region.

**Learning Disabilities performance**

There are three national performance standards relating to learning disabilities. North Tyneside CCG’s performance in 2018/19 is described below and is based on the latest published data.

All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.

**Reliability on inpatient care for people with a learning disability and/or autism**

The number of adults who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural needs is reducing within North Tyneside. The CCG is in the lowest performing quartile across England. This performance standard is based on the performance of a collaboration of CCGs, Local Authorities and NHS England Specialised Commissioners. Due to the small numbers involved it is not possible to measure at a CCG level.

**Proportion of people with a learning disability on the GP register receiving an annual health check**

53.2% of people with a learning disability on the GP register received an annual health check in 2017/18. The CCG is above the England average of 51.4%.

**Completeness of the GP learning disability register**

71% of people were registered on a GP learning disability register in 2017/18. The CCG is in the highest performing quartile across England. The CCG is above the England average of 49.0% and is in the highest performing quartile across England.
Carers’ services

We continue to promote the welfare of carers who support a family member or friend who due to illness, disability, mental health or substance misuse could not manage without their support.

This year has seen North Tyneside CCG become more actively engaged in working with a range of partners and stakeholders across health and social care and third sector partners in responding to the Health and Wellbeing Board’s objective in developing ‘An integrated approach to identifying and meeting carer health and wellbeing needs across all ages’.

This includes taking the lead role in the establishment of a Carers Partnership Board along with key partners to ensure collective and individual responsibility within the North Tyneside Health and Social Care system in meeting the statutory duties in support of carers and improve the carers’ experience, ensuring that they are safeguarded and their welfare is promoted.

The Partnership Board started in June 2018 and since then has developed a comprehensive joint plan that identified a range of actions that include:

- Developing a programme of support to primary care to identify all carers
- Improve timely access to information and support by increasing opportunities for carers to find out what is available to them and how to access it
- Ensure a targeted workforce is trained to recognise adult and young carers and parent carers to assess their needs across education and healthcare. In doing so, ensure all young carer assessments consider whether it is appropriate or excessive for the young carer to provide care for the person in question
- Review quality and assurance processes across education, health and care to ensure carer’s needs are identified and met during assessment and review processes

In addition, we have invested in the commissioning of a young carers project that provides young carers with emotional support, help with access to education/employment and working directly with the young carers to develop coping mechanisms and identify further levels of support.

Maternity services

In July 2018, NHS North Tyneside CCG received its NHS Outcomes Framework rating for 2017/18 for maternity, scoring “requires improvement”.

There was slight underperformance against the national average in two areas, which resulted in the “requires improvement” rating - choices in maternity (59.3% against national average of 60.8%) and maternal smoking at delivery (10.9% against national average of 9.7%).

However, our performance was better than the Cumbria North East regional average in both cases (choices 58.8%, smoking 16.25%), and our maternal smoking performance is the best in the region. More recent data shows an improved position for the CCG in relation to choices in
maternity and maternal smoking at delivery which should have a positive impact when the 
maternity services are reassessed in 2019. We hope that the rating will improve from the 
current ‘requires improvement’ rating.

North Tyneside women are served by Northumbria Healthcare midwives, but deliver their 
babies at both Northumbria Specialist Emergency Care Hospital (NSECH) and Royal Victoria 
Infirmary (RVI), Newcastle. We are working with both our local foundation trusts to try to 
upgrade performance where possible.

Newcastle Hospitals has recently received its annual maternity survey from the Care Quality 
Commission in which it performed “better than expected”, showing how ratings can vary 
depending on exactly what is measured. The unit has Stage 3 UNICEF Baby Friendly status.

All women are offered the choice of where to deliver their baby at their booking appointment – 
NSECH or RVI, consultant-led or midwife-led, or at home – and they can change this as their 
pregnancy progresses should they wish to.

Women receive personalised care and are involved in decisions about their care. Women are 
also supported to feed their babies in their preferred way, including breastfeeding.

**Maternity performance**

There are three national performance standards relating to maternity services. North Tyneside 
CCG’s performance in 2018/19 is described below. All performance and quality data is sourced 
from validated national sources, including NHS England, NHS Digital and Department of 
Health.

**Neonatal mortality and stillbirths**

The CCG had a rate of 2.65 still births and deaths per 1,000 in 2016 which is lower than the 
England average. The CCG is in the highest performing quartile across England.

**Women’s experience of maternity services**

89.6% is the CCG’s rate for women’s experience of maternity services, which is above the 
England average of 82.7% in 2018. The indicator is a composite value, calculated as the 
average of six survey questions from the National Maternity Services Survey. The CCG is in 
the highest performing quartile across England.

**Choices in maternity services**

61.5% is the CCG’s rate for choices in maternity services, which is above the England average 
of 60.4% in 2018. The indicator is a composite value, calculated as the average of six survey 
questions from the CQC Maternity Survey.
Maternal smoking at delivery

10.3% of pregnant women were smoking when they gave birth to their child in Quarter 3 2018/19. The CCG’s average percentage is below, and therefore better than, the England average of 10.5%

Improving quality

Overview

In order to commission high quality care successfully, we actively promote engagement, transparency and successful relationships between all key stakeholders involved in the delivery of health and care services. This is in order to realise our vision of a health system shaped by patient and citizen participation and is designed with improved outcomes and patient experience at its heart.

Quality systems and processes

Quality Review Groups (QRGs) are in place for all foundation trusts and local private hospital providers. They focus on assurance relating to the clinical quality of commissioned services across the domains of clinical quality; patient safety, patient experience and clinical effectiveness.

This includes triangulation of data from a range of sources including mortality indices, patient experience programmes including the Friends and Family Test, staff surveys, patient surveys, serious incidents, complaints, soft intelligence and the internal processes in place within providers to ensure the robust management of these issues.

The CCG reviews the feedback received from these various sources as well as via patient and public consultation and engagement. We use this information to determine how services will be commissioned in the future, ensuring that we meet patients’ needs. An example of this work is described in this report in relation to how the CCG commissions services for people with mental health needs. During 2017/18, Launchpad was instrumental in developing a workshop called KOSMOS which enabled people to share their experiences, via the KOSMOS arts based project, of gaining support to manage their mental health needs. The outcomes were shared with the CCG and, moving into 2018/19 continued to be a source of influence on how we develop the mental health services we commission. The work that the CCG undertook with Healthwatch into crisis services for adults, described earlier in this report, is another example of acting on such feedback to change how we commission services.
During 2018/19 the CCG has continued to receive specific assurance in areas such as safe staffing levels, incident reporting, management and learning processes, falls management and harm minimisation, compliance with NICE guidance, action on mortality and sepsis and the avoidable harms outlined in the NHS Safety Thermometer. Assurance relating to national reports is also sought including gap analysis and action taken to address any issues.

The QRGs also oversee the assurance process for provider cost improvement plans, maintaining a constructive dialogue with providers throughout the year ensuring that plans are quality impact assessed for any potential quality or safety issues.

The CCG member practices continue to play a key role in the identification and reporting of clinical quality intelligence about our providers. The Safeguard Incident and Risk Management System (SIRMS) enables practices to report data on incidents, experiences and issues that they and their patients have with various providers within the local healthcare system.

Reporting rates are declining across North Tyneside practices, 100% of practices have access to SIRMS and it is expected that incidents reported during 2018/19 will be in excess of 380. Where quality issues are identified, they are discussed collaboratively with providers and feedback/learning is requested for identified themes, trends and significant individual patient safety issues.

We have a robust process in place for the assurance, management and closure of serious incidents reported by commissioned services. The serious incident closure panel ensures that serious incidents are only closed when the CCG has evidence that lessons have been learned and all actions have been taken to prevent re-occurrence. The CCG received ‘Substantial Assurance’ from internal audit that the serious incident closure process within the CCG is robust.

The CCG is an active member of the local Quality Surveillance Group, at which information and intelligence on Providers is shared between NHS England and the local CCGs and other agencies. This is then communicated to our Quality and Safety Committee and Governing Body as part of the assurance process.

We have continued to work in collaboration with the Care Quality Commission (CQC), sharing review information and provider action plans when there has been any concern regarding quality issues. During 2018/19 we have continued with a schedule of quality assurance visits in partnership with the local authority to all independent nursing homes.

In addition, we attended quarterly information sharing meetings with each nursing home provider in partnership with the local authority. We have also continued to undertake assurance visits with our acute trusts and independent hospital providers.

Regular meetings continued with Healthwatch North Tyneside as part of a strong and collaborative working relationship, which includes membership of the CCG Patient Forum, Health and Social Care Integration Partnership working groups and the Health and Wellbeing Board.
We place a high priority on sepsis awareness raising and education on the use of the National Early Warning Score (NEWS), and this will be included in service specifications and in any local incentive schemes funded by the CCG.

**Safeguarding**

The Governing Body has delegated responsibility for monitoring and assuring safeguarding to the Quality and Safety Committee and this is explicit in our constitution and the Quality and Safety Committee terms of reference.

The Executive Director of Nursing and Chief Operating Officer is the lead officer for safeguarding, supported by the CCG employed Head of Safeguarding; Designated Nurse Safeguarding Children, the Designated Nurse Safeguarding Adults, the Designated Nurse Looked After Children, and the Designated Doctor Safeguarding Children, the Designated Doctor Looked After Children and the Named GP Safeguarding Children and Adults.

In addition to regular and detailed reports to the Quality and Safety Committee, reports are provided to the CCG Governing Body at a private session at every meeting. The CCG also works closely with providers to ensure that safeguarding remains part of regular discussions at the QRGs, receiving regular reports outlining the internal assurance process and activity around adults and children at risk.

The Governing Body members and CCG staff receive safeguarding adults and children training and are clear about their respective roles and responsibilities. The CCG is an active member of the Safeguarding Adults Board and the Local Safeguarding Children Board.

Safeguarding of children is an important element of contract monitoring with providers, and assurance is sought through regular meetings, quality review groups and Section 11 provider audit reports to the Local Safeguarding Children Board. Quarterly monitoring is also in place using a safeguarding children performance dashboard. During 2018/19 the CCG received significant assurance from NHS England when benchmarked against the regional safeguarding audit tool.

In relation to adults, we have robust information sharing mechanisms in place with the CQC and North Tyneside Council. The local authority and the CCG have joint monitoring arrangements in place for nursing homes, which have identified opportunities for improvement across a range of areas. When a Serious Case Review, domestic review or any other review occurs, the CCG works with partner agencies to ensure that it meets national and local policies and procedures. Relevant information is shared amongst any partner agencies, using a coordinated approach, regarding any case identified and recommendations are made following a learning review.

Currently the CCG receives a safeguarding performance dashboard from the following providers:

- Northumbria Healthcare NHS Foundation Trust (NHCFT) in relation to children, including Looked After Children and adults
In addition to the dashboards, the CCG receives information and assurance from a variety of other sources for example:

- North Tyneside Safeguarding Children Board – the CCG is represented on the board and all of the sub-groups
- Quality Review Groups – safeguarding is a standing agenda item
- North of Tyne Child Death Overview Panel

**PREVENT**

The Counter-Terrorism and Security Act 2015, places a duty on certain bodies in the exercise of their functions to have “due regard to the need to prevent people from being drawn into terrorism”. Those bodies are referred to “specified authorities” and include NHS trusts.

The statutory guidance: ‘Prevent Duty Guidance’ was published in 2015 and clarifies that all specified authorities subject to the duty will need to ensure they provide appropriate training for staff involved in the implementation of this duty.

The CCG monitors implementation of the PREVENT agenda through the Quality Review Groups (QRGs). The PREVENT strategy is part of the Governments overall counter-terrorism strategy called CONTEST. The aim of the PREVENT strategy is to reduce the threat to the UK from terrorism by safeguarding and supporting those individuals vulnerable to radicalization, and so prevents them becoming terrorists or supporting terrorism.

In health, training is delivered in partnership between NHS England, CCGs and health providers.

In line with statutory requirements, the CCG has a PREVENT lead who in conjunction with provider leads is responsible for driving the strategy forward in North Tyneside and providing support and advice.

The PREVENT lead role includes training and education, monitoring and reporting locally, regionally and if required nationally. The lead also attends and receives updates from the North of England PREVENT forum and ensures this information is disseminated to relevant agencies.

The CCG’s health providers report on training compliance with PREVENT via the PREVENT national reporting system and is also monitored via the NHS Standard Contract. It is also
monitored through the QRGs and have developed action plans to enable them to meet the compliance targets set by NHS England.

We have been delivering PREVENT basic awareness sessions to our staff since 2014 to ensure they have the required knowledge and skills to fulfil their role. At the present time, we are compliant with PREVENT training requirements.

The CCG Safeguarding Team has delivered Workshop to Raise Awareness of PREVENT (WRAP) level3 training to all North Tyneside GP practices. WRAP is a higher level of training which is a requirement for all clinical staff working with adults, children and young people who could potentially contribute to assessing, planning, intervening and evaluating care where there are safeguarding concerns.

Primary care staff can now access national e-learning that meets the requirements of both the basic PREVENT awareness and WRAP training. The CCG safeguarding team continues to deliver face to face WRAP sessions for CCG and primary care staff via a scheduled programme.

NHS England’s Mental Capacity Act 2005 A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance sets out our duty to ensure that the legislation, guidance and policy relating to the Mental Capacity Act (MCA) are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised and protected. In North Tyneside we use the framework for tendering, contracting and monitoring and ongoing assurance.

The CCG has an appointed lead nurse for MCA and Deprivation of Liberty Safeguards (DoLS) to strengthen the clinical team, providing training and advice.

**Workforce and staff experience**

The CCG recognises that our staff are our greatest asset and therefore strive to ensure their health and wellbeing is paramount. We support flexible working and encourage positive workforce practices.

We are committed to a ‘whole system’ approach to workforce development to ensure that it is fit for the future. There are three areas of focus: CCG staff, primary care and the staff working within the provider organisations that we commission services from.

The CCG continues to monitor Safe Staffing information through the QRGs and during assurance visits.

The future sustainable delivery of high quality care is dependent upon an agile, adaptive workforce that can respond to the changing context of care delivery.

In order for providers to work effectively with Health Education North East (HENE), we will work in collaboration to ensure that future commissioning priority areas and large scale change are identified. This will enable the projected workforce changes to be made for undergraduate, post graduate and continuing professional development programmes.
We will continue to work in partnership with HENE and the North East Leadership Academy to maximise the opportunities to influence workforce development now and in the future.

We are also working with member practices to identify future workforce needs in response to the changing landscape of primary care. As commissioners, we will ensure that we have robust succession and talent management systems in place for our own CCG workforce.

We are committed to help grow the next generation of clinical leaders and will work with key stakeholders to turn this commitment into a reality.

**Education offer for general practices**

The CCG values the importance of education, training, and development (ETD), in order to support the delivery of high-quality care.

Building on informal feedback from practices and models from other areas, the CCG has developed a proposal for a new education programme that aims to provide something which is more relevant and useful for practices in order to improve care for patients and support GPs and staff. Towards the end of the year the CCG was engaging with primary care to shape the offer with a view to implement in the next financial year.

**Patient experience**

Robust complaints processes ensure that we are notified of all complaints relating to our patients as soon as they are recorded.

Provider complaints are managed under the provider’s complaints procedures and reported to us through their board level patient experience report, which is shared at our Quality Review Group meetings.

We continue to work with member practices and the NHS England team to develop and assure quality and safety in primary care.

**Pathology collaboration**

One of our main work streams is the regional Pathology Collaboration Programme, which has been established to explore the opportunities to network laboratory services across North Cumbria and the North East.

A key driver for this work is the need to ensure the region can retain and recruit the workforce needed for this critical service area. The network will improve the resilience, sustainability and efficiency of services, improve access to diagnostic results for clinicians and patients, provide the opportunity to standardise pathology testing where clinically appropriate and for laboratories to undertake joint procurement for pathology consumables and equipment.
In November, a major engagement event was held with over 90 clinicians, scientists and managers from all of the trusts providing pathology services across the region. The purpose of the event was to ensure that the clinical and laboratory requirements necessary for a sustainable, high quality, resilient and efficient service are central to the planning of the North Cumbria and North East Pathology Service.

The next key phase of the North Cumbria and North East Pathology Service development is to work with specialty clinical groups, operational managers, trust and system leadership teams to evaluate the potential options and phasing of the network formation.

**Optimising the use of over the counter medicines**

Working with all the clinical commissioning groups in the region, the CCG supported a behaviour change campaign which focused on persuading patients to purchase low cost over the counter medicines for self-care and minor conditions instead of using an NHS prescription.

The NHS each year spends millions on medications that can be purchased over the counter at a lower cost than that which would be incurred by the NHS – for example, a pack of 12 anti-sickness tablets can be purchased for £2.18 from a pharmacy whereas the cost to the NHS is over £3 after including dispensing fees, and over £35 when you include GP consultation and other administration costs.

The costs of these products could be used to fund other NHS services for example:

- £22.8 million spent on constipation treatments – enough to fund around 900 community nurses
- £3 million spent on athlete’s foot and other fungal infections treatments – enough to fund 810 hip operations
- £2.8 million spent on diarrhoea treatments – enough to fund 2,912 cataract operations

A campaign to raise awareness with patients and the public around the costs of prescribing medicines that are routinely available for the patient to buy from pharmacies and other outlets, such as paracetamol and hay fever medication was developed. The overall aim was to save money on prescribing costs for items that patients can easily buy to treat self-limiting minor ailments, which would allow the savings to be used elsewhere in the healthcare system.

A suite of communications materials and tools were produced and distributed to GP practices, walk-in centres, A&E departments and pharmacies for prescribers who wanted to use it to help with the discussion during interaction with patients to promote self-care. The approach was supported by proactive communications through the media, information on CCG websites and social media.

During a 12 month period, the campaign made savings of over 1 million across the region helping redirect money to other urgent healthcare needs.
In March 2018 NHS England released the findings from a national consultation and recommendations on the conditions for which over the counter items should not be routinely prescribed in primary care. The findings mirrored the local evidence and research showing that the North East and North Cumbria areas were ahead of the curve and had already made significant savings prior to the recommendations being released.

### CCGs win landmark high court victory over pharmaceutical companies

Along with other CCGs in the region, we won a landmark case against two multinational drug companies, saving millions of pounds in the treatment of the wet age-related macular degeneration (wet AMD).

The victory follows the adoption of a choice policy by all 12 CCGs in the North East and North Cumbria, to offer patients the chance to be treated with Avastin as an alternative to the more expensive Lucentis or Eylea.

Drug companies Novartis and Bayer took legal action to try to stop the CCGs from offering Avastin to patients – even though it has been found by NICE to be just as clinically effective and safe. A well-known cancer drug, Avastin is widely used around the world, including the EU and private practice in the UK, to treat wet AMD. Avastin is around 30 times cheaper than the most expensive alternative.

In a landmark ruling, the judge dismissed the appeal by the drug companies on all four grounds. The claimants were also ordered to pay the CCGs’ legal costs. The ruling provides vital clarity for the NHS in the region and nationally, and clinicians can be absolutely reassured that the use of Avastin for wet AMD is lawful, safe and effective.

Avastin is equally effective, and much less expensive and could save £13.5 million per year for the 12 CCGs involved, which can be ploughed straight back into caring for our patients. That’s enough to pay for an extra 270 nurses or 266 heart transplants every year.

### Better Care Fund

The North Tyneside Better Care Fund plan will take the North Tyneside health and care system closer to the goal of health and social care integration through a range of services aiming to maintain people in their own homes and avoiding hospital admission when possible.

This includes integration of reablement, immediate response and overnight home care services, intermediate care services, improving the coordination of mental and physical healthcare services and 24/7 crisis support.

The current plan encompasses the financial years 2017/18 and 2018/19. We are awaiting publication of the guidance for 2019/20 but are working with Local Authority colleagues to prepare our new plan.
North Integrated Care Partnership

North East and North Cumbria NHS organisations are currently working towards becoming a single Integrated Care System (ICS), supported by four Integrated Care Partnerships (ICPs). The NHS Long Term Plan published in January 2019 sets out clear expectations for all Integrated Care Systems.

The North Integrated Care Partnership (ICP) is the largest of the four ICPs in the North East and North Cumbria aspirant Integrated Care System (ICS). The North ICP footprint covers a population of 1.025m with the following statutory organisations:

- **Three CCGs** - NHS Northumberland CCG, NHS North Tyneside CCG and Newcastle Gateshead CCG
- **Three NHS foundation trusts** – Northumbria Healthcare NHS FT, The Newcastle upon Tyne Hospitals NHS FT and Gateshead Health NHS FT
- **Four local authorities** – Northumberland County Council, North Tyneside Council, Newcastle County and Gateshead Council
- **One mental health trust** – Northumberland Tyne and Wear NHS FT
- **One ambulance trust** - North East Ambulance Service NHS FT

The North ICP is building on a long history of partnership working across health and social care, and through this collaboration the results have been positive and greater than any individual organisation could have achieved alone. As a footprint we are growing and developing as the North ICP system, and are starting to understand what working together as a system might offer in facing the challenges ahead, and delivering much more for the people who we serve.

A North ICP Forum has been established bringing together NHS Partners and Local Authority partners. This forum is chaired by the CCG’s Accountable Officer, Mark Adams and will seek to drive forward the North ICP agenda whilst also recognising that the most important level of working for us all must continue to be place based work for the people who live within the boundaries of each of the local authorities.

We will agree areas of ICP level work where it makes sense to do so together on wider geographies and where there is an expectation that we might deliver additional benefits for the people living in each of the local authority and CCG areas.

An essential element for our success will be engagement and co-production with patients, service users and the public to help us develop and realise our vision and ambitions for the system. Engagement with a wide range of partner organisations within the North ICP footprint is critical to the success of this plan and to help shape health and social care for the future.

A North ICP event took place in February 2019 as part of the ICS ‘Big Conversations’ and provided the opportunity to widen discussions around clinical strategy, workforce and priorities, to identify further areas of work that should and could be done collectively across North Cumbria and the North East.
Northern CCG Forum and Northern CCG Joint Committee

In common with all CCGs in the region, we played an active role in the Northern Clinical Commissioning Group Forum which operated until May 2018.

The Forum provided leadership to the North East and North Cumbria health system, addressed national and regional policy issues and carried out business on a joint basis where this achieved the best outcome. This included areas like winter pressures, CQUIN, implementation of new services and avoidance of inequitable treatment through ‘postcode prescribing’. At its meeting in May 2018, the Forum agreed that it should be stood down and its business should transfer to the Northern CCG Joint Committee.

The CCG is a member of the Northern CCG Joint Committee which makes decisions on subjects recommended to it. These are confined to issues that pertain to all CCG areas in Cumbria and the North East initially the commissioning of specialist acute services and ‘NHS 111’ services. During 2018/19 the Joint Committee also considered the following:

- Breast symptomatic services
- Specialised commissioning within the emerging Integrated Care System (ICS)
- Sustaining quality clinical services across North Cumbria and the North East
- Communications and engagement for integrated health and care
- North of England Commissioning Support Unit (NECS) annual review 2017/18
- Collaboration with the Academic Health Science Network (AHSN) North East North Cumbria
- Local non-executive community networks
- Primary care research strategy

Where appropriate, meetings are held in public and members of the public are welcome to attend to observe the Joint Committee at work.

Clinical priority areas

In the section below, we describe other applicable performance standards against which the CCG is measured, in addition to those already detailed under service specific topics.

All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.
G = Met expected standard

A = Just below expected standard

An overall assessment is provided on an annual basis against the Improvement and Assessment Framework, including a rating for six clinical areas. The latest rating for each of the six clinical areas were awarded to the CCG:

- Cancer - Good
- Dementia - Good
- Mental Health – Outstanding
- Diabetes – Outstanding
- Learning Disabilities – Good
- Maternity – Requires Improvement

Healthcare associated infections

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises.

All CCG’s have objectives for HCAIs set by NHS England for Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C Diff). CCGs are required to meet national standards for both MRSA and C Diff.
MRSA

There is a zero tolerance of MRSA (Methicillin resistant Staphylococcus Aureus), which means that all commissioner and provider targets are zero. North Tyneside CCG had no reported cases of MRSA in 2018/19 to date.

Clostridium Difficile

The CCG had 44 episodes of Clostridium Difficile against an annual threshold of no more than 73 cases for 2018/19. This means that the CCG had less than half of the annual threshold for C Diff cases in North Tyneside for the year.

Mixed-sex accommodation

Under the NHS constitution, providers of NHS funded care are expected to eliminate mixed sex accommodation.

There have been no breaches of the mixed sex accommodation standard for North Tyneside CCG patients.

Referral to treatment

91.8% of patients waited less than 18 weeks to receive initial treatment in February 2019. This is below the national standard of 92%. This is the first time in over three years the measure has not been met by the CCG. The CCG is working with both Foundation Trusts to understand where the increasing demand and capacity constraints are.

Engaging people and communities

In order to commission high quality care successfully, we actively promote engagement, transparency and successful relationships between all key stakeholders involved in the delivery of health and care services. This is in order to realise our vision of a health system shaped by patient and citizen participation and is designed with improved outcomes and patient experience at its heart.

We have much to celebrate in relation to our activities to involve and collaborate with patients, public and partner organisations, as well as our member practices. This was acknowledged in the 2018 NHS England Improvement and Assessment Framework.

Using NHS England’s ‘10 principles of participation’ the CCG was rated as ‘good’ overall.

We enable our stakeholders to get involved by:
• Having a robust involvement strategy and action plan
• Dedicated involvement contracts with the Community Healthcare Forum to enable effective engagement with our communities
• Appropriate communication and engagement mechanisms
• Ensuring information is provided in the required format and additional support needs are met
• Dedicated ‘Get Involved’ section on the CCG website https://www.northtynesideccg.nhs.uk/get-involved/
• MY NHS database
• Use of social media

We have several partners in North Tyneside, working with the CCG to ensure that the patient and carer voice is influential in service developments:

• Community and Health Care Forum
• Healthwatch
• Launchpad
• Patient Forum

The CCG has, with North Tyneside Council, jointly funded the Community Healthcare Forum to consult with North Tyneside residents, carers, relatives and the community and voluntary sector about the planning and delivery of health and social care services.

With the Community Healthcare Forum as partners, we have an ongoing dialogue with many of the hard to reach groups in the borough. This trust has evolved over many years and is continually expanding, and helps to ensure that guidance on the Department of Health & Social Care protected characteristics is followed.

The Forum provides invaluable support and assistance to ensuring that the Patient Forum is appropriately administered and this continue din 2018/19. The Forum was also instrumental in the work of the Patient Forum and its sub-groups, ensuring that people were involved and engaged.

For 2019/20 and onwards, North Tyneside CCG has commissioned the Community Health Care Forum to deliver and manage a patient story software called Sensemaker.

All engagement opportunities are also raised with Healthwatch North Tyneside, and in turn they cascade this to their membership. Where agreed, Healthwatch also undertakes active engagement exercises to feed into CCG specific service reviews and developments. An example during 2018/19 was the research undertaken by Healthwatch into the patient experience of mental health crisis. The outcomes of this research were taken into account by the CCG and a new service for people with mental health needs experiencing a crisis was subsequently commissioned by the CCG.
Launchpad North Tyneside is an independent user-led group by and for people who currently or in the past have used mental health services or who would be seen as eligible to do so. Launchpad North Tyneside is involved in the design, delivery and evaluation of mental health services and works to ensure the voices of service users and survivors are heard by those who make decisions about mental health services in North Tyneside.

During 2017/18, Launchpad was instrumental in developing a workshop called KOSMOS which enabled people to share their experiences, via the KOSMOS arts based project, of gaining support to manage their mental health needs. The outcomes were shared with the CCG and, moving into 2018/19 continued to be a source of influence on how we develop the mental health services we commission.

The CCG was praised in its IPSOS Mori 360 stakeholder survey for the above work with comments describing how the CCG is moving towards real co-production.

In relation to the Patient Forum, we describe below in more detail the purpose of the Patient Forum, its meetings and the various work that the Patient Forum Working Groups are involved in.

The CCG Lay Members also hold the CCG to account on our approach to engagement.

**Developing the infrastructure for engagement and participation**

The CCG hosts a dedicated communications and engagement committee, which includes representatives from the CCG, the North Tyneside Patient Forum, North Tyneside Healthwatch and the North of England Commissioning Support.

To reinforce our commitment to patient care we have a public involvement programme, allowing patients to have a say in many of the decisions we make. Most GP practices already run patient participation groups (PPG), these groups play an important role in increasing public involvement, and ensuring healthcare is delivered in the best way to meet local needs.

Listening to, and communicating with, local people and stakeholders will increase understanding and confidence in local health services. Our work with the community and voluntary sector provides an opportunity for patients to have their say as well as providing the CCG with invaluable insight into the health challenges faced by local people.

**Patient Forum**

The Patient Forum is a committee of the Governing Body. Patient and public involvement is reported to every meeting of the CCG Governing Body that is held in public.

The aim of the Patient Forum is to have membership from each of the 27 GP Practices in North Tyneside and come from practices own patient groups. Most Practices have active patient groups with scheduled meetings throughout the year and others run virtual groups to engage with their patient population.
Agenda items for the Forum are a mixture of CCG areas for discussion, and member led issues for meetings. As a result of members areas of special interests identified within development sessions and inductions, these are matched with CCG priorities and a series of smaller Working Groups have therefore been established to enable more in-depth discussion and influence.

The Patient Forum members met six times during 2018-19, and were involved with a series of health discussions giving an opportunity to share their experiences of services in North Tyneside.

Topics for discussion included NHS North Tyneside CCG Commissioning Priorities, Sustainable Transformation Plans, North Tyneside's Cancer Plan, Medicines Optimisation as well as ongoing dialogue about service planning and delivery.

Additionally, over the past year, the Forum has been involved in:

- Developing publicity materials, including a video and app, helping to prevent falls in North Tyneside
- Digital signage in GP practices
- Organising back pain workshops
- The Palliative Care Initiative
- GP practice website audits
- The development of a bespoke mental health app
- The support and development of Care Plus
- A community nursing review

Patient Forum working groups

The Forum has a series of smaller working groups and members with areas of special interest join these to work on specific areas of development.

Mental health

The mental health app that Forum members have been involved in developing is almost complete. A great deal of work has been undertaken to ensure this is a comprehensive and useful resource for residents of North Tyneside.

During 2017/18, a mapping exercise of mental health services in North Tyneside was undertaken by Forum members. This was then shared with Healthwatch North Tyneside and Launchpad, and an information leaflet has been developed which is available for members of the public to highlight the services that are available.
The leaflet was launched during the mental health action week in May 2018 and was a great success with a range of workshops available from hands on art work to involvement in a listening project.

Members received information from the Memory Clinic as a follow up discussion from members’ earlier involvement with the production of a service questionnaire. This discussion also included the work of Age UK North Tyneside and their peer support for people with dementia. Other services visiting the mental health patient forum included the Children & Adolescent Mental Health Service (CAMHS) team and the North Tyneside Talking Therapies service.

A number of services have been highlighted to attend future meetings to enhance member’s knowledge of services in the borough.

Communications

North Tyneside CCG website has a dedicated section for the Patient Forum newsletter and members have produced 14 issues to date.

Newsletters are cascaded to GP practices and they are encouraged to laminate a copy for their waiting rooms and include it on their own website.

The newsletter is also distributed to the Community Health Care Forum’s wider contact list of voluntary and community sector organisations and community buildings.

The group continues to work hard on the newsletter to bring all of the elements together with the aim of raising the profile of the Forum and sharing current NHS initiatives.

Future Care

Members continue to be involved in discussions on the development of Care Plus, a multi-disciplinary team model for the care of the frailest patients with complex long term conditions.

The Royal Quays Intermediate Care Rehabilitation Unit is based at Princes Court, operated by Akari Care. The service aims to provide intensive multi-disciplinary care to patients recently discharged from hospital, who are well enough for discharge but need additional support before they go home. Patient Forum members visit the service twice a year to understand what developments have taken place or are planned.

North Tyneside CCG has produced a Falls Strategy, with Forum member involvement from the start of the process. In addition, members were instrumental in the creation of publicity material to be used in a regional campaign. A promotional video is also in circulation.
End of life care

Palliative care services in North Tyneside is an area of work that members of the group feel passionately about.

A combined service information leaflet is being developed, which will provide all of the key information that patients and their families may find useful.

The ambitions for services are continually being addressed within multi-agency teams, each bringing their area of expertise.

The work plan for this group will include Electronic Palliative Care Co-ordination System (EPaCCS) as well as Chronic Obstructive Pulmonary Disease (COPD).

The Palliative Care Project in conjunction with Northumbria University is ongoing and explores the possibilities for improving patient and carer experiences, and looking at how information is shared between families and health professionals.

Members of the group have had the opportunity to inform the publicity material to be used during the research. Three focus groups held during June and July 2018 will inform the process.

In partnership with Northumbria University, the NHS Northern England Clinical Networks is preparing a research project to establish how information is shared between health professionals and families. The group has taken an active role in the questionnaire and supporting paperwork.

Self-care and wellbeing

The back pain workshops supported by members continue to be held on a monthly basis and future dates for 2019 are being planned.

Sessions are very informative with lots of opportunity for questions on back problems.

Patient Forum ‘Future Care’ programme involvement

Over the next 12 months the Patient Forum will be actively involved with Future Care/Primary Care Network developments, as well as specific areas of work within the existing working groups. This will take the form of ongoing projects, as well as time-limited task and finish groups.

We would like take the opportunity to acknowledge the excellent work of the North Tyneside CCG Patient Forum. The Forum plays a key role in keeping patient and public engagement at the core of our work, and the efforts of the members is invaluable to the CCG.

We would also like to take the opportunity to thank all of our partners and members of the public who have helped us this year.
Reducing inequalities

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

We have demonstrated our commitment to equality, diversity and human rights (EDHR) in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work as evidenced below.

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

We engage closely with the Patient Forum, Community Health Forum and Patient Public Involvement Groups on projects such as the Falls Strategy, Urgent care, Future Care, Care Plus and Mental Health re-configuration to improve outcomes and reduce health inequalities.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders.

We aim to ensure that comments and feedback from our local communities are captured and, where possible, giving local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.

Through the North of England Commissioning Support Unit (NECSU), we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads meetings. Also nationally NECSU has been awarded E&D Partner status for 2016/17 and have continued to work closely with partners as part of the alumni programme for 2017/18.

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

Further information can be found at:

- PHE Local Authority Health Profiles: [www.healthprofiles.info](http://www.healthprofiles.info)
- Public Health England – Local Health: [www.localhealth.org.uk](http://www.localhealth.org.uk)
Public Sector Equality Duty (PSED)

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

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

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

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

Governance

The CCG Board (Governing Body), through its delegation to the Quality & Safety Committee, ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity; develops and delivers national and regional diversity-related initiatives within the CCG; provides a forum for sharing issues and opportunities; functions as a two-way conduit for information dissemination and escalation; monitors progress against the equality strategy and supports us in the achievement of key equality and diversity objectives.

An annual assurance report is submitted to the Quality & Safety Committee outlining relevant updates in relation to Equality, Diversity and Health Inequalities.

Equality Strategy

Our Equality Strategy was refreshed in 2017 and aims to ensure that the CCG promotes equality of opportunity to all our patients, their families and carers, and our staff, and to proactively address discrimination of any kind.

We are fully committed to meeting the diverse needs of our local population and workforce, ensuring that none are placed at a disadvantage.

The Equality Delivery System 2 - Our Quality Objectives

We have implemented the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010.
Working through the EDS2 framework has provided an opportunity to raise equality in service commissioning and gain insight into the local population’s diverse health needs.

The Quality & Safety committee approved plans detailing actions we will take for 2018-2019 to ensure that individuals, communities and staff are treated equitably.

We have used the NHS Equality Delivery System 2 (EDS2) to develop and prepare our equality objectives, our action plan and objectives are outlined below:

**Objective 1** – Continuously improve engagement, and ensure that services are commissioned and designed to meet the needs of patients.

**Objective 2** – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular the ageing population and those with a sensory need or disability.

**Objective 3** – Monitor and review staff satisfaction to ensure they are engaged, supported and represent the population they serve.

**Objective 4** – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

The objectives and actions set out within the plan are monitored and updated throughout the year to improve patient outcomes, reduce health inequalities and aid PSED compliance.

**Our Staff - Encouraging Diversity**

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

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

By working closely with Department for Work and Pensions (DWP), we have maintained our ‘Level 2 Disability Employer’ status for 2018 - 2020 by demonstrating our commitment to employing the right people for our business and continually developing our people.

**Workforce Race Equality Standard**

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

**Equality Impact Assessments**

Our Equality Impact Assessment (EIA) Toolkit has been implemented into core business processes to provide a comprehensive insight into our local population, patients and staff’s diverse health needs.

The Toolkit 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 reassignment) 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.

Our EIA process ensures that we can consider the impact or effect of our policies, procedures and functions on the population we serve. For any negative impacts identified we will take immediate steps to deal with such issues as part of the action plan set out in the Toolkit. This will ensure equity of service delivery is available for all as well as the opportunity to continuously monitor progress against challenges identified to monitor and reduce inequality for our local population.

The EIA is embedded into our governance process and sign off from the Clinical Commissioning and Contracts Committee is required for monitoring and completion.

**Accessible Information Standard (AIS)**

The Accessible Information Standard aims to make sure that disabled people have access to information that they can understand, and access to any communication support they might need.

The Standard tells organisations how to make information accessible to patients, service users and their carers and parents. This includes making sure that people get information in different formats if they need it, such as large print, braille, easy read, and via email.

The CCG has due regard to the standard by obtaining feedback from the Patient Forum and Communications Working Group in relation to how we can improve our communication methods and make them more accessible.

CCG activity in relation to the AIS is also captured and monitored through the following Equality Objective action:

- Objective 2 – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular the ageing population and those with a disability.
Further information on the standard can be found on NHS England’s website at:
www.england.nhs.uk/ourwork/accessibleinfo/

**Government preparations for an EU Exit 'no deal' scenario**

Matt Hancock MP, Secretary of State for Health and Social Care, wrote to all CCGs about the preparations for a ‘no deal’ Brexit scenario and what the health and care system needs to consider in the period leading up to March 2019

This included information about a scheme to ensure a sufficient and seamless supply of medicines in the UK in the event of a ‘no deal’ Brexit, the Government will ensure the UK has an additional six weeks' supply of medicines in case some imports from the EU are affected.

The letter advises that the local NHS do not need to take any steps to stockpile additional medicines, beyond their business as usual stock levels, and that there is no need for clinicians to write longer NHS prescriptions.

NHSE is seeking daily assurances from CCGs and providers that effective arrangements are in place to ensure continuity of NHS services in the event of a ‘no deal’ EU Exit.
Accountability report

MARK ADAMS
Accountable Officer
21 May 2019
Corporate Governance Report

Members Report

Member profiles
Membership of the CCG Governing Body is summarised in table 10 below. Profiles of members are given on the CCG website. [www.northtynesideccg.nhs.uk/about-us/meet-the-team/](http://www.northtynesideccg.nhs.uk/about-us/meet-the-team/)

Member practices
The CCG is made up of the 27 GP practices in North Tyneside, as listed below:

Table 5: List of GP practices in North Tyneside

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Practice Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>49 Marine Avenue Surgery</td>
<td>Park Parade Surgery</td>
</tr>
<tr>
<td>Appleby Surgery</td>
<td>Park Road Medical Practice</td>
</tr>
<tr>
<td>Beaumont Park Medical Group</td>
<td>Portugal Place Health Centre</td>
</tr>
<tr>
<td>Bridge Medical</td>
<td>The Priory Medical Group</td>
</tr>
<tr>
<td>Bewicke Medical Centre</td>
<td>Redburn Park Medical Centre</td>
</tr>
<tr>
<td>Collingwood Health Group</td>
<td>Spring Terrace Health Centre</td>
</tr>
<tr>
<td>Forest Hall Medical Group</td>
<td>Swarland Avenue Surgery</td>
</tr>
<tr>
<td>Garden Park Surgery</td>
<td>The Village Green Surgery</td>
</tr>
<tr>
<td>Lane End Surgery</td>
<td>Wellspring Medical Practice</td>
</tr>
<tr>
<td>Mallard Medical Group</td>
<td>West Farm Surgery</td>
</tr>
<tr>
<td>Marine Avenue Medical Centre</td>
<td>Whitley Bay Health Centre</td>
</tr>
<tr>
<td>Monkseaton Medical Centre</td>
<td>Wideopen Medical Centre</td>
</tr>
<tr>
<td>Nelson Medical Group</td>
<td>Woodlands Park Health Centre</td>
</tr>
<tr>
<td>Northumberland Park Medical Group</td>
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</tbody>
</table>

CCG Council of Practices
The Council of Practices comprises a nominated GP from each of the 27 GP practices that form the CCG. Its terms of reference require it to meet at least four times a year. In 2018/19 the Council of Practices met six times.

Composition of Governing Body
The membership of the CCG Governing Body is set out in the CCG constitution. The composition of the Governing Body for 2018/19 is shown in table six.
Table 6: Membership of the CCG Governing Body

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Chair</td>
<td>Dr Richard Scott</td>
<td>Male</td>
</tr>
<tr>
<td>Chief Officer</td>
<td>Mr Mark Adams</td>
<td>Male</td>
</tr>
<tr>
<td>Deputy Lay Chair</td>
<td>Ms Mary Coyle MBE DL</td>
<td>Female</td>
</tr>
<tr>
<td>Lay Member (audit and governance)</td>
<td>Mr David Willis</td>
<td>Male</td>
</tr>
<tr>
<td>Lay Member (patient and public involvement)</td>
<td>Mrs Eleanor Hayward</td>
<td>Female</td>
</tr>
<tr>
<td>Secondary Care Specialist Doctor</td>
<td>Dr Neela Shabde</td>
<td>Female</td>
</tr>
<tr>
<td>Executive Director of Nursing &amp; Chief Operating Officer (registered nurse)</td>
<td>Dr Lesley Young-Murphy</td>
<td>Female</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>Mr Jon Connolly</td>
<td>Male</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Dr Ruth Evans</td>
<td>Female</td>
</tr>
</tbody>
</table>

Table 7: Non-voting members of the Governing Body

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Contracting &amp; Commissioning</td>
<td>Mrs Anya Paradis</td>
<td>Female</td>
</tr>
<tr>
<td>Head of Governance</td>
<td>Mrs Irene Walker</td>
<td>Female</td>
</tr>
<tr>
<td>Director of Public Health</td>
<td>Mrs Wendy Burke</td>
<td>Female</td>
</tr>
</tbody>
</table>

Committee(s), including Audit Committee

Membership of the CCG Audit Committee

Table 8: Audit Committee

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair of Audit Committee</td>
<td>Mr David Willis</td>
<td>Male</td>
</tr>
<tr>
<td>Member of Audit Committee</td>
<td>Ms Mary Coyle MBE DL</td>
<td>Female</td>
</tr>
<tr>
<td>Member of Audit Committee</td>
<td>Dr Shaun Lackey</td>
<td>Male</td>
</tr>
</tbody>
</table>
Membership of the Clinical Commissioning and Contracts Committee

The Clinical Commissioning and Contracts Committee reports directly to the Governing Body and assists the Governing Body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation.

Table 9: Clinical Commissioning and Contracts Committee

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of post holder</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer</td>
<td>Mr Mark Adams</td>
<td>Male</td>
</tr>
<tr>
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<tr>
<td>Medical Director</td>
<td>Dr Ruth Evans</td>
<td>Female</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>Mr Jon Connolly</td>
<td>Male</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>Dr Shaun Lackey</td>
<td>Male</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>Dr Alex Kent</td>
<td>Female</td>
</tr>
<tr>
<td>Director of Contracting &amp; Commissioning</td>
<td>Mrs Anya Paradis</td>
<td>Female</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>Mr Philip Horsfield</td>
<td>Male</td>
</tr>
<tr>
<td>Deputy Director of Nursing, Quality &amp; Patient Safety</td>
<td>Mrs Maureen Grieveson</td>
<td>Female</td>
</tr>
<tr>
<td>Head of Improvement &amp; Development</td>
<td>Mr Walter Charlton</td>
<td>Male</td>
</tr>
<tr>
<td>Head of Finance</td>
<td>Mr Jeff Goldthorpe</td>
<td>Male</td>
</tr>
<tr>
<td>Head of Governance</td>
<td>Mrs Irene Walker</td>
<td>Female</td>
</tr>
<tr>
<td>Head of Planning &amp; Commissioning</td>
<td>Mr Steve Rundle</td>
<td>Male</td>
</tr>
</tbody>
</table>
More details about the work of the CCG, its Governing Body and its committees are given in the Governance Statement.

**Register of Interests**

The CCG has arrangements in place for the effective management of conflicts of interest. Details of company directorships and other significant interests held by members of the Governing Body and other CCG committees are recorded in the Register of Interests.

The Register of Interests is available on the CCG website at: [www.northtynesideccg.nhs.uk/news-media/publications/register-of-interest/](http://www.northtynesideccg.nhs.uk/news-media/publications/register-of-interest/)

**Personal data related incidents**

There has been one personal data related incident during 2018/19. This was contained within the CCG and did not require reporting to the Information Commissioner.

**Statement of Disclosure to Auditors**

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

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

**Modern Slavery Act**

North Tyneside CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.
Statement of Accountable Officer’s Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers’ equity and cash flows for the financial year.
In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting 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 Group Accounting Manual issued by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the financial statements, and
- Prepare the financial statements on a going concern basis

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

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information
- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

MARK ADAMS

Accountable Officer

21 May 2019
**Governance statement**

**Introduction and context**

North Tyneside CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

**Scope of responsibility**

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

**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.
**CCG Constitution**

The CCG had a fully compliant constitution at the time of authorisation, endorsed by the member practices and approved by NHS England. The CCG Constitution has been updated to version 15.1 and approved by NHS England on 28 March 2018. The CCG governance structure is shown in figure 6.

![NTCCG Governance Structure](image_url)

**Figure 6: North Tyneside CCG governance structure**

The scheme of reservation and delegation is part of the CCG’s constitution and sets out the split of responsibilities and decision making between the Membership Body (Council of Practices) and the Governing Body.

The constitution is available here: [www.northtynesideccg.nhs.uk/news-media/publications/constitution/](http://www.northtynesideccg.nhs.uk/news-media/publications/constitution/)
Council of Practices

The 27 nominated member practice representatives meet together as the Council of Practices. The responsibilities of the Council of Practices are set out in the CCG Constitution and there are agreed terms of reference.

The Council of Practices acts as a forum for clinical engagement, and provides an area for members to give input and insight into the development of ongoing clinical transformation, new models of care and primary care.

On behalf of the CCG, the Council of Practices holds to account the Governing Body through two way communication about the overall performance of the Group. The Council of Practices is chaired by the Clinical Chair of the CCG, who is also chair of the Governing Body. GP Practice Managers attend the Council of Practices but are not voting members.

The Council of Practices is required by its terms of reference to meet no less than four times a year, and it met six times in the 12 month period starting 1 April 2018.

During 2018/19, discussions at meetings of the Council of Practices included:

- Primary Care Commissioning
- Falls
- Finance Reports
- Locality Directors’ updates
- Commissioning Intentions
- Conversations with Chief Executives from: Northumbria Health Care Foundation Trust; Northumberland, Tyne & Wear Foundation Trust; The Newcastle upon Tyne Hospitals NHS Foundation Trust; and North East Ambulance Services

The Council of Practices reviewed its effectiveness by members completing an anonymous survey early in 2019. Overall, the results of the survey were positive and members determined that no significant improvement actions were required.

CCG Governing Body

The Governing Body is constituted in line with the Health and Social Care Act 2012, and associated CCG regulations.

The membership of the NHS North Tyneside CCG Governing Body is set out in the CCG Constitution.
The membership of the Governing Body during the year beginning 1 April 2018 is set out in the accountability report.

The Governing Body is the main decision making committee of the CCG. A list of voting members is shown at table six and the non-voting members are shown at table seven.

The Governing Body holds meetings in public thereby ensuring accountability and transparency of decision making.

The Governing Body develops, implements and delivers the strategic priorities of the Group, working with the Council of Practices, and the chief officer/accountable officer.

The Governing Body has delegated authority for all decisions of the CCG, except those explicitly reserved to the Council of Practices. It is accountable to the CCG for all decisions which it makes and is held to account by the CCG through its representative committee, the Council of Practices.

The Standing Orders state that the Governing Body will meet no less than four times per year. During the year beginning 1 April 2018, the CCG Governing Body has met nine times - five times in public April 2018 to March 2019, with papers posted in public in advance of the meeting and notices placed inviting public attendance. On some occasions, members of the public have attended. The Chair was present at all meetings in public.

The 2018/19 Annual Accounts and Annual Report were presented in public at the CCG Annual Public Meeting on 26 June 2018.

Throughout the year, the CCG Governing Body was supported by seven committees, each chaired by a lay member of the Governing Body (except the Clinical Commissioning and Contracts Committee which is chaired by the Chief Officer): the Audit Committee, the Remuneration Committee, the Clinical Commissioning and Contracts Committee, the Quality and Safety Committee, the Patient Forum, the Finance Committee and the Primary Care Committee.

The CCG Governing Body receives regular reports from its committees on the quality of commissioned services, finance, performance, public & patient involvement, and governance. Other items of business discussed by Governing Body in 2018/19 have included:

- Quality
- Safeguarding
- Improvement and Assessment Framework
- Operational Plan and Commissioning Priorities
- Healthwatch North Tyneside Annual Report
• Director of Public Health Annual Report
• General Data Protection Regulation (GDPR)
• Northern CCG Joint Committee
• North Tyneside Cancer Plan
• Winter planning
• Corporate objectives
• Communications and Engagement Strategy

In addition to the formal meetings held during the year, there has been a development programme including four Governing Body development sessions covering:

• Northumbria Specialist Emergency Care Hospital (NSECH) Reset
• Counter fraud
• Direction of travel of NHS
• Risk management

The Governing Body completed a self-assessment of its operation and effectiveness during 2018/19. In January 2019 an on-line questionnaire (based on the UK Corporate Governance code, focusing on leadership, effectiveness, accountability, remuneration and relations with stakeholders and on the Department of Health & Social Care Board Governance Assurance Framework (2012) focusing on effective board room practice) was circulated to all Governing Body members.

The collated responses were reported to the Governing Body in March 2019. Whilst the self-assessment results were positive, the Governing Body agreed to look in more detail at members’ objectives; arrangements for appraisals and its development programme.

**Audit Committee**

The Audit Committee is a committee of the Governing Body. It was in operation throughout the 12 month period starting 1 April 2018, and has continued to operate since the period end.

The committee provides the CCG Governing Body with an independent and objective view of the CCG’s system of internal control, including financial systems, business systems, performance information, financial information and compliance with laws, regulations and directions governing the CCG.
The Audit Committee has agreed terms of reference. The committee is comprised entirely of independent members, as follows:

- CCG Lay Member for Governance and Audit (Chair) - David Willis
- CCG Deputy Lay Chair - Mary Coyle
- One other member with the relevant skills and experience as nominated by the Governing Body - Dr Shaun Lackey

Mr Willis and Ms Coyle have been members of the Audit Committee for the whole year 2018/19. Dr Lackey joined the Audit Committee on 21 September 2018.

The CCG internal and external auditors, Chief Finance Officer, Head of Finance and Head of Governance routinely attend the Audit Committee. The Chief Officer routinely attends annually and the Counter Fraud Officer has a standing invitation.

In accordance with the terms of reference, the Audit Committee meets not less than five times per financial year. In 2018/19 the Audit Committee met six times. On each occasion, Audit Committee members met privately and then with the internal and external auditors prior to the CCG officers joining the meeting. The Chair was present at all meetings.

The Audit Committee Chair provides a written briefing to all members of the CCG Governing Body after each meeting of the Audit Committee.

The Audit Committee receives assurances from the Quality & Safety Committee and the Finance Committee.

The Audit Committee’s main activities throughout the 12 month period starting 1 April 2018 have been:

- Overseeing the risk management processes across the CCG
- Approval and monitoring of the CCG’s audit plans
- Counter fraud
- Financial polices
- Financial reports
- Receiving assurances on quality and safety
- Receiving audit reports in-year
- Reviewing the annual report, annual governance statement and annual accounts for the Governing Body

The Audit Committee completed a self-assessment of its operation and effectiveness during 2018/19. In February 2019, an online questionnaire (based on the NHS Audit
Committee handbook) was circulated to all members and attendees of the CCG Audit Committee. Overall, the results of the survey were positive and members determined that no significant improvement actions were required.

**Remuneration Committee**

The Remuneration Committee was in operation throughout the 12 month period starting 1 April 2018 and has continued to operate since the period end.

The roles and responsibilities of the committee are set out in the CCG Constitution. The Remuneration Committee has agreed terms of reference.

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

The committee is comprised entirely of lay members, as follows:

- CCG Deputy Lay Chair (Chair) - Mary Coyle MBE DL
- CCG Lay Member for Governance and Audit - David Willis
- CCG Lay Member for Patient and Public Involvement - Eleanor Hayward

All members were in post at the time of CCG authorisation. All have been in post continuously from 1 April 2018 and remain in post.

The CCG Head of Governance attends the Remuneration Committee and the Chief Officer, Executive Director of Nursing & Chief Operating Officer and Head of Human Resources (from the Commissioning Support Unit) are in attendance as required.

When an individual is the subject matter of discussion at any time during the committee meeting, that individual is excluded from the meeting. The quorum for the meeting is two members. As there are three members the committee remains quorate even when a member is excluded. The Chair was present at all meetings.

The terms of reference require that the Remuneration Committee will meet at least annually.
The Remuneration Committee has met four times in the period from 1 April 2018 to March 2019. The principal items of business were:

- Remuneration
- Remuneration and staff report
- Agenda for Change (AfC)
- Benchmarking

**Clinical Commissioning and Contracts Committee**

The Clinical Commissioning and Contracts Committee is a committee of the Governing Body. The responsibilities of the Clinical Commissioning and Contracts Committee are set out in its agreed terms of reference.

The Clinical Commissioning and Contracts Committee assists the Governing Body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation. It is chaired by the Chief Officer. The membership of the Clinical Commissioning and Contracts Committee is shown at table nine.

The Clinical Commissioning and Contracts Committee meets no less than eight times per year.

The Clinical Commissioning and Contracts Committee met nine times in the period 1 April 2018 to 31 March 2019. The main items of business have included:

- Quality & risk updates
- Quality, innovation, productivity and prevention projects and schemes
- Future Care
- Continuing health care
- Commissioning intentions
- Operating plan
- Financial plan
- Procurements
- Risk Assurance Framework
- Finance, contract and performance reports
- Better Care Fund
- Intermediate care
- Right Care
- Improvement and Assessment Framework
• North Tyneside Cancer Plan update
• Voluntary and community sector development
• Corporate objectives
• Value based clinical commissioning
• Communications and Engagement Strategy

The Clinical Commissioning and Contracts Committee completed a self-assessment of its operation and effectiveness during 2018/19. The self-assessment was presented to the January 2019 committee.

Members concluded that, given that the Clinical Commissioning and Contracts Committee is a new committee (only eight months old) the results were good.

Quality and Safety Committee

The Quality and Safety Committee was in operation throughout the 12 month period starting 1 April 2018. The roles and responsibilities of the committee are set out in its agreed terms of reference.

The Quality and Safety Committee is responsible for ensuring the appropriate governance systems and processes are in place to commission, monitor and ensure the delivery of high quality safe patient care in commissioned services. The Quality and Safety Committee provides assurances to Governing Body and Audit Committee.

The Quality and Safety Committee membership comprises:

• Deputy Lay Chair (Chair of the Committee) – Ms Mary Coyle MBE DL
• Secondary Care Specialist Doctor – Dr Neela Shabde
• Member Practice GP Representative – Dr Riaan Swanepoel
• Medical Director - Dr Ruth Evans
• Executive Director of Nursing & Chief Operating - Dr Lesley Young-Murphy
• Deputy Director of Nursing, Quality and Patient Safety – Mrs Maureen Grieveson
• Practice Manager nominated by the Council of Practices – Mrs Alice Southern
• Head of Governance – Mrs Irene Walker
• Head of Safeguarding: Designated Nurse Safeguarding Children – Mrs Jan Hemingway
• Head of Planning & Commissioning – Mr Steve Rundle
The Quality and Safety Committee has met a total of ten times in the year from 1 April 2018 to 31 March 2019. The Chair was present at all but one meeting. The Quality and Safety Committee provides regular reports to the Governing Body.

The main items of business throughout the period starting 1 April 2018 have been:

- Integrated Governance Report
- Integrated Quality and Performance Report
- Continuing healthcare (CHC)
- Death under Deprivation of Liberty Safeguards (DoLS)
- CQC published reports
- Provider quality accounts
- Healthcare acquired infections
- Never events
- Safeguarding
- Serious incident and management
- Quality update – Primary Care Quality Group
- Commissioner assurance visits
- Information governance
- Equalities and diversity
- Risk management
- Health and safety
- Polices for approval

The committee completed a self-assessment of its effectiveness in January 2019 and the collated results were reported to the March 2019 meeting. Committee members received the results of the self-assessment and collectively agreed that there is constructive challenge in the meetings. The members decided that it would be useful to have a free text box in future surveys.

**Patient Forum**

The Patient Forum was in operation throughout the 12 month period starting 1 April 2018 and has continued to operate since the period end.

There have been six meetings of the patient forum between April 2018 and March 2019, and the Chair of the Committee has attended all six meetings.
The Patient Forum assists the CCG in its duty to secure public involvement and engagement in the planning, development and operation of commissioning arrangements, providing a clear patient and carer voice direct to the Governing Body.

The Patient Forum is chaired by the CCG Lay Member for Public and Patient Involvement, Mrs Eleanor Hayward and facilitated by the North Tyneside Community and Health Care Forum. Dr Lesley Young-Murphy, the Executive Director of Nursing and Chief Operating Officer, is the lead officer for the Patient Forum.

The Patient Forum aims to have membership from each of the 27 GP Practices in North Tyneside. Agenda items for the Forum are a mix of CCG areas for discussion and member-led issues.

The Patient Forum is strong, robust and acts as a critical friend to the CCG and its Governing Body. Members are encouraged to challenge and debate throughout all engagement processes. The strength of the Forum is the dedication and commitment within the membership as well as their passion for local health services.

The Patient Forum is supported by a range of working groups. The topics were decided by Forum members, and are compatible with CCG plans and priorities.

The Patient Forum programme of work for 2018/19 is described in the Performance Overview: Engaging People & Communities section of this report.

Finance Committee

The Finance Committee was in place in April 2018 and remains in place. There are agreed terms of reference for the committee. The remit of the committee is to oversee the financial position of the CCG. The committee’s agenda is driven by the priorities identified by the CCG and the associated risks.

The committee membership is as follows:

- Lay Member for Patient and Public Involvement (Chair) – Mrs Eleanor Hayward
- Lay Member for Governance and Audit – Mr David Willis
- Chief Officer - Mr Mark Adams
- Chief Finance Officer - Mr Jon Connolly
- Clinical Director – Dr Ruth Evans

The terms of reference require that the Finance Committee will meet at least monthly. The committee has met 11 times during the period April 2018 to March 2019 and continues to meet. The Chair was present at all meetings.
The principal items of business were:

- Monthly Finance Update Report
- Risk Assurance Framework
- Efficiency savings
- Investments
- CCG incentive scheme
- PWC review
- Medicines optimisation

**Primary Care Committee**

The Primary Care Committee is a committee of the Governing Body.

The committee functions as a corporate decision-making body for the management of delegated functions. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions as set out in Schedule 2 (delegated functions) and in accordance with section 13Z of the NHS Act.

The committee was established in April 2015 and remains in place. There are agreed terms of reference for the committee. The terms of reference were reviewed by the committee and a revised version was approved by the Governing Body in March 2018 to reflect delegated primary care commissioning.

The committee membership is as follows:

- CCG Deputy Lay Chair - Ms Mary Coyle MBE, DL (or in her absence the lay member for Patient and Public Engagement – Mrs Eleanor Hayward) *(voting member/s)*
- A Director from North Tyneside CCG – Dr Lesley Young Murphy, or deputy *(voting member)*
- The Chief Finance Officer – Mr Jon Connolly or deputy *(voting member)*
- A Director (or designate) from NHS England *(non-voting member)*
- Clinical Director or their nominated GP *(non-voting member)*
- Practice Manager – Mr Philip Horsfield *(non-voting member)*

There is a standing invitation to the meetings of this committee to specified partners in a non-voting capacity, namely the North Tyneside Health and Wellbeing Board and Healthwatch North Tyneside.

The terms of reference require that the Primary Care Committee will meet not less than four times per year in public. The committee has met five times in public during
the period April 2018 to March 2019 and continues to meet. The Chair was present at all meetings.

The principal items of business included:

- Operational update
- Quality update
- Locality working
- Extended access
- Local Enhanced Service Performance
- Digitisation of GP records
- Boundary changes
- North East International GP Recruitment Programme
- Primary care budget 2018/19
- Strategy update
- Primary care committee process and financial limits
- GP Patient Survey
- Cumbria and North East Primary Care Research Strategy
- Primary care policies and procedures

The committee completed a self-assessment of its effectiveness and the collated results were reported to the February 2019 meeting.

Committee members received the results of the self-assessment and agreed that the results did not highlight any significant issues and the committee is well embedded.
### Attendance records for CCG Governing Body and committees

**Table 10: Attendance Records for the Governing Body and associated committees for 2018/19**

<table>
<thead>
<tr>
<th>Name</th>
<th>Post Held</th>
<th>No. of Possible Attendances</th>
<th>No. of Actual Attendances</th>
<th>No. of Possible Attendances</th>
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<th>No. of Possible Attendances</th>
<th>No. of Actual Attendances</th>
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<td>Dr Richard Scott</td>
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<tr>
<td>Ms Mary Coyle</td>
<td>Lay Vice Chair</td>
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<td>Mr Dave Willis</td>
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<td>Mrs Eleanor Howard</td>
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<tr>
<td>Mr Neil Shadde</td>
<td>Secretary Care Specialist Doctor</td>
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<td>Dr Lindsay Young Mitchell</td>
<td>Executive Director of Nursing &amp; Chief Operating Officer</td>
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<td>Dr Stevan Loved</td>
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<tr>
<td>Dr Nick Kent</td>
<td>Clinical Director</td>
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<td>Dr Phil Heselwood</td>
<td>Practice Manager Clinical Audit Committee member</td>
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<td>Mr Alan Southern</td>
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<td>Mrs Bramon-Greaves</td>
<td>Nurse Director, Quality and Patient Safety</td>
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<td>Dr James Lomel</td>
<td>SP, Q&amp;S Committee Member</td>
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</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>Head of Governance</td>
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</tr>
<tr>
<td>Mrs Anya Penauds</td>
<td>Director of Contracting &amp; Commissioning</td>
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<tr>
<td>Mr Jan Hemingway</td>
<td>Designated Nurse Specificity</td>
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<tr>
<td>Mr James Martin</td>
<td>Commission Manager &amp; Performance Manager</td>
<td>6</td>
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<tr>
<td>Dr Steven Ruddle</td>
<td>Head of Planning &amp; Commissioning</td>
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<tr>
<td>Mrs Sally Charlton</td>
<td>Head of Improvement &amp; Development</td>
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<tr>
<td>Mr Jeff Goldthorpe</td>
<td>Head of Finance</td>
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</table>

*Low attendance at some committees attributable to long term absence or reduced capacity where the member works across more than one CCG*
UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance.

However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group and best practice.

Discharge of statutory functions

In light of recommendations of the 2013 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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group’s statutory duties.

Risk management arrangements and effectiveness

The CCG’s risk management strategy is underpinned by a risk management policy approved by Governing Body. The aims of the policy are to:

- Ensure that the CCG’s assesses its risk appetite
- 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 mitigation

Risk is identified by the relevant director and is recorded on the Risk Assurance Framework, which captures how the risk is evaluated and controlled.

The Risk Assurance Framework is reviewed quarterly by committees of the Governing Body, each reviewing and agreeing the risks which fall under their remit to
ensure that risks are properly identified, assessed and are being managed in line with the CCG’s risk appetite. This approach ensures that risks are managed effectively towards achieving the target risk score.

As the CCG focuses on its role as a commissioner of safe and high quality services, it seeks to embed the principles and practice of risk management into its commissioning function.

As a commissioner, the CCG seeks to ensure that all services commissioned meet nationally identified standards which are managed through the contracting process.

Equality Impact Assessments are completed for all CCG policies and projects, thereby ensuring integration into core business.

Incident reporting is openly encouraged and reported through the Quality and Safety Committee. All projects and QIPP schemes are risk assessed and managed appropriately through the Clinical Commissioning and Contracts Committee. Financial risk is overseen by the Finance Committee and clinical risk by the Clinical Commissioning and Contracts Committee and Quality and Safety Committee.

The CCG’s Patient Forum works with the CCG to identify risks to services. Public stakeholders are involved in managing risks contributing to CCG engagement, consultations and plans.

**Capacity to handle risk**

Governance structures ensure responsibility for the identification, evaluation and management of risk is embedded.

The Governing Body provides clear direction and leadership through approval of the risk policy, setting the risk appetite, receiving assurances from its committees that risk is properly managed and escalation through the Risk Assurance Framework (RAF). The RAF identifies the risks to compliance with statutory obligations and these are categorised as strategic risks.

The Governing Body receives assurance on the effective management of risk by receiving the RAF every quarter. The RAF aligns each strategic and corporate risk to the CCG’s corporate objectives and explains the controls in place to achieve the target risk level (risk score). Assurances are recorded on the RAF using the ‘three lines of defence’ methodology.

The governance structure assigns the oversight of corporate risks to the relevant Governing Body committee, i.e. Clinical Commissioning and Contracts Committee, Quality and Safety Committee and Finance Committee. In this way the CCG is assured that risks are reviewed by those with expert subject knowledge and the authority to drive improvement in the management of risk. These are then reviewed
by the Audit Committee who provides assurance to the Governing Body that the RAF reports the effective identification and management of risk.

Risk management training is provided on an ongoing basis through instruction from the Head of Governance on induction and thereafter through the continuous interpretation and application of the risk policy, supported by the Head of Governance.

The organisation has learned from best practice and its approach to risk management now includes a more frequent reporting cycle, the consolidation of the corporate risk register and assurance framework into one document - the RAF - the separate identification of strategic risks and corporate risks, the addition of target risk scores to the RAF, and inclusion of the three lines of defence in the RAF. Internal Audit provided substantial assurance in 2018/19 for governance and assurance arrangements.

**Risk assessment**

Our risk policy sets out how risks are assessed and scored including gross, residual and target risk scores.

Key corporate risks throughout 2018/19 are summarised as follows:

- Risk of unexpected and unacceptable decline in quality of services due to a focus on the Financial Recovery Plan
- Risk of delayed mobilisation of the urgent care contract
- Failure to mobilise 111 Clinical Advisory Service (CAS) service
- Delayed transfer of primary care records and/or medical supplies
- Intermediate Care - delayed discharges, and not realising their potential for rehabilitation
- Delayed ambulance handovers
- Contingency arrangements in the event of a no deal EU exit are not in place
- Inconsistency with the quality and timeliness of electronic discharge summaries (EDSs) to GP practices and community teams
- Patients are prescribed contraindicated medications
- New service delivery models rely on untested partnership working
- Capacity in Primary Care and system support for new ways of working challenges the delivery of sustainable Primary Care Services.
- Reduced capacity at director level leading to issues in delivery of the CCG’s remit
The CCG has risk mitigation plans in place to reduce risks to the target level and these are documented on the RAF and assured by Audit Committee.

The Governing Body noted that the CCG had effectively managed its risks in 2018/19. At year end the CCG had five red risks open, of which only two were open at the start of the year.

The CCG will continue to manage risks associated with patient safety and the quality of services and achievement of performance targets with rigour. Strategic risks remain permanently on our RAF to ensure these remain high priority.

Other sources of assurance

Internal Control Framework

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

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

The CCG system of internal control includes:

- A Governing Body that ensures that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance
- An approved CCG constitution, incorporating standing orders, scheme of delegation and prime financial policies
- A Governance Handbook has been introduced
- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure
- An appointed Accountable Officer who is responsible (amongst other duties) for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
- By working closely with the chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation’s ongoing capability and capacity to meet its duties and responsibilities
• An appointed Chief Finance Officer who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the CCG’s resources

• Staff members are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices and procedures

**Internal audit service**

One important feature of the system of internal control is the work of the internal audit service. Through a systematic programme of work, internal audit provide assurance on key systems of control.

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

**Policies**

Another key feature of the system of internal control is the application of a range of policies and procedures.

The CCG has a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named director lead and staff are advised and reminded of the CCG’s polices. Polices are reviewed at their due date.

The CCG Quality and Safety Committee receives assurance reports relating to statutory and mandatory training, compliance with health and safety, fire safety and first aid at work, information governance, equalities and diversity, and business continuity planning. There is commitment to continuing professional development, with robust processes in place for staff supervision, training, objective setting, performance review and appraisal.

The CCG has a Freedom to Speak Up: Raising Concerns (Whistleblowing) policy which is monitored by the Audit Committee.

**Annual audit of conflicts of interest management**

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of
conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out an annual internal audit of conflicts of interest and received substantial assurance.

This audit report was issued 6th May 2019.

Data quality
The CCG has a data quality policy. This policy defines data and explains data standards and the importance of data validation.

Robust data is provided to the Council of Practices, the Governing Body and other committees of the CCG.

The Governing Body reviewed its self-assessment in January 2019 and the members who participated in the survey agreed unanimously that the Governing Body is supplied with information and support in a timely manner, in a form and of a quality appropriate to enable it to discharge its duties.

The results of the Audit Committee’s self-assessment in February 2019 showed that all respondents agreed that the quality of committee papers received allowed them to perform their role effectively.

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 Data Security and Protection toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

We have established an information governance management framework and are developing, or have developed, information governance processes and procedures in line with the Data Security and Protection toolkit.

We have ensured all staff undertake annual information governance training, and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.
There are processes in place for incident reporting and investigation of serious incidents.

The CCG has submitted a compliant Data Security and Protection toolkit for 2018/19. This has been audited with only one low level finding highlighted.

**Business Critical Models**

The CCG does not have any business critical models.

**Third party assurances**

The CCG relies on several external support services providers, including:

- The NHS Shared Business Service (SBS)
- Electronic Staff Records (ESR) (McKesson)
- NHS Business Services Authority (BSA)

<table>
<thead>
<tr>
<th>Assurance Source</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll Services</td>
<td>“Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. The CCG, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year. The assurance letter for 2018/19 provides an assurance level of substantial”</td>
</tr>
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</table>
| North of England Commissioning Support Unit (NECS) | “NHS England’s internal auditors, Deloitte LLP, via an ISAE 3402 Type II report issued on 30 April 2019 and covered the period from 1 April 2018 to 31 March 2019. This report identified some weaknesses in the operation of controls during the period, which were set out in their ‘Basis for Qualified Opinion’ section of the report.”  
However, the controls tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved throughout the period 1 April 2018 to 31 March 2019. |
| The NHS Shared Business Service (SBS) | “Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) has been provided by the NHS SBS’ auditors, PwC LLP, via an ISAE 3402 report issued on 16 |

Table 11: Third-party assurances
<table>
<thead>
<tr>
<th>Assurance Source</th>
<th>Commentary</th>
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<tbody>
<tr>
<td>April 2019. The report provided reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2018 to 31 March 2019, and that the controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2018 to 31 March 2019.”</td>
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<tr>
<td>Primary Care Support Services (Capita Business Services Limited)</td>
<td>“Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority and Capita for 2018/19 has been provided by the NHS BSA’s auditors, PwC LLP, via an ISAE 3402 Type II report issued on 30 April 2019. The report provided reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2018 to 31 March 2019 and customers applied the complementary controls referred to in the scope paragraph of the assurance report, and the controls tested […] provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2018 to 31 March 2019.”</td>
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<tr>
<td>Assurance Source</td>
<td>Commentary</td>
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<tr>
<td></td>
<td>and the controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2018 to 31 March 2019.”</td>
</tr>
<tr>
<td>Local Counter Fraud Specialist</td>
<td>The “Local Counter Fraud Specialist is required to submit an annual Self-Review Tool (SRT) to NHS Counter Fraud Authority in relation to the CCG’s anti-fraud, bribery and corruption arrangements, which provides an overview of the CCG’s counter fraud activity, progress against NHSCFA requirements and assists the CFO and audit committee in monitoring and managing the counter fraud service. The completed SRT for 2018/19 was reviewed by the audit committee chair and authorised by the Chief Finance Officer prior to submission on 30 April 2019. The CCG’s overall rating for 2018/19 was assessed as amber. The CCG has not been subject to an NHSCFA quality inspection in 2018/19.”</td>
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</table>

**Control issues**

All CCGs in England are subject to an annual assessment framework, led by NHS England. At the time of publication the CCG is awaiting its rating for 2018/19.

The CCG has in place a robust system of internal control. The CCG has assurances from the Head of Internal Audit and from other sources to support this assessment.

The CCG reported one information governance breach which was closed without the requirement to report to the Information Commissioner. Secure emailing arrangements have been reviewed, updated and staff reminded of correct procedures.

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

The Governing Body receives reports from its relevant committees (Finance Committee, Clinical Commissioning and Contracts Committee, Quality & Safety Committee and Audit Committee) providing assurance that the CCG uses its resources economically, efficiently and effectively.

The CCG budget comprises the commissioning budget and the operating budget. The 2018/19 budget was approved by the Governing Body. The Governing Body received regular reports against budget throughout the year.
The CCG commissioning budget is deployed to commission healthcare for the population of North Tyneside, in line with national guidance.

The CCG works in close partnership with local healthcare providers. Regular contract monitoring meetings and Quality Review Group meetings are held with all the principal providers.

A Quality, Innovation, Productivity and Prevention (QIPP) savings programme has been in place throughout the year.

The CCG external auditors have concluded that ‘in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.’

In respect of the CCG operating budget, there is an agreed staffing structure, balancing the roles of clinical leaders, including the Clinical Chair, Medical Director, Executive Director of Nursing and Chief Operating Officer, Clinical Directors and Clinical Leads. CCG staff are organised into three Directorates.

The remuneration committee sets the remuneration of Very Senior Managers and Clinical Leaders (for whom there are no national pay scales). The Senior Management Team ensures that remuneration for posts in the CCG structure is in line with national guidance, to ensure consistency between posts.

As part of the improvement and assessment framework for 2018/19, the CCG at the time of publication is still awaiting confirmation of its quality of leadership assessment and overall end of year rating. When the assessments are published they will be available at the following links:

https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/

https://www.nhs.uk/service-search/Performance/Search

Delegation of functions

The CCG currently contracts with a number of external organisations for the provision of back office services and functions, and as such has established an internal control system to gain assurance from these. These external services include:

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs and is fundamental in producing NHS England group financial accounts through the use of an integrated financial ledger system
• The provision of financial accounting services from the North of England Commissioning Support Unit
• The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
• The provision of the ESR payroll systems support from McKesson
• The provision of Primary Care Support Services from Capita Business Services Limited

Assurance on the effectiveness of the controls is described under the Other Sources of Assurance section and the outcome of these audits is reported to the Audit Committee.

**Counter fraud arrangements**

Our counter fraud activity plays a key part in deterring risks to the organisation’s financial viability and probity.

An annual counter fraud plan is agreed by the Audit Committee, which focuses on the deterrence, prevention, detection and investigation of fraud.

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

An accredited counter fraud specialist is contracted to undertake counter fraud work proportionate to identified risks.

The CCG Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.

A member of the Governing Body is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

There were no reported incidents of fraud during 2018-19.

In December 2017 the final report of the focused quality assessment of compliance against NHS Protect standards for commissioners 2017/18 (Fraud, Bribery and Corruption) rated the CCG overall green rating for its work in Strategic Governance and an overall amber rating for its work in Inform and Involve.

Results were reported to the Audit Committee and an action plan for improvement was agreed. The actions are now complete.
Head of Internal Audit opinion

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

The Head of Internal Audit concluded that:

*From my review of your systems of internal control, I am providing an opinion of substantial assurance that the system of internal control has been effectively designed to meet the organisation’s objectives, and that controls are being consistently applied.*

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

**Table 12 Assurance levels**

<table>
<thead>
<tr>
<th>Area of Audit</th>
<th>Level of Assurance Given</th>
<th>RAG</th>
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<tr>
<td>Assurance Levels</td>
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<tr>
<td>Substantial</td>
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<tr>
<td>Good</td>
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<tr>
<td>Reasonable</td>
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<tr>
<td>Limited</td>
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<tr>
<td>High-Level Review of Governance and Assurance Arrangements</td>
<td>Substantial</td>
<td></td>
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<tr>
<td>Conflicts of Interest</td>
<td>Substantial</td>
<td></td>
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<tr>
<td>Financial and Strategic Planning</td>
<td>Substantial</td>
<td></td>
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<tr>
<td>Cost Improvement and QIPP (including Service Transformation)</td>
<td>Substantial</td>
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<tr>
<td>Contract and Performance Monitoring (including Value Based Commissioning)</td>
<td>Substantial</td>
<td></td>
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<tr>
<td>Key Financial Controls</td>
<td>Substantial</td>
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<tr>
<td>Data Security and Protection Toolkit</td>
<td>No assurance level given.</td>
<td>N/A</td>
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At the time of our review (February 2019) we found that 17 out of a sample of 18 requirements could be evidenced and substantiated. Feedback was provided to the CCG to enable action on the remaining requirement before the final submission date of 31 March 19.
Area of Audit | Level of Assurance Given | RAG
---|---|---
Primary Medical Care Commissioning | Substantial |  
Continuing Healthcare and Funded Nursing Care | Substantial |  
Safeguarding Arrangements | Substantial |  
Medicines Management Arrangements | Substantial |  

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, 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 Board
- The Audit Committee
- The Clinical Commissioning and Contracts Committee
- The Quality and Safety Committee
- The Finance Committee
- Internal Audit

The Governing Body develops, implements and delivers the strategic priorities of the Group and receives assurances from the Audit Committee, the Quality and Safety Committee and the Clinical Commissioning and Contracts Committee. Substantial assurance has also been received from the Head of Internal Audit.

In addition to the assurances provided by management processes, the work of the Internal Auditors and External Auditors and oversight of the Governing Body and CCG committees, the CCG is subject to the national assurance process through the NHS England Improvement and Assessment Framework.
The CCG has regular dialogue with the NHS England local team and participates in the formal assurance process. An overall assessment is provided on an annual basis against the framework, including a rating for six clinical areas.

The CCG was given the following rating for each of the six clinical areas for 2018/19 (which is the latest data available):

- Cancer - Good
- Dementia - Good
- Mental Health – Outstanding
- Diabetes – Outstanding
- Learning Disabilities – Good
- Maternity – Requires Improvement

Data for 2018/19 will be available online from July 2019 at: https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/
Conclusion

The system of control described in this report has been in place in the CCG for the year ended 31 March 2019 and up to the date of the approval of the annual report and accounts.

The work undertaken in 2018/19 across the range of assurance providers to the CCG has shown that:

- The CCG has met its statutory duty to ensure expenditure does not exceed income.
- The Head of Internal Audit concluded an overall Opinion of ‘substantial assurance’

I have concluded that the CCG did have a generally sound system of internal control in place continuously throughout the year, designed to meet the organisations objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

MARK ADAMS

Accountable Officer

21 May 2019
Remuneration and staff report

The remuneration and staff report gives details of CCG staff and remuneration. It sets out the CCG’s remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

Remuneration report

Remuneration Committee

The roles and responsibilities of the committee are set out in the CCG Constitution. The Remuneration Committee has agreed terms of reference.

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

The committee is comprised entirely of lay members, as follows:

- CCG Deputy Lay Chair (Chair) – Ms Mary Coyle MBE DL
- CCG Lay Member for Governance and Audit – Mr David Willis
- CCG Lay Member for Patient and Public Involvement – Mrs Eleanor Hayward

All members were in post at the time of CCG authorisation. All have been in post continuously from 1 April 2018 and remain in post.

Policy on the remuneration of senior managers

The remuneration committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff.

The committee is comprised entirely of independent members. Details of remuneration committee membership, meeting frequency, items of business and meeting attendance are given above. Further details about the committee are provided in the governance statement within this report, e.g. frequency of meetings and attendance.

The remuneration committee has delegated authority from the Governing Body to make recommendations on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG. 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 out with the 'Very Senior Management Pay Framework'. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to all very senior managers (VSMs) (except clinicians) employed by the CCG are permanent in nature and subject to six months’ notice of termination by either party.

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 Very Senior Managers**

Where one or more senior managers of a CCG are paid more than £150,000 per annum on a pro-rata basis, equivalent to the Prime Minister’s salary, information is disclosed in the remuneration report.

During 2018/19 North Tyneside CCG had five senior managers who were paid more than £150,000 per annum on a pro-rata basis.

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

The Remuneration Committee critically reviews the salary of very senior managers when making recommendations to Governing Body regarding their remuneration.
### Senior manager remuneration (including salary and pension entitlements)

Table 13 - North Tyneside CCG remuneration report 2018/19 (this has been subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary (bands of £5,000)£000</th>
<th>Expense payments (taxable) to nearest £100 £00</th>
<th>Performance pay and bonuses (bands of £5,000) £000</th>
<th>Long-term performance pay and bonuses (bands of £2,500) £000</th>
<th>All pension related benefits (bands of £5,000) £000</th>
<th>TOTAL (bands of £5,000) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Richard Scott</td>
<td>Clinical Chair</td>
<td>60-65</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>267.5-270</td>
<td>330-335</td>
</tr>
<tr>
<td>Mr Mark Adams</td>
<td>Accountable Officer</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55-60</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>Executive Director of Nursing &amp; Chief Operating Officer</td>
<td>115-120</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-17.5</td>
<td>130-135</td>
</tr>
<tr>
<td>Mr Jon Connolly</td>
<td>Chief Finance Officer</td>
<td>105-110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Ruth Evans</td>
<td>Medical Director</td>
<td>80-85</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>25-27.5</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Neela Shabde</td>
<td>Secondary Care Doctor</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>Director of Contracting and Commissioning</td>
<td>80-85</td>
<td>55</td>
<td>-</td>
<td>-</td>
<td>37.5-40</td>
<td>125-130</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>Head of Governance</td>
<td>60-65</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-17.5</td>
<td>75-80</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>Clinical Director</td>
<td>75-80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85-87.5</td>
<td>160-165</td>
</tr>
<tr>
<td>Dr Alexandra Kent</td>
<td>Clinical Director</td>
<td>50-55</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95-97.5</td>
<td>145-150</td>
</tr>
<tr>
<td><strong>Lay members:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Mary Coyle MBE DL</td>
<td>Deputy Lay Chair</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
</tr>
<tr>
<td>Mrs Eleanor Hayward</td>
<td>Lay Member (patient and public involvement)</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr David Willis</td>
<td>Lay Member (audit and governance)</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
</tbody>
</table>
Notes for senior manager remuneration table 2018/19:

All pension related benefits information is provided by NHS Pensions. The figure shown does not reflect annual remuneration received by the individual during the year. This is the annual increase in pension entitlement expected over a twenty year period. The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme which explains the Clinical Chair value reported in 2018/19

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG’s share of remuneration of 40%. Pension benefits are reported in full by Newcastle Gateshead CCG.

Mr Jon Connolly is employed by North Tyneside CCG and works for Northumberland CCG as part of a staff-sharing arrangement since 1st March 2019. The salary disclosed above shows North Tyneside CCG’s share of remuneration of 100% until 28th February 2019 and 50% from 1st March 2019. Pension benefits are reported in full by North Tyneside CCG.

Mrs Wendy Burke, Director of Public Health is in attendance at Governing Body only. She is not employed by North Tyneside CCG and receives no remuneration from the CCG for her Governing Body role.
**Staff sharing arrangement for senior manager remuneration 2018/19**

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

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

The total remuneration earned for all work across the two CCGs in 2018/19 is shown below:

*Table 14 - North Tyneside CCG staff sharing arrangement 2018/19 (this has been subject to audit)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary (bands of £5,000)</th>
<th>Expense payments (taxable) to nearest £100</th>
<th>TOTAL (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Mark Adams</td>
<td>Accountable Officer</td>
<td>145-150</td>
<td>-</td>
<td>145-150</td>
</tr>
<tr>
<td>Mr Jon Connolly</td>
<td>Chief Finance Officer</td>
<td>110-115</td>
<td>-</td>
<td>110-115</td>
</tr>
</tbody>
</table>
## Senior manager remuneration (including salary and pension entitlements)

Table 15 - North Tyneside CCG remuneration report 2017/18 (this has been subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary</th>
<th>Expense payments (taxable) to nearest £100</th>
<th>Performance pay and bonuses</th>
<th>Long-term performance pay and bonuses</th>
<th>All pension related benefits</th>
<th>TOTAL (bands of £5,000) £ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr John Matthews</td>
<td>Clinical Chair</td>
<td>70-75</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>120-122.5</td>
<td>190-195</td>
</tr>
<tr>
<td>Mr Mark Adams</td>
<td>Accountable Officer</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55-60</td>
</tr>
<tr>
<td>Mr Jon Connolly</td>
<td>Chief Finance Officer</td>
<td>105-110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>Director of Transformation and Executive Nurse</td>
<td>110-115</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90-92.5</td>
<td>205-210</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>Director of Contracting and Commissioning</td>
<td>50-55</td>
<td>33</td>
<td>-</td>
<td>-</td>
<td>45-47.5</td>
<td>100-105</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>Head of Governance</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12.5-15</td>
<td>70-75</td>
</tr>
<tr>
<td>Dr Martin Wright</td>
<td>Medical Director</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50-52.5</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Ruth Evans</td>
<td>Medical Director</td>
<td>75-80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20-22.5</td>
<td>95-100</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>Clinical Director</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>122.5-125</td>
<td>180-185</td>
</tr>
<tr>
<td>Dr Neela Shabde</td>
<td>Secondary Care Doctor</td>
<td>0-5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0-5</td>
</tr>
<tr>
<td><strong>Lay members:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Mary Coyle MBE DL</td>
<td>Deputy Lay Chair</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr David Willis</td>
<td>Lay Member (audit and governance)</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td>Mrs Eleanor Hayward</td>
<td>Lay Member (patient and public involvement)</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td><strong>Interim:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr John Wicks</td>
<td>Chief Operating Officer</td>
<td>85-90</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85-90</td>
</tr>
</tbody>
</table>
Notes for senior manager remuneration table 2017/18:

All pension related benefits information is provided by NHS Pensions. The figure shown does not reflect annual remuneration received by the individual during the year. This is the annual increase in pension entitlement expected over a twenty year period.

Interim staff salary values are based upon the cost incurred by the CCG. Lay members and permanent staff are remunerated by North Tyneside CCG.

Dr John Matthews left Clinical Chair role on 31st March 2018

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG as part of a staff-sharing arrangement. The salary disclosed above shows North Tyneside CCG’s share of remuneration of 40%. Pension benefits are reported in full by Newcastle Gateshead CCG.

Mr Jon Connolly commenced Chief Finance Officer role in April 2017.

Mrs Anya Paradis commenced Director of Contracting and Commissioning role in August 2017.

Dr Martin Wright left Medical Director role in November 2017.

Dr Ruth Evans commenced Medical Director role in November 2017. Remuneration reported includes Clinical Director role from 1st April 2017 to 19th November.

Dr Shaun Lackey commenced Clinical Director role in May 2017.

Dr Neela Shabde commenced Secondary Care Doctor role in January 2018.

Mr John Wicks left Chief Operating Officer role in July 2017. John Wicks was not employed directly by the CCG. The salary value is based upon the cost incurred by the CCG.

Mrs Wendy Burke, Director of Public Health is in attendance at Governing Body only. She is not employed by North Tyneside CCG and receives no remuneration from the CCG for her Governing Body role.
Staff sharing arrangement for senior manager remuneration 2017/18

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

The total remuneration earned for all work across the two CCGs in 2017/18 is shown below:

Table 16 - North Tyneside CCG staff sharing arrangement 2017/18 (this has been subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary (bands of £5,000)</th>
<th>Expense payments (taxable) to nearest £100</th>
<th>TOTAL (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Mark Adams</td>
<td>Accountable Officer</td>
<td>145-150</td>
<td>-</td>
<td>145-150</td>
</tr>
</tbody>
</table>
## Pension benefits as at 31 March 2019

Table 17 - North Tyneside CCG senior officers pension benefits 2018/19 (this has been subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase in pension at pension age (bands of £2,500)</th>
<th>Real increase in pension lump sum at pension age (bands of £2,500)</th>
<th>Total accrued pension at pension age at 31 March 2019 (bands of £5,000)</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1 April 2018 (£000)</th>
<th>Real Increase in Cash Equivalent Transfer Value (£000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2019 (£000)</th>
<th>Employer's contribution to stakeholder pension (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Richard Scott</td>
<td>10-12.5</td>
<td>32.5-35</td>
<td>15-20</td>
<td>45-50</td>
<td>70</td>
<td>200</td>
<td>279</td>
<td>9</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>30-35</td>
<td>90-95</td>
<td>618</td>
<td>75</td>
<td>709</td>
<td>17</td>
</tr>
<tr>
<td>Dr Ruth Evans</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>35-40</td>
<td>282</td>
<td>48</td>
<td>342</td>
<td>12</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>30-35</td>
<td>205</td>
<td>53</td>
<td>268</td>
<td>11</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>0-2.5</td>
<td>-</td>
<td>0-5</td>
<td>-</td>
<td>42</td>
<td>14</td>
<td>64</td>
<td>9</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>15-20</td>
<td>40-45</td>
<td>192</td>
<td>84</td>
<td>292</td>
<td>13</td>
</tr>
<tr>
<td>Dr Alexandra Kent</td>
<td>5-7.5</td>
<td>-</td>
<td>5-10</td>
<td>-</td>
<td>34</td>
<td>50</td>
<td>92</td>
<td>8</td>
</tr>
</tbody>
</table>

Notes for senior officer pension benefits 2018/19:

Pensions information is provided by NHS Pensions

Cash equivalent transfer value at 1 April 2018 has been inflated by 3% in accordance with NHS Business Services Authority instructions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Benefits and related Cash Equivalent Transfer Values do not allow for a potential future adjustment arising from the McLeod judgement.
Pension benefits as at 31 March 2018

Table 18 - North Tyneside CCG senior officers pension benefits 2017/18 (this has been subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase in pension at pension age (bands of £2,500)</th>
<th>Real increase in pension lump sum at pension age (bands of £2,500)</th>
<th>Total accrued pension at pension age at 31 March 2018 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1 April 2017 (bands of £5,000)</th>
<th>Real Increase in Cash Equivalent Transfer Value (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2018 (bands of £5,000)</th>
<th>Employer's contribution to stakeholder pension (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ruth Evans</td>
<td>0-2.5</td>
<td>15-17.5</td>
<td>15-20</td>
<td>35-40</td>
<td>248</td>
<td>14</td>
<td>273</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>5-7.5</td>
<td>12.5-15</td>
<td>10-15</td>
<td>30-35</td>
<td>129</td>
<td>46</td>
<td>187</td>
</tr>
<tr>
<td>Dr John Matthews</td>
<td>5-7.5</td>
<td>15-17.5</td>
<td>15-20</td>
<td>45-50</td>
<td>227</td>
<td>122</td>
<td>359</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>2.5-5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>25-30</td>
<td>162</td>
<td>28</td>
<td>199</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>0-2.5</td>
<td>-</td>
<td>0-5</td>
<td>-</td>
<td>23</td>
<td>10</td>
<td>41</td>
</tr>
<tr>
<td>Dr Martin Wright</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>40-45</td>
<td>234</td>
<td>28</td>
<td>294</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>2.5-5</td>
<td>12.5-15</td>
<td>25-30</td>
<td>80-85</td>
<td>474</td>
<td>109</td>
<td>600</td>
</tr>
</tbody>
</table>

Notes for senior officer pension benefits 2017/18:

Pensions information is provided by NHS Pensions.

Cash equivalent transfer value at 1 April 2017 has been inflated by 1% in accordance with NHS Business Services Authority instructions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Real increase in Cash Equivalent Transfer Value has been restated in accordance with the latest guidance from NHS Pensions.

Dr Martin Wright left the CCG in November 2017. Real increases in pension are a proportion for the time in post.
Cash equivalent transfer values

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

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

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

Real increase in CETV

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

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

The CCG has not made any payment for compensation on early retirement or for loss of office in 2018/19.

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

The CCG has not made any payment to past members during 2018/19.
Fair Pay Disclosure (this has been subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in North Tyneside CCG in the financial year 2018/19 was £115-120k (2017/18: £110-115k). This was 2.2 times (2017/18: 2.2) the median remuneration of the workforce, which was £52,536 (2017/18: £50,972).

In 2018/19, no employee (2017/18, no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £1,256 to £86,867 (2017/18 restated: £1,256 to £110,000). In order to be comparable with the current year the lower end of the 2017/18 range has been restated based on actual remuneration.

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

The pay multiples ratio has remained at the same level in 2018/19. The decrease in median remuneration relates to marginal changes to the overall remuneration and number of the workforce in year.

<table>
<thead>
<tr>
<th>Table 19 - Fair Pay Disclosure (this has been subject to audit)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Band of Highest Paid Director’s Total Remuneration (£’000)</strong></td>
</tr>
<tr>
<td>115-120</td>
</tr>
<tr>
<td><strong>Median Total Remuneration (£)</strong></td>
</tr>
<tr>
<td><strong>Ratio</strong></td>
</tr>
</tbody>
</table>
Staff Report

Number of senior managers
The CCG had 13 senior managers in post at 31 March 2019.

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

Staff numbers and costs are analysed by permanent employees and ‘other.’

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

The figures exclude Chair and lay members of the Governing Body.

Table 20 - Staff Numbers and Costs (this has been subject to audit)

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of people employed</td>
<td>43.44</td>
<td>1.39</td>
<td>44.83</td>
</tr>
</tbody>
</table>

Average number based upon full time equivalent and excludes staff on outward secondment

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>2,421</td>
<td>99</td>
<td>2,520</td>
</tr>
<tr>
<td>Social security costs</td>
<td>247</td>
<td>-</td>
<td>247</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>286</td>
<td>-</td>
<td>286</td>
</tr>
<tr>
<td>Less: recoveries in respect of outward secondment</td>
<td>(34)</td>
<td>-</td>
<td>(34)</td>
</tr>
<tr>
<td><strong>Staff costs</strong></td>
<td><strong>2,920</strong></td>
<td><strong>99</strong></td>
<td><strong>3,019</strong></td>
</tr>
</tbody>
</table>
Staff composition

The CCG staff gender profile at 31 March 2019 is based upon information relating to permanently employed staff as follows:

Table 21 - Staff composition

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Senior managers</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other staff</td>
<td>47</td>
<td>18</td>
<td>65</td>
</tr>
<tr>
<td>Total staff</td>
<td>49</td>
<td>19</td>
<td>68</td>
</tr>
</tbody>
</table>

Staff sickness absence

The CCG has an agreed policy on the management of staff absence which ensures all staff are treated fairly and equitably, with the relevant support from line managers and HR advisors. The CCG also has access to occupational health services.

Table 22 - Staff sickness absence

<table>
<thead>
<tr>
<th></th>
<th>2018-19 Number</th>
<th>2017-18 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>266</td>
<td>371</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

Staff policies

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

- Providing employees systematically with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the CCG’s performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the CCG
- Membership of the North East Partnership Forum, where staff representatives and CCG managers from across the region meet together
The CCG has a positive attitude to the recruitment, employment, training and development of disabled persons and has achieved accreditation as a Level 2 Disability Confident employer. The symbol, awarded by the Department of Work and Pensions, in partnership with Job Centre Plus, demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

**Trade Union Representation**

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

During 2018/19 there were no employees of NHS North Tyneside Clinical Commissioning Group who were trade union representatives.

**Expenditure on consultancy**

The CCG did not incur consultancy expenditure during 2018/19 (2017/18, £3k)

**Off-payroll engagements**

Table 23 - Off-payroll engagements longer than six months

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing engagements as of 31 March 2019</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>For less than one year at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For between one and two years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For between two and three years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For between three and four years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For four or more years at the time of reporting</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 24 - New off-payroll engagements longer than six months

New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, greater than £245 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019</td>
<td>9</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>number assessed that fall under the remit of IR35</td>
<td>9</td>
</tr>
<tr>
<td>number assessed that do not fall under the remit of IR35</td>
<td>0</td>
</tr>
<tr>
<td>Number engaged directly (via personal service company contracted to department) and are on the department payroll</td>
<td>9</td>
</tr>
<tr>
<td>Number of engagements reassessed for consistency/assurance purposes during the year</td>
<td>0</td>
</tr>
<tr>
<td>Number of engagements that saw a change to IR35 status following the consistency review</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 25 - Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year</td>
<td>0</td>
</tr>
<tr>
<td>Total no. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. Reported in Table 13.</td>
<td>13</td>
</tr>
</tbody>
</table>

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

No exit packages including special (non-contractual) payments were made in 2018/19.
Independent auditor’s report to the Governing Body of NHS North Tyneside Clinical Commissioning Group

Opinion on the financial statements
We have audited the financial statements of NHS North Tyneside Clinical Commissioning Group (‘the CCG’) for the year ended 31 March 2019, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England (“the Accounts Direction”).

In our opinion, the financial statements:
• give a true and fair view of the state of the CCG’s affairs as at 31 March 2019 and of its net operating expenditure for the year then ended;
• have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19; and
• have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

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

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

Conclusions relating to going concern
We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:
• the Accountable Officer’s use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
• the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG’s ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

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

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

We have nothing to report in this regard.

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

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

**Auditor’s responsibilities for the audit of the financial statements**

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

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

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

**Opinion on other matters prescribed by the Code of Audit Practice**

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

We are required to report to you if:

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

We have nothing to report in these respects.

**The CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources**

**Matter on which we are required to report by exception**
We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in this respect.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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

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

Cameron Waddell
Partner
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

Date
Parliamentary accountability and audit report

North Tyneside CCG is not required to produce a parliamentary accountability and audit report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the financial statements of this report at page 126.

An audit certificate and report is also included in this annual report at page 120.
Annual accounts
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<th>Page Number</th>
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<tr>
<td>Statement of Financial Position as at 31st March 2019</td>
<td>2</td>
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<tr>
<td>Statement of Changes in Taxpayers' Equity for the year ended 31st March 2019</td>
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</tr>
<tr>
<td>Statement of Cash Flows for the year ended 31st March 2019</td>
<td>4</td>
</tr>
</tbody>
</table>

Notes to the Accounts

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<tr>
<th>Note</th>
<th>Page Number</th>
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<td>5-7</td>
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<td>Other operating revenue</td>
<td>8</td>
</tr>
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<td>Employee benefits and staff numbers</td>
<td>8-9</td>
</tr>
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<td>Operating expenses</td>
<td>10</td>
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<tr>
<td>Better payment practice code</td>
<td>11</td>
</tr>
<tr>
<td>Operating leases</td>
<td>11</td>
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<tr>
<td>Property, plant and equipment</td>
<td>12</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>13</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>14</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>14</td>
</tr>
<tr>
<td>Financial instruments</td>
<td>15</td>
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<tr>
<td>Pooled Budgets</td>
<td>15</td>
</tr>
<tr>
<td>Related party transactions</td>
<td>16</td>
</tr>
<tr>
<td>Events after the end of the reporting period</td>
<td>17</td>
</tr>
<tr>
<td>Financial performance targets</td>
<td>17</td>
</tr>
</tbody>
</table>
## Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sale of goods and services</td>
<td>-</td>
<td>(22)</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>(178)</td>
<td>(131)</td>
</tr>
<tr>
<td><strong>Total operating revenue</strong></td>
<td>(178)</td>
<td>(153)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>3,019</td>
<td>2,779</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>347,955</td>
<td>339,826</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Other operating expenditure</td>
<td>173</td>
<td>137</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td>351,175</td>
<td>342,771</td>
</tr>
</tbody>
</table>

**Comprehensive Expenditure for the year ended 31 March 2019**

<table>
<thead>
<tr>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>350,997</td>
<td>342,618</td>
</tr>
</tbody>
</table>
## Statement of Financial Position as at 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
<td>1,739</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>96</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>1,835</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>1,847</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>(22,554)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(22,554)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td></td>
<td>(20,707)</td>
</tr>
</tbody>
</table>

**Financed by Taxpayers’ Equity**

| General fund | | |
| (20,707) | (20,466) |

**Total Taxpayers’ Equity:**

| (20,707) | (20,466) |

The notes on pages 5 to 17 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 21 May 2019 and signed on its behalf by:

Accountable Officer
Mark Adams
## Statement of Changes In Taxpayers' Equity for the year ended 31 March 2019

### General fund

<table>
<thead>
<tr>
<th>£'000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2018</strong></td>
<td>(20,466)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2018-19</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>SOCNE</td>
</tr>
<tr>
<td><strong>Net Recognised CCG Expenditure for the Financial Year</strong></td>
<td></td>
</tr>
<tr>
<td>Net funding</td>
<td>SCF</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>(20,707)</td>
</tr>
</tbody>
</table>

### General fund

<table>
<thead>
<tr>
<th>£'000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2017</strong></td>
<td>(20,180)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2017-18</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>SOCNE</td>
</tr>
<tr>
<td><strong>Net Recognised CCG Expenditure for the Financial Year</strong></td>
<td></td>
</tr>
<tr>
<td>Net funding</td>
<td>SCF</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2018</strong></td>
<td>(20,466)</td>
</tr>
</tbody>
</table>

The financial statements on pages 1, 2 and 4 form part of this statement.
### NHS North Tyneside CCG - Annual Accounts 2018-19

#### Statement of Cash Flows for the year ended

**31 March 2019**

<table>
<thead>
<tr>
<th>Description</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(350,997)</td>
<td>(342,618)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Increase in trade &amp; other receivables</td>
<td>8</td>
<td>(19)</td>
</tr>
<tr>
<td>Increase in trade &amp; other payables</td>
<td>10</td>
<td>243</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(350,746)</td>
<td>(342,369)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow before Financing</strong></td>
<td>(350,746)</td>
<td>(342,369)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant in Aid Funding Received</td>
<td>350,756</td>
<td>342,331</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Financing Activities</strong></td>
<td>350,756</td>
<td>342,331</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85</td>
<td>123</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>96</td>
<td>85</td>
</tr>
</tbody>
</table>

The notes on pages 5 to 17 form part of this statement
Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the DHSC. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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.

1.3 Pooled Budgets

The Clinical Commissioning Group has entered into a pooled budget arrangement with North Tyneside Council, under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. See Note 12 for further details.

Joint operations are arrangements where contractual agreements are in place under which the Clinical Commissioning Group and one or more other parties share control. Joint ventures have rights to assets and obligations in relation to liabilities. The Clinical Commissioning Group accounts only for its share of the assets, liabilities, revenue and expenses of the arrangement.

1.4 Revenue

The majority of the Clinical Commissioning Group's funding is via Resource Allocation. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.5 Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS workers, General Practitioners and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.6 Other Expenses

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

1.7 Property, Plant & Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost, irrespective of their individual or collective cost.

Where a large asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Property, plant and equipment that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.7.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.
1.8 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.9.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in the CCG’s Statement of Comprehensive Net Expenditure. Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 Cash & Cash Equivalents

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

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Clinical Commissioning Group.

1.12 Non-clinical Risk Pooling

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

1.13 Financial Assets

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit or loss.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

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

1.13.1 Financial Assets at Amortised cost

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

1.13.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

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

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

Additionally DHSC provides a guarantee of last resort against the debts of its arm’s lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset’s original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.
1.14 Financial Liabilities
Financial liabilities are recognised on the statement of financial position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. Loans from the DHSC are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial liabilities not measured at fair value through profit or loss. The financial liabilities are classified dependant on the nature of the other parties standing within the DHSC structure.

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

1.16 Losses & Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.17 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Clinical Commissioning Group’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

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

- Determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
- Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and
- Determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare services.

There are no judgements listed.

1.17.2 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The main estimate in 2018/19 related to prescribing expenditure which is two months in arrears and is based on BSA profiling, the accrual within the accounts is £5.4m.

1.18 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.
## 2 Other Operating Revenue

<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
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<tr>
<td><strong>Income from sale of goods and services (contracts)</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Education, training and research</td>
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<td>-</td>
<td>-</td>
<td>22</td>
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<tr>
<td><strong>Total Income from sale of goods and services (contracts)</strong></td>
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<td>-</td>
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<tr>
<td><strong>Other operating income</strong></td>
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<tr>
<td>Other non contract revenue</td>
<td>178</td>
<td>56</td>
<td>122</td>
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<tr>
<td><strong>Total Other operating income</strong></td>
<td>178</td>
<td>56</td>
<td>122</td>
<td>131</td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td>178</td>
<td>56</td>
<td>122</td>
<td>153</td>
</tr>
</tbody>
</table>

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

## 3 Employee benefits and staff numbers

### 3.1 Employee benefits

<table>
<thead>
<tr>
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<th>2018-19</th>
<th>2017-18</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td><strong>Employee Benefits</strong></td>
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<tr>
<td>Salaries and wages</td>
<td>2,485</td>
<td>2,309</td>
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<td>Social security costs</td>
<td>248</td>
<td>219</td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>286</td>
<td>251</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,019</td>
<td>2,779</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,386</td>
<td>2,067</td>
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<tr>
<td>Social security costs</td>
<td>248</td>
<td>219</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>286</td>
<td>251</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>2,920</td>
<td>2,537</td>
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</table>
3.2 Average number of people employed

<table>
<thead>
<tr>
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<th>2018-19</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Permanently employed Number</td>
<td>Other Number</td>
</tr>
<tr>
<td>Total</td>
<td>44.83</td>
<td>43.44</td>
<td>1.39</td>
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</table>

3.3 Pension costs

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

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

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

3.3.1 Accounting valuation

A valuation of Scheme liability is carried out annually by the Scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the Scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

3.3.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers’ contributions of £286,127 were payable to the NHS Pensions Scheme (2017-18: £250,975) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. These costs are included in the NHS pension line of note 3.
### 4. Operating expenses

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>2,633</td>
<td>1,473</td>
<td>1,160</td>
<td>2,606</td>
<td>1,471</td>
<td>1,135</td>
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<tr>
<td>Services from foundation trusts</td>
<td>237,541</td>
<td>6</td>
<td>237,535</td>
<td>226,951</td>
<td>5</td>
<td>226,946</td>
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<tr>
<td>Services from other NHS trusts</td>
<td>258</td>
<td>-</td>
<td>258</td>
<td>355</td>
<td>-</td>
<td>355</td>
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<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>32,342</td>
<td>-</td>
<td>32,342</td>
<td>34,524</td>
<td>-</td>
<td>34,524</td>
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<tr>
<td>Purchase of social care</td>
<td>10,286</td>
<td>-</td>
<td>10,286</td>
<td>9,463</td>
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<td>9,463</td>
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<tr>
<td>Prescribing costs</td>
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<td>-</td>
<td>32,431</td>
<td>34,865</td>
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<td>34,865</td>
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<tr>
<td>Pharmaceutical services</td>
<td>919</td>
<td>-</td>
<td>919</td>
<td>645</td>
<td>-</td>
<td>645</td>
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<tr>
<td>GPMS/APMS and PCTMS</td>
<td>29,268</td>
<td>-</td>
<td>29,268</td>
<td>28,982</td>
<td>-</td>
<td>28,982</td>
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<td>Supplies and services – general</td>
<td>790</td>
<td>49</td>
<td>741</td>
<td>819</td>
<td>146</td>
<td>673</td>
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<tr>
<td>Consultancy services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Establishment</td>
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<td>770</td>
<td>224</td>
<td>61</td>
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<td>1</td>
<td>2</td>
<td>4</td>
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<td>Premises</td>
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<td>172</td>
<td>110</td>
<td>199</td>
<td>165</td>
<td>34</td>
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<tr>
<td>Audit fees</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Other professional fees excl. audit</td>
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<td>85</td>
<td>-</td>
<td>44</td>
<td>44</td>
<td>-</td>
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<tr>
<td>Legal fees</td>
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<td>132</td>
<td>-</td>
<td>71</td>
<td>71</td>
<td>-</td>
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<tr>
<td>Education, training and conferences</td>
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<td>23</td>
<td>5</td>
<td>30</td>
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<td>5</td>
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<td>Depreciation</td>
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<td>-</td>
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<td>29</td>
<td>-</td>
<td>29</td>
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<tr>
<td>Chair and Non Executive Members</td>
<td>138</td>
<td>138</td>
<td>-</td>
<td>133</td>
<td>133</td>
<td>-</td>
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<tr>
<td>Clinical negligence</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>31</td>
<td>31</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>348,157</strong></td>
<td><strong>2,302</strong></td>
<td><strong>345,855</strong></td>
<td><strong>339,992</strong></td>
<td><strong>2,173</strong></td>
<td><strong>337,819</strong></td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

The external auditor of the Clinical Commissioning Group is Mazars LLP. The audit fee for 2018/19 including VAT, was £41k.

GPMS/APMS and PCTMS relates to Primary Care Commissioning.

The expenditure within Other Professional fees excl. audit includes £30k for internal audit services provided by AuditOne.

Expenses related to Rentals under Operating Leases are within the Establishment and Premises lines. These costs can be seen in Note 6 - Operating Leases.
5 Better Payment Practice Code

### Measure of compliance

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£’000</td>
<td>Number</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>4,208</td>
<td>75,351</td>
<td>4,321</td>
<td>72,613</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>4,178</td>
<td>75,127</td>
<td>4,284</td>
<td>72,428</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>99.29%</td>
<td>99.70%</td>
<td>99.14%</td>
<td>99.75%</td>
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<tr>
<td><strong>NHS Payables</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>1,695</td>
<td>239,964</td>
<td>1,775</td>
<td>234,282</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>1,682</td>
<td>239,493</td>
<td>1,764</td>
<td>234,242</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>99.23%</td>
<td>99.80%</td>
<td>99.38%</td>
<td>99.98%</td>
</tr>
</tbody>
</table>

### 6 Operating Leases

#### 6.1 As lessee

**6.1.1 Payments recognised as an Expense**

<table>
<thead>
<tr>
<th></th>
<th>Land £’000</th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>229</td>
<td>1</td>
<td>230</td>
<td>175</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>229</td>
<td>1</td>
<td>230</td>
</tr>
</tbody>
</table>

**6.1.2 Future minimum lease payments**

<table>
<thead>
<tr>
<th></th>
<th>Land £’000</th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>191</td>
<td>2</td>
<td>193</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>39</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>After five years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>230</td>
<td>3</td>
<td>233</td>
</tr>
</tbody>
</table>

**2017-18**

<table>
<thead>
<tr>
<th></th>
<th>Land £’000</th>
<th>Buildings £’000</th>
<th>Other £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>142</td>
<td>1</td>
<td>143</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>206</td>
<td>2</td>
<td>208</td>
</tr>
<tr>
<td>After five years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>348</td>
<td>3</td>
<td>351</td>
</tr>
</tbody>
</table>
### 7 Property, plant and equipment

#### 2018-19

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or Valuation at 01 April 2018</td>
<td>86</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2019</td>
<td>86</td>
</tr>
<tr>
<td>Depreciation 01 April 2018</td>
<td>46</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>28</td>
</tr>
<tr>
<td>Depreciation at 31 March 2019</td>
<td>74</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2019</td>
<td>12</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>12</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>12</td>
</tr>
</tbody>
</table>

**Asset financing:**  
- **Owned:** 12

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>12</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>12</td>
</tr>
</tbody>
</table>

#### 2017-18

<table>
<thead>
<tr>
<th>Information technology</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or Valuation at 01 April 2017</td>
<td>86</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2018</td>
<td>86</td>
</tr>
<tr>
<td>Depreciation 01 April 2017</td>
<td>17</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>29</td>
</tr>
<tr>
<td>Depreciation at 31 March 2018</td>
<td>46</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2018</td>
<td>40</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>40</td>
</tr>
<tr>
<td>Total at 31 March 2018</td>
<td>40</td>
</tr>
</tbody>
</table>

**Asset financing:**  
- **Owned:** 40

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>40</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>40</td>
</tr>
</tbody>
</table>

#### 7.1 Economic lives

<table>
<thead>
<tr>
<th>Information technology</th>
<th>Maximum Life (years)</th>
<th>Minimum Life (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information technology</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
NHS North Tyneside CCG - Annual Accounts 2018-19

8 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19</td>
<td>2017-18</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
</tbody>
</table>

| NHS receivables: Revenue | 746       | 618       |
| NHS prepayments          | 781       | 944       |
| NHS accrued income       | 61        | -         |
| Non-NHS and Other WGA receivables: Revenue | 5          | 47        |
| Non-NHS and Other WGA prepayments | 95        | 91        |
| VAT                      | 51        | 20        |

Total Trade and other receivables

|                          | 1,739     | 1,720     |
|                          |           |           |

Total current

|                          | 1,739     | 1,720     |
|                          |           |           |

8.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
</tbody>
</table>

| By up to three months    | 18        | 18        |
| By three to six months   | -         | -         |
| By more than six months  | -         | -         |
| Total                    | 18        | 18        |

£18k of the amount above has subsequently been recovered post the statement of financial position date.
9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance as at 01 April</strong></td>
<td>85</td>
<td>123</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>11</td>
<td>(38)</td>
</tr>
<tr>
<td><strong>Balance as at 31 March</strong></td>
<td>96</td>
<td>85</td>
</tr>
</tbody>
</table>

Made up of:

<table>
<thead>
<tr>
<th>Description</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash with the Government Banking Service</td>
<td>96</td>
<td>85</td>
</tr>
<tr>
<td>Cash and cash equivalents as in statement of financial position</td>
<td>96</td>
<td>85</td>
</tr>
</tbody>
</table>

Balance at 31 March 2019: 96

10 Trade and other payables

<table>
<thead>
<tr>
<th>Description</th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: Revenue</td>
<td>2,804</td>
<td>2,028</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>2,064</td>
<td>1,720</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>1,206</td>
<td>2,905</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>15,395</td>
<td>14,789</td>
</tr>
<tr>
<td>Social security costs</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Tax</td>
<td>45</td>
<td>33</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>1,002</td>
<td>800</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td>22,554</td>
<td>22,311</td>
</tr>
</tbody>
</table>

Total current: 22,554
11 Financial instruments

11.1 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets</th>
<th>measured at amortised cost</th>
<th>Loans &amp; Receivables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19 (£’000)</td>
<td>2017-18 (£’000)</td>
</tr>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>573</td>
<td>566</td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>234</td>
<td>53</td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>5</td>
<td>46</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>96</td>
<td>85</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>908</strong></td>
<td><strong>750</strong></td>
</tr>
</tbody>
</table>

11.2 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities</th>
<th>measured at amortised cost</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19 (£’000)</td>
<td>2017-18 (£’000)</td>
</tr>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>308</td>
<td>126</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>10,046</td>
<td>9,277</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>11,115</td>
<td>12,039</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>1,002</td>
<td>800</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>22,471</strong></td>
<td><strong>22,242</strong></td>
</tr>
</tbody>
</table>

It is the Clinical Commissioning Group’s assessment that it is not exposed to any material financial instrument risk.

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

12 Pooled Budgets

Under s75 of the 2006 NHS Act, the Clinical Commissioning Group has entered into a pooled budget agreement with North Tyneside Council in relation to the Better Care Fund. For accounting purposes management has assessed that joint control does not exist.

The Better Care Fund is designed to integrate health and social care services, reduce hospital based care and promote community based services.

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

<table>
<thead>
<tr>
<th></th>
<th>2018-19 (£’000)</th>
<th>2017-18 (£’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>15,834</td>
<td>15,539</td>
</tr>
</tbody>
</table>
Details of related parties transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Governing Body / Executive Member</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
<th>Payments to Related Party £'000</th>
<th>Receipts from Related Party £'000</th>
<th>Amounts owed to Related Party £'000</th>
<th>Amounts due from Related Party £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park Road Medical Practice</td>
<td>855</td>
<td>0</td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>559</td>
<td>0</td>
<td>47</td>
</tr>
<tr>
<td>Marine Avenue Medical Centre</td>
<td>986</td>
<td>0</td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>819</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>Portugal PIP Health Centre</td>
<td>1,552</td>
<td>0</td>
<td>113</td>
<td>0</td>
<td>1,312</td>
<td>1,312</td>
<td>0</td>
<td>95</td>
</tr>
<tr>
<td>The Village Green Surgery</td>
<td>1,236</td>
<td>0</td>
<td>126</td>
<td>0</td>
<td>1,136</td>
<td>1,136</td>
<td>0</td>
<td>109</td>
</tr>
<tr>
<td>Woodlands Park Health Centre</td>
<td>733</td>
<td>0</td>
<td>97</td>
<td>0</td>
<td>621</td>
<td>621</td>
<td>0</td>
<td>99</td>
</tr>
<tr>
<td>The Priory Medical Group</td>
<td>1,695</td>
<td>0</td>
<td>118</td>
<td>0</td>
<td>1,624</td>
<td>1,624</td>
<td>0</td>
<td>127</td>
</tr>
<tr>
<td>49 Marine Avenue Surgery</td>
<td>722</td>
<td>0</td>
<td>69</td>
<td>0</td>
<td>651</td>
<td>651</td>
<td>0</td>
<td>47</td>
</tr>
<tr>
<td>Appleyday Surgery</td>
<td>842</td>
<td>0</td>
<td>69</td>
<td>0</td>
<td>714</td>
<td>714</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>Battle Hill Health Centre</td>
<td>967</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,097</td>
<td>2,097</td>
<td>0</td>
<td>363</td>
</tr>
<tr>
<td>Beaumont Park Medical Group</td>
<td>738</td>
<td>0</td>
<td>73</td>
<td>0</td>
<td>682</td>
<td>682</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>Bewick Medical Centre</td>
<td>1,368</td>
<td>0</td>
<td>103</td>
<td>0</td>
<td>1,210</td>
<td>1,210</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>Bridge Medical</td>
<td>693</td>
<td>0</td>
<td>71</td>
<td>0</td>
<td>805</td>
<td>805</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td>Collingwood Health Group</td>
<td>2,383</td>
<td>0</td>
<td>170</td>
<td>0</td>
<td>2,106</td>
<td>2,106</td>
<td>0</td>
<td>190</td>
</tr>
<tr>
<td>Earlsdon Park Medical Practice</td>
<td>4</td>
<td>0</td>
<td>184</td>
<td>0</td>
<td>689</td>
<td>689</td>
<td>0</td>
<td>347</td>
</tr>
<tr>
<td>Forest Hall Medical Group</td>
<td>1,339</td>
<td>0</td>
<td>108</td>
<td>0</td>
<td>1,095</td>
<td>1,095</td>
<td>0</td>
<td>131</td>
</tr>
<tr>
<td>Garden Park Surgery</td>
<td>1,066</td>
<td>0</td>
<td>84</td>
<td>0</td>
<td>977</td>
<td>977</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>Lane End Surgery</td>
<td>1,101</td>
<td>0</td>
<td>83</td>
<td>0</td>
<td>904</td>
<td>904</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td>Mallard Medical Group</td>
<td>608</td>
<td>0</td>
<td>67</td>
<td>0</td>
<td>589</td>
<td>589</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>Monkseaton Medical Centre</td>
<td>1,087</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>1,046</td>
<td>1,046</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Nelson Medical Group</td>
<td>802</td>
<td>0</td>
<td>57</td>
<td>0</td>
<td>657</td>
<td>657</td>
<td>0</td>
<td>88</td>
</tr>
<tr>
<td>Northumberland Park Medical Group</td>
<td>1,053</td>
<td>0</td>
<td>99</td>
<td>0</td>
<td>747</td>
<td>747</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Park Parade Surgery</td>
<td>576</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>519</td>
<td>519</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>Redburn Park Medical Centre</td>
<td>761</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>631</td>
<td>631</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>Spring Terrace Health Centre</td>
<td>811</td>
<td>0</td>
<td>50</td>
<td>0</td>
<td>761</td>
<td>761</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>Swarland Avenue Surgery</td>
<td>686</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>552</td>
<td>552</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Wellspring Medical Practice</td>
<td>835</td>
<td>0</td>
<td>64</td>
<td>0</td>
<td>695</td>
<td>695</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>West Farm Surgery</td>
<td>767</td>
<td>0</td>
<td>167</td>
<td>0</td>
<td>600</td>
<td>600</td>
<td>0</td>
<td>97</td>
</tr>
<tr>
<td>Whitley Bay Health Centre</td>
<td>1,476</td>
<td>0</td>
<td>110</td>
<td>0</td>
<td>1,292</td>
<td>1,292</td>
<td>0</td>
<td>134</td>
</tr>
<tr>
<td>Widopen Medical Centre</td>
<td>1,226</td>
<td>0</td>
<td>66</td>
<td>0</td>
<td>952</td>
<td>952</td>
<td>0</td>
<td>78</td>
</tr>
</tbody>
</table>

Payments to Related Party in the tables enclosed are for actual cash payments made during the year.

The Council of Practices comprises of a nominated GP from each of the 27 GP practices that form the CCG. They meet at least four times a year to decide on the strategic direction of the CCG. As such the GP Practices have been included within the Related Parties note above.

The list of Earlsdon Park Medical Practice was dispersed on 1st April 2018. A number of patients subsequently registered with Northumberland Park Medical Group.

On 1st October 2018 Battle Hill Health Centre closed with the list moving to Park Road Medical Centre.

Members of the North Tyneside GP Practices have carried out functions for the CCG and any remuneration received for these has been paid to the practice in recognition of their contribution. GP Practices are also entitled to additional payments in relation to extra services for patients and these are based on practice sizes and if the practice has delivered.

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 which included Northumbria Healthcare Foundation Trust, Newcastle upon Tyne Hospital NHS Foundation Trust, Northumberland, Tyne & Wear NHS Foundation Trust, and the North East Ambulance Service amongst others.

The Clinical Commissioning Group also had a number of transactions with NHS England, NHS Litigation Authority and NHS Business Services Authority amongst others. The transactions with these entities were not material.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with North Tyneside Council in respect of joint enterprises £31.0m paid in 2018/19 (£34.6m in 2017/18).

TyneHealth Ltd is a provider of healthcare services. Its members are the current 27 GP Practices in North Tyneside. There was £1,860k paid to it in 2018/19 (£738k in 2017/18).

The Clinical Commissioning Group has received revenue or capital payments from charitable funds. The Clinical Commissioning Group maintains a formal register of interests which is referred to at each of its Council of Practice, Governing Body, and Committee meetings, providing a mechanism for handling any conflicts of interest.
14 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial instruments of the Clinical Commissioning Group.

15 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>223H(1)</td>
<td>Expenditure not to exceed income</td>
<td>357,399</td>
<td>351,175</td>
<td>346,795</td>
<td>342,771</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I(2)</td>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>357,221</td>
<td>350,997</td>
<td>346,642</td>
<td>342,618</td>
<td>Yes</td>
</tr>
<tr>
<td>223I(3)</td>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>4,720</td>
<td>4,417</td>
<td>4,703</td>
<td>4,262</td>
<td>Yes</td>
</tr>
</tbody>
</table>

There are no post balance sheet events which will have a material effect on the financial instruments of the Clinical Commissioning Group.