Annual Report and Accounts 2019/20
Performance Report

Mark Adams
Accountable Officer
2 June 2020
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 2019/20. 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 2019/20.

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 222,000 service users in our borough.

As we write this annual report, the country is in the grip of the COVID-19 pandemic. Our governors, members and staff of the CCG would like to say that our thoughts are with all of our residents, especially those who have lost loved ones to the virus.

We would also like to say a special thank you to all of the care givers and our NHS staff who are working to provide care during these difficult times. Our best wishes and appreciation also go to all key workers who are working tirelessly to ensure that the essential needs of our residents and patients are met during this pandemic.

During the last months of 2019/20, the CCG has worked with GP practice staff, the local authority, trusts and other key organisations to respond to the demands being placed on the NHS due to the pandemic. Our heartfelt thanks go out to all of the staff, individuals and organisations involved in helping to manage the requirements of the system during this very difficult time.

Whilst COVID-19 has drawn our focus over the end of 2019/20, there are many achievements during the year which can be celebrated. Some of our key achievements include:

1. The CCG was delighted to receive a rating of “outstanding” by NHS England in an annual review of the CCG’s performance for 2018/19.

   The review is very important as it assesses how well the CCG has performed in key service and clinical areas, how well it has managed its finances and the quality of its leadership. The achievement of outstanding status - the highest possible rating - is a significant milestone as it means that residents in the borough are receiving some of the very best treatment in the country.

   NHS England highlighted overall accountability and leadership as areas of particular strengths. The CCG was also praised for the work it has done in improving patient access to GP services and for the outstanding ratings for cancer, mental health,
learning disabilities, dementia and diabetes services. Evidence of collaborative work with partners was also highlighted.

2. In previous reports we have described how the CCG has an obligation to meet its financial duties and support delivery of other corporate objectives. Over the last six years, the CCG has successfully implemented its financial recovery plan, delivering savings of around £53.7m.

As at the end of 2019/20 the CCG has fully repaid its deficit and has achieved the NHS England target to maintain a 1% surplus on a recurrent basis from its annual financial allocation. This means that the CCG is fully meeting the national financial requirements expected of CCGs.

This is a huge achievement and it is recognised that the CCG is only one of a very small number of CCGs in the country to have achieved this.

Achieving financial stability has allowed the CCG to invest in services.

3. The CCG has introduced an innovative voluntary sector grants award scheme in 2019/20 which sees local groups working at grassroots to tackle issues like mental health and social isolation, as well as obesity and ageing well. As a result, nine local organisations will provide extra help to improve people’s health after the CCG awarded £500,000 in grants.

Four larger grants and five smaller grants were awarded in total. The services range from creation of a ‘community shed’ to tackle loneliness and improve mental health through creative and practical activities. The community shed will also help people improve their own health with a focus on areas like smoking, healthy eating, increasing physical activity and helping people change their lifestyles.

Other schemes include extra support for families affected by domestic abuse, dance activities for people affected by dementia and provision of art activities to help people improve their mental wellbeing.

4. The CCG is proud of its work with primary care during 2019/20. Four Primary Care Networks (PCNs) were established during 2019/20, based on the same footprint as the previous Primary Care Localities and each led by North Tyneside GPs. In June 2019, the CCG’s Primary Care Committee formally approved the establishment of the four PCNs.

We recognise the vital role that PCNs play in delivering the aspirations described in the NHS Long Term Plan. PCNs will help to bring together the core elements of primary care services, helping to provide personalised, proactive and coordinated health and social care.
To help GP practices with this work, in 2018/19 the CCG made funding available 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.

Seven national specifications have been published which describe the areas that PCNs will deliver on, five of which should start in 2020 with another two in 2021. During 2019/20, PCNs have already put in place systems to offer more social prescribing and first contact physiotherapy in North Tyneside.

5. The CCG continued its focus on provision of mental health services from 2018/19 into 2019/20, working with our partners to implement a number of initiatives and investments to improve their quality and access of services.

The CCG increased funding available to children & adolescents mental health services in North Tyneside and continues to work with Northumbria Healthcare Trust to improve access to the service. We have also renewed our contract with an online counselling service – Kooth -and have extended the remit of the service to reach out to more young people.

We continue to work very closely with North Tyneside Council colleagues to develop closer ways of working between schools and mental health professionals. To this end, the CCG invested in a range of services such as speech & language therapy and occupational therapy to help support children and families.

We very quickly realised the positive impact that the newly established Recovery College has had in North Tyneside and the CCG agreed to increase funding for this service to enable more activities to be made available.

The CCG also invested in an older people’s mental health crisis service, and was successful, along with Newcastle Gateshead CCG and Northumberland CCG in gaining national funding to establish this service.

6. The CCG has invested in several innovative services for older and frail people in North Tyneside during 2019/20, the. This includes innovative schemes such Whzan which is a ‘telehealth’ system designed to help staff monitor the health of residents in nursing and residential care homes.

Whzan can help to identify the early deterioration of residents’ health and supports clinical decision-making, making sure that the patient receives the correct level of care at the correct time.

The CCG has also funded equipment and technology in local care homes to support dementia care. RITA, which stands for Reminiscence Interactive Therapy Activities, is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities to enhance their experience.
RITA’s activities tap into people’s long-term memories, to help them to recall their personal histories from child and adulthood to provide comfort and enjoyment. It also opens up topics for conversation with care home staff and their own families.

Our next project is to develop an integrated model of services for older people across North Tyneside, bringing together health and social care services, working with partners including the local authority, the acute trusts, community services and Primary Care Networks to achieve our aims.

This is an ambitious, but exciting, project. We have already held several events to help begin to shape and model what this new service will look like and we will continue to work to develop this during 2020/21.

Much of what has been achieved, as described above and throughout this annual report, has been possible 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.

Dr Richard Scott
Clinical Chair

Mark Adams
Accountable Officer

Date: 2 June 2020
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 222,116 (based on the 2020 NHS England allocations).

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

All 26 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 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 and Finance Summary 2019/20

The NHS Operational and Contracting Guidance for 2019/20 was published in January 2019. This guidance explained that the government had announced a five-year funding settlement for the NHS, which provided an additional £20.5 billion a year in real terms to the NHS by 2023/24.

The guidance further explained that the financial year 2019/20 was to be the foundation year which would see significant changes proposed to the architecture of the NHS, laying the groundwork for the implementation of the NHS Long Term Plan. This would secure the best outcomes for patients and the public from this investment, reducing pressures across the NHS and improving care access and quality.

As in previous years, the CCG was directed to take into account the priorities identified in the national guidance and its financial allocation which was to ensure we were able to meet commitments to the mental health investment standard, and increase investment in primary medical and community services, sufficient to meet the Long Term Plan commitments.

Our approach in North Tyneside was to review previous operational plans 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 line with the national timetable of April 2019. In it we describe how the CCG will continue to work to achieve the nationally identified areas, 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 Long Term Plan, 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 six years, the CCG has successfully implemented its financial recovery plan, delivering savings of around £53.7m. As at the end of 2019/20 the CCG has fully repaid its deficit and has achieved the NHS England target to maintain a 1% surplus on a recurrent basis from its annual financial allocation.

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. In 2019/20 the CCG started to implement the commitments within the NHS Long Term Plan and investing in future services.
Our Vision, Plans and Priorities

Our vision is:

“We 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 health care is delivered for the people of North Tyneside

Figure 1 below gives a pictorial representation of the CCG’s commissioning priorities which echoes our vision.

Figure 1: Priorities
Our local system is transforming and many of the traditional boundaries between providers and commissioners are being removed as part of an integrated care approach. This includes work being undertaken at a wider, strategic level as well as at a local level.

During 2019/20, we have been working across three levels of scale:

- **Place** – populations of around 150,000 to 500,000 people will be the main focus for partnership working between the NHS and local authorities. In these areas, primary care networks (providing services to populations of around 30,000-50,000 people) will support collaboration between GP practices, social care, other community based care providers and voluntary sector organisations

- **Integrated care partnerships** – populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features), focused on collaboration across NHS hospital trusts, to ensure safe and sustainable services

- **Integrated care system** – a population of circa 3.1 million people, focused on ‘at scale’ activity that achieves efficiencies

**Integrated Care System**

The keystone of the wider, regional strategic work is that of the Integrated Care System (ICS). In June 2019, the North East and North Cumbria area was confirmed by NHS England as one of a small number of ICS across the country.

The North East and North Cumbria Integrated Care System (ICS) is a regional partnership between the NHS, local authorities and others, taking collective responsibility for resources, setting strategic objectives and care standards, and improving the health of the 3.1 million people it serves.

Our ICS is a collaboration of NHS commissioners and providers, and our partners, and not a new organisation with statutory powers. The majority of our work is focused in places and neighbourhoods but, alongside this, our ICS provides a mechanism to build consensus on those issues that need to be tackled ‘at scale’.

The ICS builds on existing local place-based leadership and responsibilities of clinical commissioning groups to plan and arrange services for local populations. This involves local Primary Care Networks and NHS foundation trusts, working with local authority and voluntary sector partners in improving health and wellbeing through extending the reach and effectiveness of our services.

Based on the NHS Long Term Plan, all Integrated Care Systems were asked to create their own five-year strategic plans by November 2019, to cover the period 2019-20 to 2023-24. Our North East and North Cumbria ICS Plan outlines how we will:
• Bring together local organisations in a pragmatic and practical way
• Ensure patients get more options, better support, and properly joined-up care at the right time and place
• Relieve pressure on A&Es through more effective population health management and service coordination
• Strengthen our contribution to prevention and tackling health inequalities to help people stay healthy and moderate demand on the NHS
• Develop a new ‘system architecture’ that delivers strategic action on workforce transformation, digitally-enabled care, and the collaborative approaches to innovation and efficiency that will restore our whole ICS to financial balance

Our ICS is focused on ‘at scale’ priorities that multiply our collective impact around overarching clinical strategy and clinical networks, strategic commissioning (e.g. for ambulance services) and shared policy development. It is supported by four Integrated Care Partnerships (ICPs).

**Integrated Care Partnership**

In Northumberland, North Tyneside, and Newcastle Gateshead, NHS organisations have come together with local authorities, to lead and plan care for their population in a coordinated way as the North of Tyne and Gateshead Integrated Care Partnership (ICP).

The ICP will continue to work with our partners to develop further care models that support the balancing of capacity and demand across the health economy.

North Tyneside CCG is one of the NHS partners in the ICS and the ICP who have agreed to work together at scale where it makes most sense to do so.

The North of Tyne and Gateshead Integrated Care Partnership has developed a plan for working together on key areas identified and agreed by each of the partners. This plan has been fed into the larger ICS plan.

**Place Based Care**

Of equal, or more, importance to strategic work is the ability to respond to local need and have local accountability. This is what we called ‘place’ working at a North Tyneside level.

At a local level we have established our Future Care Programme, which brings together strands of work across the health and social care system in North Tyneside to deliver sustainable care closer to home.

One of the particular features of the programme is the integrated service model for older people. We have brought together key stakeholders from community health services, GP practices, social care and other areas to begin to shape and model how the new integrated model will work in the future.
This local approach towards integrated services will ensure that community and primary care will meet future demand, while integration of health and social care will be one of the priority areas for both the CCG and local authority to enable us to achieve the new model.

**Key issues and risks in 2019/20**

We identified a number of key risks to the achievement of our corporate objectives during 2019/20. However, these risks are not related to operational management and through rigorous management of a number of actions to mitigate these risks they have now been closed. The risks were:

- Risk that the delay in Primary Care Support England Services (i.e. delayed transfer of medical records or medical supplies) delays treatment
- Patients are prescribed contraindicated medications or there are dangerous interactions between medications that could occur, leading to harm. The risk could have been exacerbated because of separate prescribing systems in hospitals and practices that may not have been mitigated by the risk sharing processes that are in place
- Contingency arrangements in the event of a no deal EU exit are not in place which could result in disruption to services, as well as the quality and safety of services

The CCG continues to manage a number of corporate and strategic risks into 2020/21 including the following two risks which are rated red:

- Risk of failure to clearly demonstrate compliance with NHS Constitution rights and pledges
- Risk that delayed ambulance handovers impacts negatively on patient safety and patient flow

The first risk remains ‘red’ as NHS Constitution targets relating to Referral to Treatment Times (RTT), cancer 62 day waits and Accident & Emergency (A&E) waits are not being met. A system approach is being taken across the Integrated Care Partnership and Integrated Care System which are described later in this document. In addition, focused task groups have been established to examine RTT, A&E waits and cancer 62 days waiting times.

Collaborative working between Northumbria Healthcare NHS Foundation Trust, Newcastle upon Tyne Hospitals and the North East Ambulance Service is working to address delayed ambulance handovers.

Whilst mitigations and actions are in place to address these two risks, the Covid-19 emergency is likely to significantly impact on the achievement of improved performance as we move into 2020-2021.

Towards the end of 2019/20, the CCG identified two corporate risks relating to Covid-19:
• Failure to support NHS & social care system to deliver appropriate care to the residents of North Tyneside throughout the Covid-19 pandemic; and
• Response to COVID 19 impacts on system’s ability to deliver healthcare to meet the needs of the population.

COVID 19 is a national risk impacting the whole of society.

It is our duty to ensure that we prioritise supporting the frontline NHS and other services during this pandemic. We did this by establishing a Covid-19 incident room managed by CCG staff to support local services such as GP practices and nursing homes. We also redeployed some of our staff (e.g. nurses) to front line services.

We have worked very closely with the Integrated Care Partnership Level Incident Command & Control Centre to ensure that we receive and distribute national and regional guidance and information for our staff and practices.

The CCG has also participated in national and regional teleconferences to ensure that our knowledge and understanding of the COVID-19 situation is up to date, allowing us to correctly answer queries and brief our partners.

Performance summary

The CCG has continued to oversee quality improvements through our support for the various quality systems and processes in place to provide assurance that our requirements are being met.

Where we identify areas where improvements can be made, we have implemented changes to increase standards, minimise waiting lists and improve waiting times through joint working with the organisations that provide the services for North Tyneside residents.

Quality of services is always a key priority for the CCG. To this end, we have robust structures and systems in place to ensure that the services we commission are of high quality and are safe for patients and staff.

The CCG was represented on the 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.

We have a range of methods we use to ensure our services are delivered to a quality standard and provide value for money. These include processes to manage performance against the range of indicators including a mechanism to work with internal and external colleagues to identify areas of risk, and implementation of action plans to mitigate these.

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. Referral to Treatment times and cancer waiting times. 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.

We provide regular performance reports to the CCG’s Governing Body, which details the North Tyneside performance against the agreed local and national measures. This provides reassurance that the standards are being met or, if they are not being met, the Governing Body can request assurances about the measures being put in place to progress towards achieving of the standards.

Monitoring performance also helps us in understanding the effectiveness of services, together with the role of quality assurance and financial management.

Overall the CCG has performed well during 2019/20. We continue to strive to make further improvements. An emphasis on improving quality will continue into 2020/21.

Performance analysis

In this performance analysis section, we will give an overview on three key areas:

- North Tyneside Health & Wellbeing overview and strategy
- CCG financial overview
- Corporate Performance overview

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 over the last decade 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. However more recently the gain in life expectancy has plateaued for both men and women.

In North Tyneside life expectancy for men is currently 78 years which is similar to the North East, but is 1.6 years lower than that for England. Although there has been an overall increase by 1.6 years over the last 10 years, more recently this increase has stalled and life expectancy for men has not changed since 2014.

Life expectancy for women in North Tyneside is currently 82.1 years. This is slightly better than the North East average but is 1 year lower than England. While there has been an overall increase by 1.5 years for women over the last 10 years, since 2014 life expectancy for women has actually declined by 0.5 years.
Healthy life expectancy (the point at which someone moves into poor health) has reduced for men and women in North Tyneside. For men, healthy life expectancy is 60.7 years and for women this is 63.3 years. Over the last 10 years healthy life expectancy for men has improved by 0.5 years and for women 1.7 years. However, over the last 5 years this progress in healthy life expectancy has stalled, and for men in particular.

There is a relationship between lower healthy life expectancy and levels of deprivation. Men and women in our least deprived areas, on average spend 14.5 more years spent in good health compared to our most deprived communities.

Relative deprivation in North Tyneside is improving. In 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, showing an improvement since 2010. However there
are wide inequalities across the borough, with persistent pockets of deprivation particularly in the wards of Riverside and Chirton.

Men and women from our least deprived areas live longer, compared to residents from our most deprived areas. For men this is 11.5 longer and for women 10.7 years. The health inequality gap has widened by 0.9 years for men and by 1.4 years for women.

![Image of life expectancy gap](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 526 deaths in 2016 to 2018
- Although CVD mortality has declined faster than cancer; there were still 316 premature deaths in 2016 to 2018 from CVD
- COPD is one of the major respiratory diseases and smoking is a major cause of COPD. There were 222 deaths in 2016 to 2018 in North Tyneside
- 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 138 deaths in 2016 to 2018
- Social factors, lifestyle choices and late presentation, diagnosis and treatment contribute to the premature mortality. However, much of this premature mortality is preventable. In total there were 2,189 deaths in North Tyneside that were considered as preventable in 2016 to 2018
Lifestyle and behaviour

- Major risk factors for poor health include unhealthy diets, smoking, drinking too much alcohol and physical inactivity
- Just under two thirds (64.9%) of adults in North Tyneside are overweight or obese (2017-18)
- There are increasing numbers of people who have type 2 diabetes. There are 14,722 individuals in North Tyneside with type 2 diabetes (8.5%)
- It is estimated that 12.4% 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 14.9% (2018). However there is variation in North Tyneside: 1 in 4 of adults in the most deprived areas of North Tyneside smoke compared to only 1 in 6 in our least deprived areas
- Alcohol related admissions to hospital are higher in North Tyneside compared to the national average. In 2018-19 there were over 2,200 hospital admissions for alcohol-related conditions
- 23.5% of the population is drinking at levels that risk damaging health
- 62.3% of adults are classified as physically active (2017-18)
Children and young people

- 17% of children in North Tyneside are living in low income families. 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.
- By 2040 there will be; 13,000 (27% increase) more people aged between 65-84 and 5,000 (100% increase) more people aged over 85 years living in North Tyneside.
- The number of people aged over 75 living alone is predicted to rise by 41.9% by 2040.

![Population Bands (2018) vs. 2040](image)

Figure 6: Population bands by age

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, has been 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 overarching themes.

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

In addition to regular attendance at the HWBB throughout 2019-20, the CCG has led or been directly involved in the following HWBB 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 2019-20
- Refresh of the Joint Strategic Needs Assessment (JSNA)

Financial performance

Key financial performance indicators 2019/20

North Tyneside CCG has met the statutory requirement to ensure expenditure in a financial year does not exceed its allocated resource. In 2019/20, the CCG achieved an in-year surplus of £7.3m, reducing the brought forward 2019/20 deficit from £3.3m to a surplus of £4m as at 31 March 2020.

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>2019/20</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 £4.85m in 2019/20. This was spent on CCG staff and associated costs and on services from North of England Commissioning Support (NECS). The CCG operated from premises in North Shields leased from NHS Property Services in 2019/20.

Financial outturn in 2019/20

The CCG 2019/20 annual accounts are provided in full as part of the annual report. During the year, the CCG commissioned healthcare services to the value of £364.5m and incurred expenditure of £3.9m in respect of running costs. The overall closing position of the CCG was an in-year surplus of £7.3m.

Table 2: CCG 2019/20 expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute health services</td>
<td>199.2</td>
</tr>
<tr>
<td>Mental health services</td>
<td>29.5</td>
</tr>
<tr>
<td>Community health services</td>
<td>40.0</td>
</tr>
<tr>
<td>Continuing health care</td>
<td>16.5</td>
</tr>
<tr>
<td>Prescribing</td>
<td>35.6</td>
</tr>
<tr>
<td>Primary care</td>
<td>37.5</td>
</tr>
<tr>
<td>Other programme costs</td>
<td>6.1</td>
</tr>
<tr>
<td>Total programme (commissioning) costs</td>
<td>364.4</td>
</tr>
<tr>
<td>Total running costs</td>
<td>3.9</td>
</tr>
<tr>
<td>Total expenditure for 2019/20</td>
<td>368.3</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 2019/20.

### Table 3: CCG 2019/20 acute expenditure

<table>
<thead>
<tr>
<th>Trust</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumbria Healthcare NHS Trust</td>
<td>122.8</td>
</tr>
<tr>
<td>Newcastle upon Tyne NHS Trust</td>
<td>64.4</td>
</tr>
<tr>
<td>North East Ambulance Service NHS Trust</td>
<td>7.3</td>
</tr>
<tr>
<td>Other NHS Acute Services</td>
<td>2.6</td>
</tr>
<tr>
<td>Other Non NHS Acute Services</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Total 19/20 Acute Services Expenditure</strong></td>
<td><strong>199.2</strong></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 2020/21**

Covid-19 creates a significantly different context for the CCG 20/21. The planning process that was underway has been suspended while the crisis is dealt with. Interim financial arrangements are in place.

**Corporate Performance Overview**

**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 approved the introduction of a VCS grant scheme which will enable the voluntary and community sector (VCS) to apply for grants to support the delivery of CCG objectives.

The first wave of the grant scheme was successfully launched in 2019/20, which has resulted in four organisations receiving grants of up to £300,000 each for a three year period and five organisations receiving a small grant of up to £20,000 each. This has been an innovative and
exciting opportunity in North Tyneside and the CCG is working on how it will continue to roll out further grant opportunities.

The CCG has also worked with Barnardos to develop an apprenticeship scheme to encourage young people into the workplace and continues to be committed to this scheme. 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. This helps us to understand how new services being procured in North Tyneside can add a level of social value, such as increasing employment opportunities.

In the North Integrated Care Partnership (ICP) we seek to ensure that all initiatives consider sustainability and the impact on environment.

The strategic ICP priorities agreed by the North ICP Forum are as follows:

- Climate change and sustainability
- Workforce, Employment and skills
- Healthcare Prevention

Climate change organisational leads are in the process of being identified within the ICP with a view to sharing best practice and developing:

- Key performance indicators
- Opportunities for local supply
- Sustainability issues
- Potential priority areas for joint working

As part of the above, ICP Director of Public Health colleagues are reviewing the following, in order to agree the most useful areas of focus for the wider ICP footprint:

- The non-health elements of prevention such as employment and skills
- Early intervention i.e. ensuring people have access to support as early as possible to stop their needs from escalating
- Exploring demand from local authorities for social care related services and support

The intended impact is to have a mutually agreed, co-ordinated, and holistic ‘whole-system’ approach to proactively sustain and improve the health of the population, reducing health inequalities and prevent illness. This will develop further in 2020/21.
**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 its staff through a cycle to work scheme.

**Initiatives**

The CCG and its staff have worked hard this year to identify where we could minimise the impact we have on our environment. We have introduced waste recycling, stopped the use of plastic straws and stirrers and have switched the purchase of milk in plastic cartons to milk deliveries in glass bottles (which are washed and returned).

These new measures are in addition to those already incorporated into our working, such as purchasing recycled photocopying paper and the use of light sensors which detect movement and switch off soon after staff leave their desk.

**Integrated Care Partnership work**

The CCG is committed to working with its partners on climate change and sustainability. We describe earlier in this document how the North Integrated Care Partnership has been established bringing together NHS and Local Authority partners in North Tyneside, Newcastle, Gateshead and Northumberland.

This ICP has a Forum which is formed of Chief Executives and Accountable Officers of each organisation. The Forum has identified climate change and sustainability as one of three top priorities for the area. Climate change organisational leads have been identified with a view to sharing best practice and are working on opportunities for local supply, sustainability issues and identification of priority areas for joint working.
Programmes of work

In this section we describe the main programmes of work which we undertook during 2019/20, 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.

The NHS Long Term Plan

Launched in 2019, the national NHS Long Term Plan is focused on improving the quality of patient care and health outcomes. Its aim is to build an NHS fit for the future by enabling everyone to get the best start in life, helping communities to live well, and helping people to age well.

The Long Term Plan aims to improve outcomes for major diseases, including cancer, heart disease, stroke, respiratory disease and dementia, and also includes measures to:

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

To find out more see the NHS Long Term Plan website.

Future Care

During 2019, the CCG and its partners co-produced a vision for the future of health and care services in North Tyneside, which is called Future Care. It is a model of care which builds on existing services and developmental work, to deliver care closer to home, designed to meet the needs of patients across North Tyneside.

The Future Care programme is still developing in North Tyneside and we are continuing our programme of work with partners during 2020/21.

We describe Future Care as North Tyneside’s transformation programme which aims to:

- Deliver population health and wellbeing
- Deliver high quality, coordinated care
- Improve quality of life and experience of services
- Support and empower staff
- Provide effective stewardship of resources
The vision is to deliver a patient-centred sustainable health and social care system with a focus on:

- Self-care and preventing ill health
- Resilient communities and families
- People living longer and with better quality of life
- People staying as independent and as well as they can for as long as possible
- Those at the end of life to have support and care to enable them to live in the best way they can, taking into account their wishes, beliefs and values
- People dying with dignity in their chosen place of death
- A more resilient, responsive and financially stable health and social care system.
- High quality, fully integrated services
- High levels of people and staff satisfaction with services
- Evidence based practice and care models
- Reduced reliance on acute services
- Reduction in bed based care
- Right Care, Right Place and Right Time
- North Tyneside system is seen as a preferred place to work with high levels of wellbeing, satisfaction, recruitment and retention

The North Tyneside Future Care Executive oversees the direction, development and delivery of Future Care in North Tyneside. However, there are a number of health system changes in play which may provide an opportunity to formalise the development of place-based commissioning in North Tyneside. The Future Care Executive would oversee the emergent place-based commissioning system in line with the NHS Long Term Plan.

The Future Care Executive will:

- Provide oversight of the delivery of Future Care Programmes
- Receive reports from the Future Care Programme Board and monitor progress in implementing key milestones
- Act as a strategic system enabler
- Influence the development of sustainable system delivery model in the form of an ICP

The multiagency Future Care Programme Board involves all of the NHS foundation trusts working in North Tyneside, the ambulance service, TyneHealth GP Federation, North Tyneside Council, 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.
Five themes of work have been identified and agreed during 2019/20, building on the work that started during 2018/19. These are:

- Children’s services
- Community Services and Primary Care
- Mental Health
- Planned Care
- Urgent & Emergency Care

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

As we have progressed through 2019/20, the work and discussions of these work areas have influenced the CCG’s commissioning priorities as well as system service delivery.

We are starting to see real benefits from this way of working, an example being the joined up approach to improving urgent and emergency care services in North Tyneside, specifically around the Urgent treatment Centre. This is described in further detail later in this report.

**Voluntary services**

**Better Together**

The CCG recognises the voluntary and community sector (VCS) as an essential part of the health and social care system. VCS organisations work with some of our most marginalised communities, providing services that are responsive, innovative and user-led.

The work of VCS organisations makes a significant contribution to key priorities such as health and wellbeing, democracy, the environment, employability and tackling loneliness. The VCS in North Tyneside consists of more than 550 groups, clubs, charities and other organisations, with a combined income of over £57m per year. 2165 people are employed by the sector, representing 2.2% of the local workforce.

In this year, the CCG collaborated in the Better Together Strategy. The strategy sets out how North Tyneside Council, North Tyneside CCG and the VCS will work together to build strong and sustainable partnerships that makes North Tyneside a better place to live, work and visit.

The strategy sets out the ambition to maximise and make best use of collective resources and new ways of working that build capacity and a culture of collaboration and co-production. We
believe that by working better together, and by developing a stronger system and culture of partnership working, we can significantly improve outcomes for some of our most vulnerable residents.

**The CCG VCS Grants Programme**

This year saw the introduction of the North Tyneside Clinical Commissioning Group grant fund in recognition of the important role that voluntary and community sector (VCS) organisations can play in improving health and wellbeing outcomes for local people.

The scheme seeks to fund organisations that have a track record of working in North Tyneside to deliver against the following priority areas:

- Promoting wellbeing and preventative healthcare
- Promoting self-care and self-management
- Reducing health inequalities

The CCG was overwhelmed by the positive response to the scheme. The quality and range of applications was nothing short of exceptional and illustrates what the wonderful and diverse range of organisations that are providing activities and support across North Tyneside.

Nine local organisations working at a grassroots level will provide extra help to improve people’s health, tackling issues like mental health, social isolation and aging well.

**Carers services and support**

During 2019/20, North Tyneside CCG has worked with members of the North Tyneside Carers Partnership Board to review and update the ‘North Tyneside Commitment to Carers’ Document. The document aims to give clear recognition carers need in their role providing invaluable care for loved ones and acknowledges the contribution carers make to the NHS and social care.

The ‘Commitment to Carers’ document is overseen by the North Tyneside Partnership Board which in now in its second year. The partnership board, chaired by the CCG, brings together key partners including NHS Foundation Trusts, adult social care, education, child services, the Carers Centres and Healthwatch.

The role of the board is 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 carers’ experience, ensuring that they are safeguarded and their welfare is promoted.
Key achievements in 2019/20

- Development of a Primary Care Carers Champion Programme to support GP practices to identify patients who play a caring role and assess their health and wellbeing needs through appropriate and timely access to information and support. The Programme is due to be rolled out in 2020/21
- Working with foundation Trusts, social care organisations and community services to collate advice and information materials and make them available for carers
- Established a task and finish group to identify a range of tools and materials in the support of workforce training to help people recognise when a person is in a caring role
- The CCG has also contributed to those services who continue to provide emotional support to carers including those caring for people with mental health conditions and young carers

Primary care services and Primary Care Networks

Establishment of Primary Care Networks (PCNs) is one of the central components of the NHS Long Term Plan. A PCN is one or more general practices working together with a range of local providers to offer coordinated health and care services to a defined patient population of typically between 30,000 and 50,000.

PCNs are not new legal bodies, but their formation required existing providers of general practice to work together and to share funds on a scale not previously seen in UK general practice.

Within 2019/20 the development of PCNs in North Tyneside has broken down into three phases:

- PCN registration and mobilisation
- Development of PCN provided services
- Development of the wider network (Living Well Locally)

Phase 1 - PCN registration and mobilisation

In North Tyneside, CCG GP practices had already been working in a supported way across four separate localities for a number of years. PCN development has naturally built on these working arrangements and relationships.

With tight timescales in relation to PCN registration and mobilisation, a significant amount of engagement took place with GP practice, Council of Practices, joint workshops with the Local Medical Council, and individual discussions with practice partners to agree the geographical footprints on which PCNs would be formed in North Tyneside. This resulted in four PCNs successfully being formed on 1 July covering the following populations:
• Wallsend 40,543 people
• North Shields 56,549 people
• Whitley Bay 52,075 people
• North West North Tyneside 72,795 people
(population data as at June 2019)

Phase 2 - Development of PCN provided services

The CCG supported each PCN to understand their level of maturity and assess their development needs. Funding was provided to each PCN to develop and provide services to the patients in their network. This includes the following services:

• All four PCNs took on responsibility for providing additional access to GP practices in the extended hours service with 30 minutes of additional time per 1000 patients being provided across the PCN each week.
• All four PCNs have employed a Social Prescribing Link Worker to work with different patient cohorts and support them to access social prescribing.
• North Shields and Wallsend have employed a team of mental health nurses to provide additional capacity and specialist support for patients with mental health needs in general practice.
• North West North Tyneside and Whitley Bay PCNs have employed a team of nurses to work specifically with care homes.

Phase 3 - Development of the wider network (Living Well Locally)

The current PCN Direct Enhanced Service (DES) is focused very much on GP practices, but the CCG recognises that primary care is broader than just general practice.

Networks need to develop to include membership from community services, social care, and the voluntary sector, all working together based on principles of transparency, equity and collaboration in order to coproduce services for their local population.

The CCG has been working with partner organisations to develop these networks called Living Well Locally.

We have put in place governance structures to support Networks to make and action decisions on the provision of services for their population. This includes an Integration Board, a Programme Board, and a Living Well Locally Board.

Additionally, funding has been provided to the PCNs to support them to hold facilitated workshops with stakeholders to agree local priorities and coproduce a Living Well Locally implementation plan for 2020-21. We will be working on this further during 2020/21.
Online GP appointments

The CCG had received feedback from patient groups about the challenges they were facing accessing GP appointments. The CCG therefore took action to explore how we could help with this.

Patient Forum members, CCG staff and GPs attended a presentation from LIVI, a company which offers an online GP appointment system. Our aim was to explore whether to implement an online appointment system locally ahead of the national requirement for practices to offer patients and online consultation option by 2021.

Patient Forum members asked a range of questions about how the system would work and if there are any information governance implications. Forum members expressed enthusiasm for the project and the CCG has now commissioned LIVI for a pilot initiative in North Tyneside.

Patient Forum members will continue to be involved in 2020/21 as more workshops are arranged to help shape how LIVI could operate beyond the pilot period.

Children’s and Maternity services

Women in North Tyneside are served by Northumbria Healthcare midwives, but deliver their babies at both Northumbria Specialist Emergency Care Hospital (NSECH) and Royal Victoria Infirmary (RVI) in Newcastle.

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.

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.

The CCG is very pleased that maternity performance has improved considerably in 2019/20 compared to the previous year.

Maternity performance

There are three national performance standards relating to maternity services. North Tyneside CCG’s performance in 2019/2020 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 4.04 still births and deaths per 1,000 in 2017 (latest data available) which is lower than the England average.
The CCG regularly attends the Special Educational Needs and Disabilities (SEND) patient forum to share information with parents and carers as well as listening to feedback about services.

During the year, forum members raised concerns about the existing continence service as it did not provide a service appropriate for children with special needs. As a result, the CCG has commissioned an additional new continence service for children with special education needs and disabilities.

This service will provide support for children to manage their bowel movements and help parents develop coping strategies. The service will improve children’s health by reducing the impact of continence issues in their lives and minimizing the effects on their bodies.

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**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 and ranked 4th out of 189 CCGs.

**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**

11.09% of pregnant women were smoking when they gave birth to their child in Quarter 2 2019/20. The CCG’s rate is above the England average of 10.4%.

Additional investment from the CCG has been used to recruit a qualified specialist Stop Smoking Advisor with designated administrative support in 2020/21. This additional team will strengthen the offer of individualised, woman-centred service across community, hospital and home settings.

**Continence services for children**

The CCG regularly attends the Special Educational Needs and Disabilities (SEND) patient forum to share information with parents and carers as well as listening to feedback about services.

During the year, forum members raised concerns about the existing continence service as it did not provide a service appropriate for children with special needs. As a result, the CCG has commissioned an additional new continence service for children with special education needs and disabilities.

This service will provide support for children to manage their bowel movements and help parents develop coping strategies. The service will improve children’s health by reducing the impact of continence issues in their lives and minimizing the effects on their bodies.
Looked after children project

The CCG’s Designated Nurse for Looked After Children attends the North Tyneside Children in Care Council. Through these discussions, looked after children said that they would like an electronic tool to help them develop their skills to manage their own health needs ready for when they live independently. These skills include issues like managing medication, exercise, sleep problems, healthy eating, drugs and alcohol and emotional health.

After listening to their ideas, the CCG worked with University College London to develop a tool which is provided for looked after children in North Tyneside when they have their annual statutory health assessments.

The tool, known as MyHealth, was launched by the Children in Care Council and was later highlighted as an innovative project at a Royal College of Nursing conference.

Mental Health

Mental health has been one of the CCG’s main priorities for several years. During 2019/20, 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

Barnardos Strategic Alliance

Following an approach by the national charity Barnardo’s, partners in North Tyneside formed a long term strategic alliance to improve outcomes for children and young people, focusing on mental health and wellbeing, with dedicated funding awarded over an eight year timescale.

The strategic alliance will test different care models and make changes to the care system, with a focus on prevention and early intervention.

This is one of only three such alliances in the whole of the UK and the only one in England. We are delighted to be chosen for this work and look forward to continuing the work of the alliance in 2020/21 onwards.

Department of Education (DfE) Pilot: Mental Health Assessments of Looked After Children

Following an application and interview process, the DfE has selected North Tyneside as one of nine pilot sites to carry out a two year trial of a more in depth Mental Health Assessment of Looked After Children.

North Tyneside will continue to use the existing strength and difficulties questionnaires with carer, teacher and child (over 11 years old) but in addition to this, will also be using a range of tools to gain a more comprehensive picture of looked after children’s mental health and a
better understanding of the carer’s perspective on their relationship with the child or young person.

**Criminal Justice Enhanced Case Management approach: Trauma Recovery Model**

We are conscious that young people in the criminal justice system have a disproportionate amount of childhood and adolescent trauma. The Youth Justice Strategic Board (which the CCG is a member of) was successful in obtaining £60,000 in additional funding from NHS England which will be used to train a range of local practitioners working with young offenders and their families in an Enhanced Case Management approach, based on the Trauma Recovery Model (TRM).

**KOOTH Online Counselling**

The CCG has continued to commission an online mental health counselling and wellbeing service for children and young people in North Tyneside.

KOOTH provides online services for children and young people from the age of 11 years. The provision includes counselling, access to self-help materials, articles and moderated online forums.

The new contract commits more CCG funding to enable the service to extend to include young people up to the age of 25 years old.

**Children & Adolescents Mental Health Services (CAMHS)**

Due to the continued increase in referrals for specialist mental health provision for children and young people, the CCG provided additional funding to the CAMHS services during 2019/20 to improve access and reduce waiting times especially for neurodevelopmental assessments and the emotional pathway.

During 2019/20, the CCG worked with Northumbria Healthcare Foundation Trust, which provides most of the CAMHS services in North Tyneside, to employ additional staff in the service and to review some ways of working within the service. We continue working closely together to continue to make further improvements in future.

**Working Age Adults**

For working age adults, we have focussed on two main areas in 2019/20 - Talking Therapies services and pathways for adults with Attention Deficit Hypertension Disorder (ADHD) and with Autistic Spectrum Disorder (ASD).

We have also invested in two voluntary sector services - the North Tyneside Recovery College and the Together in a Crisis Service. This recognises the significant benefits these services will
bring to people with mental health needs in North Tyneside, and also as a result of listening to what patients and carers were telling us about access to particular services.

**Talking Therapies/Improving Access to Psychological Therapies (IAPT)**

There are several targets which CCGs are expected to achieve in relation to IAPT services, one of which is an expectation that a percentage of adults will access the service.

The percentage target is set nationally and increased in 2019/20. However, there continued to be an increase demand for step 3 & 4 service provision which are more intensive levels of mental health support, therefore the CCG made additional recurrent investment into the service to increase the workforce in line with the increased demand.

One of the reasons for the reduction in access rates is the establishment of alternative services. Each of the Primary care Networks in North Tyneside have contracted for a social prescribing service. Additionally, two of the PCNS are also piloting a primary care mental health service which is demonstrating positive initial outcomes. However, as a consequence, fewer people are accessing the Talking Therapies service.

The CCG is working with our provider partners, the Metal Health Network and with the Integrated Care System to undertake some pathway work to demonstrate that the access target, though useful in some circumstances, should not hinder innovative new developments like those described above.

We started this work at the end of 2019/20 but this has been paused during the COVID-19 pandemic. However, we are very keen to pick this back up again during 2020/21.

**Adult pathways for ADHD & ASD**

Due to the continued increase in demand for assessment and treatment on both the adult ADHD and ASD pathways, the CCG recognised the additional pressure this was placing on the services, leading to longer waiting times for access to the service. We provided additional funding to enable additional capacity into the service and reduce waiting times.

**Recovery College**

In 2019 a new Recovery College was developed in North Tyneside offering a range of social action programmes for people in North Tyneside who have mental health needs.

A social action approach focusses on people’s strengths, identity and potential, rather than their medical diagnosis. It draws on their own experiences to support others and recognises the valuable role people with their own personal experience can play in ensuring services are designed around people’s needs.

The programme developed was:
- Designed in collaboration with people with personal and professional experience of mental health problems
- Open to everyone free of charge (individuals, family members, carers, professionals)
- Different, but complementary to, the support provided by professional led treatment services.

Based on the feedback we received on a similar service in 2017, we ensured that the new service would include a dedicated Recovery College worker. A wide range of people were involved in the research and consultation around the new service, with individuals and representatives working together in a steering group.

The service began in September 2019 and has proven very popular with very positive feedback received so far. As a result, the CCG has committed additional funding to the service which will allow the Recovery College to expand the range of activities and programmes on offer and for additional venues to be considered.

The Recovery College’s prospectus is being designed in consultation with mental health service users.

**Together in a Crisis Service**

A review of the pathway for people in mental health crisis focused on ensuring that people get timely access to the right services for their needs. Carried out in partnership with HealthWatch North Tyneside, the review aimed to gather patient and carer input to help improve the pathway as well as informing future commissioning decisions.

One key suggestion was that patients would benefit from a low-level crisis support service for people who feel they are experiencing a mental health crisis but do not reach the threshold for access to the crisis team.

The CCG listened to this suggestion and commissioned a service called Together in a Crisis, provided by Mental Health Concern. The service links closely with the Cumbria Northumberland Tyne & Wear Mental Health foundation Trust’s crisis service, but provides support and signposting to people who do not meet the criteria for the crisis team. Early evaluation has shown that patients now feel more supported and more aware of the services available to them.

The CCG has now also commissioned additional services from Together in a Crisis to meet the same needs for older people and is working with Mental Health Concern and key partners to get it up and running.
Dementia and Older People’s Mental Health

In October 2019 the CCG relaunched the Mental Wellbeing in Later Life Board (MWLLB) with the aim of promoting older persons mental health in a way that complements current ways of working.

We have reviewed National Standards of Dementia Care and North Tyneside CCG are committed to work in a collaborative and innovative way with partners to address the needs of those affected by dementia.

With this in mind, the clinical lead for the Older Peoples Strategy is reviewing the current strategy and is working alongside mental health colleagues to ensure we improve and integrate mental and physical health care, including significant changes to current frailty services.

During 2019/20, the Admiral Nurse Service was reviewed. This service is currently provided by Age UK North Tyneside and aims to improve post-diagnostic support for people with dementia and their carers.

Between August 2019 and January 2020 Healthwatch North Tyneside spoke to 61 people about their experiences of memory and dementia services for older people to find out what we do well and what we could do better. Our Memory Assessment and Management Services were highly rated and people told us that they found the Admiral Nursing service “invaluable”.

To ensure increased numbers of patients and their carers receive benefit from the Admiral Nurse Service, the CCG has increased the outcomes expected from the investment and will continue our development during 2020/21. We are now working to implement the new specification and enhanced service with Age UK North Tyneside.

During 2019/20, the CCG, along with other neighbouring CCGs, was successful in bidding for national funding to review support services for older people in a crisis. Consequently, an implementation group was established, involving key stakeholders, and the Older Adults Crisis Service Northumberland/North Tyneside was launched.

Part of this was expanding the Together in a Crisis Service provided by Mental Health Concern to include older people, as described earlier in this report. Members of staff were recruited to enable the older persons pathway to be operational from January 2020.

Mental health performance

There are six national performance standards relating to mental health. North Tyneside CCG’s performance in 2019/20 is described below.

All performance and quality data is sourced from validated national sources, including NHS England, NHS Digital and Department of Health.
Improving Access to Psychological Therapies – Recovery

55.3% of patients which have finished treatment are moving to recovery in 2019/20. This is above the national standard of 50.0% and therefore meets the standard.

Improving Access to Psychological Therapies (IAPT) – Access

4.0% of patients accessed psychological therapies in quarter 4, 2019/20. This is below the England average of 4.7%.

North Tyneside Talking Therapies service - provided by Northumbria Foundation Trust - has seen a decrease in referrals to the IAPT service. The service has now employed a number of additional staff which is focused on improving access within North Tyneside.

A strategy has been developed which includes targeting previously underrepresented groups such as veterans and mature males. The referral process is also being streamlined using online self-referral forms and digital media to promote engagement events.

Early intervention of psychosis (EIP)

68.1% of people experiencing their first episode of psychosis waited two weeks or less to start treatment in January 2020. This is above the national standard of 56% and therefore meets the standard.

Mental health out of area placements

The CCG had a rate of 51 out of area placements for November 2019. This is below the England average rate of 129.

Estimated diagnosis rate for people with dementia

69.9% of people aged 65 and over are on the dementia register in January 2020. This is above the England average of 67.6%.

Dementia care planning and post-diagnostic support

78.7% of patients diagnosed with dementia have had a care plan and have had a face to face review in the last 12 months in 2018/19. This is above the England average of 78.0%.
Learning disabilities and neurodevelopmental services

The CCG continues to work in partnership with the local authority, providers and the voluntary sector to ensure high quality service provision to meet the needs of North Tyneside residents with a learning disability.

In line with the Transforming Care agenda, in 2019/20, the CCG has provided significant additional funding to the Community Learning Disability Team to develop an enhanced community model which includes the following pathways.

Crisis aversion

This builds on the existing community learning disability provision. The pathway will provide an all age specialist service offering rapid response, assessment, intervention, and training to avert and manage crisis for people who have a learning disability, complex behavioural and or mental health needs.

Forensic Learning Disabilities

A Forensic Learning Disabilities Service currently operates in North Tyneside which provides support for people with a learning disability at risk of offending, as well as delivering appropriate support to enable patients currently residing within secure hospital settings to move back into the borough.

The expansion of the current service will allow the team to offer outreach support to specialist providers to underpin placements at times of increased need, reducing the need for hospital admissions. It will provide in-reach assessment and support to those people currently residing within secure hospitals. We expect that this will ensure excellent discharge planning and continuity of care.

Learning Disabilities Forum

The CCG has set up a learning disabilities health forum, with representatives from the Local Authority, Public Health, Northumbria Healthcare NHS Foundation Trust and LD:North East.

This group has used its networks to identify and feed in issues for consideration by commissioners. For example, the group considered concerns raised that some people with learning disabilities are unaware that they have an option to have an annual health check and might benefit from an “easy read” guide to those checks.

Forum members subsequently created a set of easy read guides about what to expect from an annual health check, as well as other procedures, to support people with learning disabilities and their carers.
Stopping the over medication of people with a Learning Disability (STOMP)

In North Tyneside, additional resource is being deployed into the Community Learning Disability team to support the consultant psychiatrist to implement STOMP reviews and provide additional behavioural support interventions.

We are aware that people with a learning disability are often prescribed psychotropic medication, much more so than other people. These medications affect how the brain works and can help people to stay safe and well. However, they can cause problems if they are taken for too long.

STOMP is about improving the use of psychotropic medicine and offering non-drug therapies instead, involving patients, carers and staff in the decision making process.

Special Educational Needs & Disability (SEND)

North Tyneside has seen a continued increase in demand on special school places. To ensure the health requirements of pupils with complex and challenging health needs continue to be met in their education setting and as identified in their educational, health and care plan (EHCP), the CCG has provided additional funding to increase capacity in speech and language, occupational therapy, physiotherapy and special school nursing.

CCG staff have worked closely with the SEND Youth Forum to promote annual health checks for young people aged 14 years and over with a learning disability, as the update of annual health checks among children with special needs is low. This is a priority area for the CCG as these children are a vulnerable group whose health would benefit from an annual check.

Working together, we shared questionnaires with the children’s short break home and Joint Special Schools Council, which showed that many children and families did not know they were entitled to an annual health check or what is involved.

We delivered a practical training session so that forum members could talk confidently about health checks with their peers and encourage more people to take up the health check.

Feedback from the forum has now developed into an action plan to inform and engage with more children & young people with learning disabilities.

Learning Disabilities performance

There are three national performance standards relating to learning disabilities. North Tyneside CCG’s performance in 2019/20 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.
Planned care

Advice & Guidance Service

During 2019/20 North Tyneside CCG worked with Northumbria Healthcare NHS Foundation Trust to establish a wide range of new advice & guidance services.

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. This allows patients to be treated more effectively in primary care, with rapid access to specialist input, rather than waiting for an outpatient appointment and having the inconvenience of travelling to the hospital.

This work is continuing in 2020/21.

Outpatient Project

The CCG worked with Northumbria Healthcare on a project called the Outpatient Project. The project aims 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.

The project will reduce the amount of unnecessary follow-up appointments, and ensure that those that are necessary can be done virtually where appropriate. This is more efficient and saves patients the inconvenience of travelling to hospital.
This work is continuing in 2020/21.

**Faecal Immunochemical Test**

During 2019/20, North Tyneside CCG trained all local GP practices in the use of the new Faecal Immunochemical Test (FIT) - an alternative to colonoscopies for some patients, and rolled this out across the CCG.

The FIT involves patients collecting a sample at home and then sending it in for analysis. Using the FIT means that fewer patients need to go undergo colonoscopies – this is a good thing as all procedures have some level of risk and colonoscopies are particularly unpleasant procedures.

**Pain Management Service**

The CCG worked with Northumbria Healthcare to transform the pain management service from being doctor-led to being psychology and physiotherapy-led, and the new ‘Living Well With Pain’ service launched in July 2019.

The concept of living well with pain is in line with current international thinking about the best way to manage chronic pain. It is based on recognising that sometimes there is no cure to the pain but people can develop ways of living well with their pain.

Early indications are that the service is working well, and positive feedback has been received. As with any new service, the CCG is continuing to work with the service to make improvements to how it operates and to develop it further.

**Atrial Fibrillation Optimisation Demonstrator Programme**

North Tyneside CCG was one of 22 CCGs nationally chosen to join the NHS England Atrial Fibrillation (AF) Patient Optimisation Demonstrator Programme, which aimed to review all patients who have AF but are not being treated with anticoagulant medication.

The CCG trialled a new approach where GPs worked with anticoagulation specialists to review patients’ records in ‘virtual clinics’ i.e. without the patient being present. Those patients who might benefit from anticoagulants had individual shared decision making conversations about the pros and cons of treatment, before agreeing on what treatment to have, if any.

The programme runs until 30 June 2020, and if it is has been successful the approach will be rolled-out nationally.

**Medicines Optimisation**

During 2019/20 the CCG continued its work to ensure efficient and effective use of the CCG’s prescribing budget, enabling people to manage their own health, reduce the need for acute
intervention, maintain independence, support improved medicine-taking behaviour, reduce variation and improve outcomes.

This included:

- Implementing interventions to support optimal medicine-taking to enhance the quality of life and experience of care for people with long term conditions. For example, delivering medicine optimisation solutions for patients who are less visible to healthcare services but who are becoming frailer, with a reducing ability to cope; helping to maintain their independence whilst minimising the risk of harm
- Continuing to reduce waste within the overall system through increasing use of electronic prescribing and repeats systems
- Working closely with care homes to optimise medicines and medicine processes to minimise avoidable waste
- Supporting judicious use of antibiotics to appropriately manage infections and minimise the risk of the development of healthcare-acquired infections. The CCG established a working group to focus on this, and also bought 31 point-of-care testing machines to help GPs decide when patients need antibiotics – these machines help differentiate between bacterial and viral infections
- Supporting prescribers to prescribe appropriately for patients with difficult to treat, persistent symptoms - reducing the risk of harm, variation in treatment and improving the quality of care
- Supporting local implementation of NICE clinical and technical guidance supporting the development of local integrated pathways and guidance, allied to effective horizon scanning
- Improving the management of prescribed oral nutrition-optimising treatment and delivering more defined outcomes
- Establishing a working group to bring partners across North Tyneside together to deliver strategic change in medicines optimisation
- Publishing its Medicines Optimisation Strategy

**Medicines Value Programme**

The Medicines Value Programme aims to ensure greater value from the NHS' £18.2 billion medicines bill through improving health outcomes, reducing waste, over-prescribing and over-treatment and addressing excessive price inflation by drug companies.

The guidance covers 25 different medicines and is addressed to Clinical Commissioning Groups (CCGs) to support them to fulfil their duties around appropriate use of their resources.

The guidance supports CCGs in their decision-making, addresses unwarranted variation, and provides clear national advice to make local prescribing practices more effective. It does not remove the clinical discretion of the prescriber in accordance with their professional duties.
Across the whole range of medicines covered in the guidance, North Tyneside CCG performs very well and is consistently within or well below the lower 50th percentile for performance across the combined portfolio of medicines.

Further information is available online at: [https://openprescribing.net/measure/lpzomnibus/ccg/99C/#lpzomnibus](https://openprescribing.net/measure/lpzomnibus/ccg/99C/#lpzomnibus)

**Over-the-counter prescribing campaign**

Every year, the NHS spends:

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

Working across the NHS system in the region, our partners at NHS North of England Commissioning Support developed a campaign aimed at patients, to support efficiencies in over-the-counter prescribing.

We continue to take part in the campaign aimed to raise awareness of the costs of prescribing medicines that are routinely available to buy from local pharmacies, such as paracetamol and hay fever medication.

The overall aim was to save money on prescribing costs for items that patients can buy easily and cheaply to treat self-limiting minor ailments, which would allow the savings to be used elsewhere in the healthcare system.

For example, a pack of 12 anti-sickness tablets can be purchased for £2.18 from a pharmacy, but costs the NHS over £3 after including dispensing fees, and over £35 when you include GP consultation and other administration costs. Similarly, some common tablets are on average four times more expensive when provided on prescription.

A suite of materials were distributed to GP practices, walk-in centres, A&E departments and pharmacies for prescribers who wanted to use it to help with the discussions with patients about self-care. This was supported by further communications through the media, CCG websites and social media. Campaign information and resources are available at [www.mymedicinesmyhealth.org.uk](http://www.mymedicinesmyhealth.org.uk).

In its first 12 months, the campaign made savings of over £1m across the region. As the campaign continues to run, savings continue to be made, meaning NHS funds can be used to meet other healthcare needs.
CCGs win landmark high court victory over pharmaceutical companies – an update

North Tyneside CCG, along with other CCGs in the North East and Cumbria won a landmark legal case against Bayer and Novartis in 2018 in relation to the choice policy adopted by the 12 CCGs in the North East and North Cumbria, which allows patients the option to choose Avastin for wet age-related macular degeneration (wet AMD) alongside the two current options, Lucentis and 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 companies on all four grounds.

The ruling in 2018 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.

The drug companies subsequently launched an appeal against the High Court judgement. However the Court of Appeal decided in favour of the NHS and the ruling was upheld. This decision removes any remaining uncertainty over the choice policy and clinicians can be reassured that the use of Avastin for the treatment of wet AMD is lawful, safe and effective.

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 continue with its existing NHS RightCare Evaluation Plans.
These are:

- Respiratory services in North Tyneside to improve the pathway for accessing services and receiving treatment
- Trauma and injury (focusing on work around reducing the number of people who fall in North Tyneside due to a health related issues)
- Gastroenterology services to improve the pathway for accessing services and receiving treatment
- Medicines optimisation to ensure efficient and effective use of the CCG’s prescribing budget, enabling people to manage their own health, reduce the need for acute intervention, maintain independence, support improved medicine-taking behaviour, reduce variation and improve outcomes
- Managing patients with complex needs offering a robust alternative service to reduce frequent user activity (usually to A&E and non-elective admissions) and also other avoidable unscheduled care contacts

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.

**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 2019/20 plan continued to build on the previous two year plan and met the national requirements required of the Better Care fund.
Long term conditions

Personalised care planning continues to be at the core of the CCGs approach towards a proactive system of care and support for people with long term conditions. A key element of the work undertaken this year is a move away from the previous focus on individual diseases and towards a more generic approach in which the patient’s goals drive the delivery of care.

The introduction of universal personalised care as set out in the NHS Long Term Plan, and the introduction of Primary Care Networks, has provided the CCG with the opportunity to refocus on delivering and supporting the care of people with multi-morbidity and addressing the inequalities in health that currently exist in North Tyneside.

We now place a greater emphasis on supporting delivery of medicine optimisation programmes for people with long term conditions, greater access to social prescribing and access for personal health budgets which all help to underpin step-up supported self-management and personalised care.

We have worked with VODA, North Tyneside Council, public health colleagues and local Primary Care Networks to develop a video providing an overview of health and wellbeing in North Tyneside. The video includes interviews and clips from a variety of health professionals who discuss long term plans for North Tyneside and how the local health and wellbeing community is being supported.

Key areas of focus in 2019/20:

- Scoping new delivery models for supporting housebound patients with co-morbidities
- Expanding the ‘House of Care Model’ used in the management of diabetes and adopting the model to be the centre-piece of long term conditions management with greater attention paid to the contribution that people make towards managing their own health
- Greater use of personal health budgets for people who have a long term condition, complex needs and wheelchair users

Improving services for people who have a respiratory condition

As we have described above, North Tyneside CCG continues to be actively engaged in the Respiratory RightCare Programme, working alongside Northumberland CCG and Northumbria Healthcare Trust.

The programme aims to implement a respiratory plan, including 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:
• The development of Gold Standard Pathway Management Guidance for the effective diagnosis and treatment of patients with the following conditions:
  o Pneumonia
  o Asthma in adults
  o COPD
• Design of a new community based spirometry diagnostic and FeNo Testing model for patients at risk of asthma and COPD due to commence in Spring 2020 with full roll-out across North Tyneside by March 2021
• Established full roll-out of community based pulmonary rehabilitation for lower acuity patients
• Completed the roll-out of myCOPD self-management and support tool with the potential of reaching 1,400 patients to gain independence, increase self-confidence and manage their condition more effectively to minimise the risk of acute exacerbations

Cancer services
Cancer is the biggest cause of death from illness in every age group in England with 130,000 deaths per year. Mortality is significantly higher in males than in females.

It is estimated that 280,000 people are diagnosed with cancer each year in England, increasing by 2% per annum with the expectation that new diagnoses will reach 3.4 million a year by 2030. Survival rates are lower than the best in Europe, quality of care is variable and the needs of people living with and beyond cancer are not always met.

The NHS Long Term Plan sets out a wide range of specific steps designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond the disease.

North Tyneside CCG continues to work closely with Northumbria Healthcare NHS Foundation Trust, Newcastle upon Tyne NHS Foundation Trust, the North Tyneside Public Health Team, and the Voluntary Sector towards achieving the key milestones set out in the NHS Long Term Plan. During 2019/20, we have worked on several initiatives and measures aimed at achieving the Long Term Plan requirements and delivering improved services and outcomes for patients.

Working towards faster diagnoses and treatment
Lung Cancer Case Finding. Diagnosing people faster and earlier is one of the most effective ways to diagnose cancer. In North Tyneside around 52% of cancers are detected in stages 1 and 2. However we know detection rates for lung cancer are mostly detected at stages 3 or 4.

The CCG has been working with the Northern Cancer Alliance on new approaches for referring and diagnosing lung cancer more quickly and prioritise the rapid adoption of a new early diagnosis technique through the commissioning of a lung cancer case finding programme. This involves working with our colleagues in primary care in identifying those patients eligible for a new screening programme that involves the use of low dose CT scanning.
Human Papillomavirus Testing (HPV). Almost all cervical cancers are linked to HPV. Screening for high-risk strains for HPV means that the virus can be monitored and any cell changes spotted early.

The introduction of a HPV vaccine which is now available to all 12 year old and 13 year old boys as well as girls in school year eight is seen as a milestone in cancer prevention.

Successful roll out of the vaccine was completed in North Tyneside this year in line with the milestone set by NHS England.

Additionally, we have worked with the North Tyneside Public Health Team on rolling out the ‘Screening Saves Lives Campaign’ which is aimed at hard to reach groups to encourage cervical screening and support embedding ‘HPV First’ within primary care.

Faecal Immunochemical Test (FIT) for haemoglobin. During 2019/20, the CCG successfully rolled out the new FIT systematic testing in primary care as part of national bowel screening programme. More detail on this is included in the Planned Care section above.

Personalised care and support

More people are living longer with and beyond cancer. The NHS Long Term Plan sets out bold ambitions for the acceleration of the commissioning and provision of personalised care for people affected by cancer to live the lives they want beyond their diagnosis.

Early diagnosis and improvements in treatment means that survival rates are increasing. In North Tyneside around 50% of patients will now survive at least five years. Coupled with a growing number of new cases each year, this means that the number of cancer survivors will double in just 20 years. However early deaths remain worse than the England average.

Personalising aftercare and putting patients more in control of their recovery is an essential part of improving the patient experience. This means that receiving care should be tailored to the need of the individual resulting in improved quality of life outcomes.

During 2019/20, North Tyneside CCG worked closely with Newcastle upon Tyne FT and Northumbria Healthcare FT to progress our ambition that by 2020/21 every cancer patient receives four key interventions:

- Health needs assessment – Everyone with cancer is offered a holistic needs assessment and a personalised care plan that focusses on individual needs along with an end of treatment summary for the individual and those involved in their care
- Health and Wellbeing information and support – Including the provision of accessible information about emotional support, coping with side effects, financial advice, getting back to work and making health lifestyle choices
- Risk stratification pathways and after care follow up and support for self-management - Reduced time that professionals spend seeing patients who are doing well after treatment with rapid re-access to their cancer team, including telephone advice and support
- **Primary Care Cancer Care Review** – A quality assured discussion between the individual and their GP/primary care nurse about their care journey.

**Improving patient experience**

In 2019/20, the North Tyneside Cancer Public Engagement Forum was established, hosted by MacMillan with additional support from the North Cancer Alliance Communication and Engagement Lead.

The Forum is a sub-group of the North Tyneside Cancer Locality Group and is set up to seek views on how patient outcomes can be improved, in terms of survival, quality of care and patient experience.

Key aims of the forum include:

- Engaging with the community (patients, carers, members of the public, VCS organisations) of North Tyneside to understand what matters most and provide opportunities to get involved in specific workstreams of the North Tyneside Cancer Plan
- Work alongside the North Tyneside Cancer Locality Group in co-designing new approaches and improve services delivered to North Tyneside

Group members have attended training sessions and identified ways of engaging and feeding back to participants. These include using a visual note taker who relayed conversations back to the group.

The feedback was shared with the other work streams involved with the Cancer Plan as well as the Health & Wellbeing Board.

**Improving cancer support in primary care**

In 2019/20, the CCG developed a Cancer Champion Training Programme, supported and delivered by Cancer Research UK. The model is based upon having a non-clinical member of a GP practice’s team, for example a member of the administration team or HCA, who is put forward to support targeted work around the earlier diagnosis of the cancer agenda.

The main aim of the Cancer Champions Training programme is to increase and embed knowledge skills and capacity on the following cancer topics:

- Prevention and risk reduction
- Screening
- Symptom awareness

17 out of 26 practices across North Tyneside participated in the programme, which comprises a stage one beginner’s programme and a stage two advanced programme.
In February 2020, the CCG hosted a Cancer Master Class for Primary Care. Over 44 participants attended across our 26 practices. The master class focussed on cancer pathways, treatments, improving the patient experience and realistic medicine. Feedback from delegates was extremely positive and the CCG will look to establish further events in 2020/21.

**Cancer performance**

2019/20 saw an unprecedented increase nationally in two week wait (2ww) cancer referrals with significant demand in urology, breast and colorectal pathways. This level of demand reflects the underlying year on year growth in demand and there is now more than double the number of urgent referrals compared with 2010.

The number of referrals has grown by more than 10% in each of the last two years. This has placed significant pressure on local foundation trusts to deliver the 62 day referral to treatment target.

Work continued throughout the year on developing improvement plans to improve the patient flow through the cancer pathways. This included initiatives such as straight to test, patients tracking and upgrades to system technology.

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.

<table>
<thead>
<tr>
<th>Two week wait all cancers</th>
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<tbody>
<tr>
<td>89.4% of patients referred by their GP urgently with suspected cancer were given an outpatient appointment within two weeks in March 2020. This is below the national standard of 93%.</td>
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January and February 2020, saw an increase in cancer referrals following the Christmas period. Both Trusts are continuing to implement their cancer improvement plans and have made modifications in their referral pathways with trajectories to improve performance.

<table>
<thead>
<tr>
<th>Two week wait for an urgent referral for breast symptoms</th>
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</thead>
<tbody>
<tr>
<td>80.4% of patients who were referred urgently with breast symptoms were seen within two weeks in March 2020. This is below the national standard of 93%.</td>
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</table>

The increase in demand over the Christmas period has significantly impacted on the breast pathway. Initiatives have been put in place to accelerate patients through the pathway, such as straight to testing.
31 day treatment – all cancers

93.7% of patients who were diagnosed with cancer waited less than 31 days for their treatment to commence in March 2020. This is below the national standard of 96%.

Patient demand for cancer services is increasing significantly. Since 2017/18, there has been a 10% year on year increase in GP referrals for suspected cancer. When compared to five years ago, this is an increase of almost 60%.

The increase in the number of GP referrals is down to a combination of different factors including the changing age demography of North Tyneside with more people living longer, the high levels of deprivation and poverty in some parts of North Tyneside which attribute to poor health, the increasing awareness of the disease driven through national campaigns and changing medical practice and changes in guidelines and referral thresholds which has been lowered to a 3% conversation rate.

Changes to cancer screening programmes such as the recent lowering of the screening age for bowel cancer from 60 to 50 and the introduction of FiT testing may also have an impact on the demand for diagnostics and cancer services and will continue to have in the future.

Although performance has slipped against the cancer targets, it is important to note some of the positives which emphasise the exceptional care that the two local trusts continue to provide to patients despite the immense pressures on these services.

Both trusts have been working to increase the speed of diagnosis for cancer services. The planned development of rapid diagnostic and assessment centres known as 'one stop clinics' will help to streamline diagnosis for people with suspected cancer. It is hoped that these one stop clinics will be particularly useful for speeding up the diagnosis of certain cancers, including breast cancer.

31 day treatment - surgery

93.7% of people diagnosed with cancer and requiring surgery waited less than 31 days in March 2020. This is below the national standard of 94%.

During 2019/20, our local providers have undertaken significant reviews to understand what happens in each step of the cancer pathway up to treatment and surgery. This includes:

- Redesigning demand and capacity planning processes and involving key staff in implementing new ways of working.
- Integrating the Somerset IT system with the Trusts Patient Administration System (PAS), thus allowing for the tracking patients through each stage of their journey and proactively addressing potential blockages, Did Not Attend’s, etc.
- Instigating straight to test in colorectal and urology pathways.
- Making best use of data intelligence to understand trajectories and trends and plan services accordingly.
Through these improvements, our trusts are now able to demonstrate more effective ways in streamlining pathways and performance throughout the year has improved.

However challenges remain around access to radiology and oncology resulting in a 0.3% shortfall in achieving the target. Both trusts continue to make improvements in cancer pathways. The advent of lung cancer case finding and the development of Rapid Diagnostic Centres are two enablers as we move forward in 2020/21.

### 31 day treatment - anti-cancer drugs

100% of patients who required drug treatment for a cancer diagnosis waited less than 31 days to receive their treatment in March 2020. This is above the national standard of 98%.

### 31 day treatment – radiotherapy

97.7% of patients who were diagnosed with cancer and required radiotherapy waited less than 31 days for their treatment to begin in March 2020. This is above the national standard of 94%.

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

82.8% of patients who were diagnosed with cancer following an urgent referral from their GP waited less than 62 days for their treatment to begin in March 2020. This is below the national standard of 85%.

Since 2017/18, there has been a 10% year on year increase in GP referrals for suspected cancer. When compared to five years ago, this is an increase of almost 60%.

The increase in the number of GP referrals is down to a combination of different factors including the changing age demography of North Tyneside with more people living longer, the high levels of deprivation and poverty in some parts of North Tyneside which attribute to poor health, the increasing awareness of the disease driven through national campaigns and changing medical practice and changes to guidelines and referral thresholds which has been lowered to a 3% conversation rate.

Changes to cancer screening programmes such as the recent lowering of the screening age for bowel cancer from 60 to 50 and the introduction of FiT testing may also have an impact on the demand for diagnostics and cancer services and will continue to have in the future.

The demand placed on Tertiary Centres proved to be the biggest challenge in achieving the 62 day standard. Both Tertiary Centres in the Cumbria and North East have failed to achieve the standard due to the continued rise in demand and increase in onward referrals from other Trusts.

Major changes to how trusts manage their internal pathways and trust to trust pathways have taken place over the last year. Service improvement teams in both trusts have
mapped out each pathway and used real time information as a way to challenge traditional ways of working. One of the key improvements has been the early involvement of senior clinicians in the planning of a patient’s pathway, particularly at point of diagnosis through to continued tracking at each stage of the patient’s journey.

62 days screening to first treatment for cancer – screening service

91.7% 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 in March 2020. This is above the national standard of 90%.

Cancers diagnosed at an early stage

52% of all new cases of cancer diagnosed are at stage 1 and 2 in 2017. This is below the England average of 52.2%

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.

The CCG is leading on a multi-agency approach to improving cancer outcomes. This includes using the Northern Cancer Alliance Transformation Fund to develop a range of initiatives that focus on prevention. This includes targeted work directly with GP practices with the highest smoking prevalence rates and working with practice teams to improve the update of smoking quitters.

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%.

Death rates due to cancer have decreased significantly over the last two decades however cancer remains the significant cause of premature death in North Tyneside. Although North Tyneside is showing improvements in survivorship outcomes, it fairs significantly worse than the national average by more than 10% compared to the better performing CCG’s.

Morbidity rates are more prevalent with the more socio-economically deprived groups where life expectancy is less than those least deprived groups. Smoking rates amongst poorer communities is significantly worse and 86% of lung cancer is directly attributable to smoking.

We also know that patients diagnosed with lung cancer have an average life expectancy of 12-14 months however there is little evidence in North Tyneside on how patients access the right palliative support. The proportion of deaths under 75 years due to cancer are considered to be amendable to health intervention. We know that excess mortality is
linked to later presentations and delay in diagnosis.

Currently, around 53% of cancer patients are diagnosed at stage 1 or 2. However the majority of Lung Cancers are diagnosed at stage 4.

The CCG is working across the ICP level in collaboration with the Northern Cancer Alliance to develop a range of initiatives to improve life expectancy for people living with cancer. This includes the implementation of lung cancer case finding which targets people over 55 with a diagnosis of chronic obstructive pulmonary disease (COPD) receiving low dose computed tomography (CT).

Evidence from national pilots suggest improvements with more people diagnosed earlier. This year saw the introduction of FiT testing for bowel cancer and human papillomavirus (HPV) screening as part of the cervical screening programme. The CCG will continue to embed these initiatives within primary care during 2020/21.

Cancer patient experience

9.0 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). This is higher than the England average of 8.8. 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 people receiving a health needs assessment.

Clinicians across the region have joined forces to improve how the local NHS uses endoscopy (telescope test) to diagnose cancer of the stomach and oesophagus (gullet) by working together to improve patient safety and using 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. 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.

This is intended to improve cancer diagnosis, help people avoid unnecessary endoscopy and offer better treatment options for patients. This includes looking at how they eat and lifestyles factors such as excess alcohol consumption and maintain a good body weight as well as medication.

Improving care for older people in North Tyneside

Advances in healthcare have helped people to live longer than ever before. As a result, the number of older people in North Tyneside is growing significantly and this rate of growth is projected to speed up over the next 20 years.

This is good news for us all, but it creates a challenge for the NHS – as we get older we tend to develop long term conditions and need more health and social care. Although NHS funding has increased in recent years, it has not done so at a rate that has kept pace with the rising level of demand for healthcare services.
Our ageing population

- One in four of the residents of North Tyneside are aged 60 or over, and that number is expected to increase to increase by 2030
- 75% of 75 year olds in the UK have more than one long term condition, rising to 82% of 85 year olds
- Between 2007/08 and 2013/14 the numbers of A&E attendances by people aged 60 or over increased by two-thirds, a steeper increase than is expected by demographic change alone

What is North Tyneside CCG doing to support local people to age well?

North Tyneside CCG regards the provision of services for older people and particularly our frail elderly population as a priority.

In recent years the CCG has pioneered a number of innovative approaches to providing community-based care and support to the elderly. This approach was continued in 2019/20 with the following initiatives taking place:

Care Plus Initiative

We have significantly increased the rate of referrals to North Tyneside Care Plus. This means that far more frail elderly people have been able to access proactive multidisciplinary healthcare in their own homes, reducing the likelihood that they will require treatment in hospital in the future

Falls Services

We have extended the pilot period for the new community-based pathway of care for falls. The community falls pathway aims to reduce the number of older residents who harm themselves by falling. It consists of a number of different services which work together:

- **Community Falls Clinic** – A multidisciplinary community-based team providing assessment and healthcare interventions for patients who have had a fall or are deemed to be at risk of harming themselves by falling
- **Safe & Well Checks** – When visiting older people’s homes in North Tyneside the Tyne & Wear Fire Service will carry out a basic falls risk assessment and provide equipment to help reduce that risk in future (e.g. ferrules, helping hands etc.)
- **Falls First Responders** – Calls to 999 or NHS 111 from people who have fallen without seriously injuring themselves can be referred to a trained first-aider in North Tyneside Council’s Care Call service. This usually results in the patient receiving help more quickly than they would otherwise and allows ambulance services to focus on those in greatest need
- **Strength & Balance Programme** – A 12 week exercise programme aimed at older people which is designed to improve strength and balance and thus reduce the risk of a future fall
Medication reviews for frail patients

We commissioned a frailty pharmacist service to provide access to home-based medication reviews for frail elderly patients. The service aims to minimise the number of medication-related problems that older people experience and optimise the use of pharmaceutical medications.

Access to healthcare in care homes

Additional resources have been made available to improve access to healthcare for nursing home resident in North Tyneside.

All nursing homes in the borough are now aligned to a named GP practice, with healthcare professionals visiting the homes regularly to provide proactive care to patients and advice and guidance to staff.

Integrated Frailty Pathway

In our engagement work with patients and carers we have discovered that patients find existing frailty services unclear and complicated. Having listened to what patients and carers are telling us, we are developing an integrated model of services for older people across North Tyneside.

This will bring together health and social care services, working with partners including the local authority, the acute trusts, community services and Primary Care Networks. Our aim is to provide a new integrated frailty pathway, which will be seamless across acute, primary and secondary care settings.

We are co-producing this model with patients, forum members, local authority and health care partners.

We have held several events to help begin to shape and model what this new service will look like, involving members from our Patient Forum. Over 130 people attended our last event and more stakeholder events are planned for 2010/21.

Reminiscence Interactive Therapy and Activities (RITA)

During the past year, local nursing and care homes reported increasing levels of distress and anxiety from residents with dementia. With an ageing population and increasing prevalence of dementia in North Tyneside, we commissioned the new RITA system for the borough.

RITA is a touch screen PC and tablet system, pre-loaded with a bank of music, films, videos, games and even iconic speeches, which can be tailored to individual needs. The impact on individuals using RITA as part of their personal care has been immense.

One care home has explained how they have used RITA to help settle a non-English speaking resident. Family members have recorded key phrases to help members of staff communicate with the resident, which is helping her to settle into her new life at the home. The family have
also included family photos, which are helping to calm the resident and is also helping the care home staff to understand more about the resident’s life.

We have gathered feedback on RITA from residents, family members, care home staff and managers through a range of interviews, surveys, roadshows and billboards. This has helped to identify a wide range of clinical benefits including a reduction in resident falls, a reduced need for one-to-one care, less agitation and challenging behaviour and a reduction in the length of time that patients are staying in hospital.

**Whzan**

Whzan which is a ‘telehealth’ system which we introduced into care homes in North Tyneside during 2019/20. It is designed to help staff monitor the health of residents in nursing and residential care homes.

Whzan can help to identify the early deterioration of residents’ health and to support clinical decision-making, making sure that the patient receives the correct level of care at the correct time.

**Urgent care**

**Integrated urgent care service**

Demand for urgent and emergency care services (both attendances and non-elective admissions), has risen across North Tyneside for the last few years; a demand which is set to continue as people live longer with increasingly complex and often multiple long term conditions.

Previously, the CCG had undertaken an extensive consultation exercise about our urgent care services and we worked with stakeholders to review our urgent care centre provision. Feedback had been clear that people wanted a single site in North Tyneside which would meet their needs.

Following further engagement, the CCG awarded a contract to Northumbria Healthcare NHS Foundation Trust to provide urgent treatment services at the North Tyneside General Hospital site on Rake Lane in North Shields.

The development of the new integrated urgent care centre in October 2018 has provided residents living in North Tyneside the opportunity to receive responsive GP-led healthcare 24 hours a day, 7 days a week. This service is interoperable as part of the wider urgent care system and aims to provide safe, sustainable and consistently high quality care.

The urgent care centre integrates with the NHS 111 service to allow appointments to be booked directly from NHS 111 into the urgent care centre. The service also incorporates a GP out of hours service, which will offer advice and help, including home visits, between midnight and 8am.
The CCG Patient Forum members asked if they could visit the service at regular intervals to find out how well the system works for patients. Service staff expressed their appreciation for the members input and considered their points for improvements.

The CCG has taken the suggestions into account, along with similar feedback from a Healthwatch North Tyneside report, and is working with the Trust to make improvements.

**Key achievements 2019/20**

- Delivery of an integrated model of urgent care, as described immediately above
- Provision of a comprehensive model of Same Day Emergency Care in both medical and surgical specialities
- Direct access for the ambulance service, NEAS, to ambulatory care and direct consultant advise for paramedics
- Provision of an acute frailty service, achieving clinical frailty assessment within 30 minutes of arrival
- Improved uptake of the UEC-RAIDR app that 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

**Strategic work**

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

The network ensures effective co-ordination of urgent and emergency care services across the North East and North Cumbria in the implementation of the NHS Long Term Plan. The network’s goal is to have a highly responsive, 24/7, seamless urgent and emergency care model, which reduces demand on emergency services and reducing unwanted variation in services across the region.

Over the past 12 months, the network has implemented and supported a series of improvements to ease pressure on services across the region. These include:

**Digital record-sharing (Great North Care Record):** Emergency doctors, nursing staff, hospital pharmacists and consultants use MIG (Medical Interoperability Gateway) to help make clinical decisions, with over 150,000 records viewed every month (as of January 2020). Out of hours providers, North East Ambulance Service/111 clinicians and the vast majority of the region’s hospital trusts are now live on the system.

MIG is a secure system that provides the most up-to-date patient information, such as diagnoses, medications, details of hospital admissions and treatments.
With the network’s support, MIG has been rolled out successfully across the region, meaning that every GP practice now shares patients’ records with the clinicians involved in their care - resulting in safer, faster, more effective care, with less time wasted getting hold of medical records, or patients having to answer questions more than once.

Work is now in progress to introduce the Health Information Exchange (HIE). Led by Newcastle Hospitals as part of the Great North Care Record, this will be a major new step allowing two-way sharing of data, documents and images. It will improve the flow of information between organisations and ultimately improve care for people in our region.

111 Online is now available across the region, offering a fast, convenient alternative to the NHS 111 telephone service and a good option for people who want to access NHS 111 digitally. Usage across the region continues to increase.

Free NHS falls training for care home staff has been offered again this year. This is specially designed course helps staff to confidently manage residents who suffer falls. The course is delivered by North East Ambulance Service with support from the network and NHS England.

Service Finder is now live, enabling healthcare professionals to connect patients to the most suitable services first time, and supporting better distribution of demand across the urgent and emergency care setting.

A new regional communications campaign was launched to raise public awareness of how best to access urgent and emergency care services across the region during the winter. The campaign included:

- Proactive media
- TV advertising on ITV Tyne Tees, ITV Hib, Sky Adsmart and Sky Regional
- Radio advertising on Heart FM, Capital FM
- Major digital and social media campaign
- Outdoor advertising including buses, Metro, billboards etc
- Advertising with Evening Chronicle and Evening Gazette

Every North East GP practice now accepts appointments through NHS 111, putting the region in the forefront of change within the NHS nationally and ensuring that patients are directed to the right service to meet their needs.

This also enables direct booking of appointments to out of hours services. New quarterly reporting to CCGs and GP practices has been implemented to enable active management of time slots made available for 111 bookings.

Community Pharmacy Consultation Service is now live, with 575 pharmacies across the region signed up. This enables NHS 111 to access pharmacies to treat minor ailments and urgent repeat prescriptions.
The network will continue to work on vital initiatives with an ambitious three-year delivery plan to reduce hospital admissions and attendances at A&E departments by making better use of GPs and pharmacists and to help patients improve their own health.

Through the network, the region’s hospitals aim to 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 also reduces the risk of queuing ambulances and unnecessarily long waits in A&E.

**Winter 2019/20**

Nationally, for the first time, NHS accident and emergency (A&E) performance has not seen a recovery during the summer months. Also, a national pattern of decline in performance has also been reflected across our region.

It should be noted that A&E performance at both the Northumbria Hospital and at the RVI in Newcastle where most North Tyneside patients attend, have still been amongst the very best in the country.

However, the CCG recognises that more improvements can be made and we continued to work with the North East and North Cumbria Urgent and Emergency Care Network during the winter period of 2019/20 to effect more improvements. Trusts and partners were asked to focus on the several key areas which would improve the flow through accident & emergency provision and reduce pressures on the system. Initiatives in the North East included:

- Testing a range of options to improve flow through emergency departments, including revised shift patterns, increasing numbers of senior clinical decision-makers at front of house (and in reviewing patients for accelerated discharge), ensuring GP out of hours services are adequately resourced, and concentrating the efforts of e.g. community matrons in nursing homes to avoid admissions
- Reviewing local governance arrangements for dealing with urgent and emergency care pressures and development of winter delivery agreements between partners
- Reviewing bed capacity in each Trust, using flexible staffing arrangements to relieve pressure on the Emergency Department
- Deploying medical trainees more flexibly at times of extreme pressure
- Agreeing how the ambulance divert policy is triggered to ensure ambulances can take people to the most appropriate Trust for accident & emergency care to avoid long waits and queues.
- Acute providers working to ensure that ambulances are offloaded and crews released within a maximum of thirty minutes
- Supplementing the national winter communications campaign with some messaging of our own across the Integrated Care System area

It is through working collectively across the region that we can meet the increasing demand on emergency services and, as issues arise, can be addressed.
A regional debrief session took place in March 2020 in order to take stock and learn lessons from winter 2019/20 – sharing best practice, and identifying gaps as well as managing pressures through the use of tools and technology.

**Urgent care performance**

**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.

Both of the CCGs main providers for A&E have achieved the standard of 95% with The Newcastle Hospitals Foundation Trust achieving 95.7% and Northumbria Healthcare Foundation Trust achieving 97% in March 2020.

**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.

The CCG did not achieve two of the four category response times for 2019/20 (category 2 and 3).

The CCG continues to work with the provider as part of a four year regional contract investment plan to improve performance and ensure that the target is met in 2020/21.

The four year plan developed in 2018/19 was in response to concerns raised by NEAS in relation to the financial challenges along with a number of significant issues around service provision. This resulted in the development of a four year regional investment plan to improve performance through the implementation of year on year service improvements. These include: reconfiguration of the dispatch desk, increasing NEAS clinical triage rate in line with other ambulance services and strengthening the 999-call taking function.

In addition to these improvement areas, the CCG agreed to standardise how Urgent Treatment Centres are led in line with a new national specification as a way to reduce variation across the region and in doing so, alleviate the challenge NEAS faced in working into different operational systems.

CCG’s agreed to provide additional funding which is predicated on NEAS delivering an agreed performance improvement. Monitoring of Response Standards in line with the four year Ambulance Response Programme investment plan continues.
End of life and palliative care

Shared Palliative Care Summary (SPCS)

A significant area of focus for 2019/20 has been the successful development of the ‘Shared Palliative Care Summary’ which works across multiple care agencies to promote the development of integrated care for palliative care patients.

Category 1 response time

Category 1 is: An immediate response to a life threatening condition, such as cardiac or respiratory arrest

The average time an ambulance took to respond to a category 1 ambulance call was 6 minutes and 32 seconds in 2019/20. This is below the national standard of 7 minutes.

Category 2 response time

Category 2 is: A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport

The average time an ambulance took to respond to a category 2 ambulance call was 25 minutes and 56 seconds. This is above the national standard of 18 minutes but lower than the regional Cumbria, North East (CNE) average of 29 mins 28 seconds which the North East Ambulance Services (NEAS) achieved for 2019/20.

Category 3 response time

Category 3 is: An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting

90% of all category 3 ambulance calls were responded to within 3 hours, 49 minutes. This is above the national standard of 2 hours 0 minutes but lower than the regional CNE average of 3 hours and 51 minutes which NEAS achieved for 2019/20.

Category 4 response time

Category 4 is: A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic

90% of all category 4 ambulance calls were responded to within 2 hours, 50 minutes. This is below the national standard of 3 hours 0 minutes.
This has enabled a multi-agency approach through the collation and sharing of data intelligence, and enables informed collective working and decision making across a number of professional boundaries.

The work has been overseen and led by the CCGs Clinical Lead for Palliative and End of Life Care, Dr Kathryn Hall, whose leadership, determination and expertise in the field of end of life care has been instrumental in this innovative development.

The North Tyneside Palliative Care/End of Life Work Plan

North Tyneside CCG continues to strive towards ensuring patients who are palliative and/or nearing the end of life, along with their families and loved ones, receive the highest standard of care possible.

This year, we have worked with some of our key partners in the development of a three year work programme which sets out six key ambitions:

1. Each person is seen as an Individual
2. Each person has fair access to care
3. Maximise comfort and well-being
4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

Strategic Achievements 2019/20

The development of Shared Palliative Care Summary (SPCS) has helped to underpin the CCGs strategic achievements this year including:

- 22 of the 26 GP practices in North Tyneside are trained and signed up to SPCS with 360 plans in place
- An estimated 50% of palliative patients have an emergency care plan in place
- An increase on the percentage of palliative care patients in the register rising from 0.64% in 2018 to 0.81% by March 2020
- An increase in the number of non-cancer patients registered on the palliative care register
- An increase in the number of people living in care homes on the palliative care register by 30%
- People living in care homes on the end of life pathway who die in their place of residence currently stands at 85%
- People on the end of life pathway dying in their preferred place of death has increased from 60% to 64% which is amongst the highest in the country
- A reduction in avoidable attendances at A&E resulting in admission has fallen from 750 annually to 430 annually
**Improve 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 public 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 collating 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.

During 2019/20 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 local service providers. 100% of practices have access to SIRMS within North Tyneside.

304 incidents were reported during 2019/20. Where quality issues are identified, they are discussed with providers and feedback/learning is requested for any identified themes, trends or 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 2019/20 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 raising sepsis awareness and education on the use of the National Early Warning Score (NEWS). 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/Chief Operating Officer is the lead officer for safeguarding in the CCG. Support is given from a range of other officers which provides robustness and resilience in the CCG’s safeguarding processes:

- The Head of Safeguarding (CCG employed)
- The Designated Nurse Safeguarding Children
- The Designated Nurse Safeguarding Adults
- The Designated Nurse Looked After Children
- The Designated Doctor Safeguarding Children
- The Designated Doctor Looked After Children
- 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 North Tyneside Safeguarding Adults Board and North Tyneside Safeguarding Children Partnership.

Safeguarding of children is an important element of contract monitoring with providers, and assurance is sought through regular meetings and quality review groups. Quarterly monitoring is also in place using a safeguarding children performance dashboard.

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 Safeguarding Adults Review, Serious Case Review, Domestic Homicide Review or any other type of learning review occurs, the CCG works with partner agencies to ensure that national policies and procedures are followed and that learning is shared and acted up on by agencies.

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
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) in relation to children and adults
- North East Ambulance Service (NEAS) in relation to 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 Partnership (NTSCP) – The CCG is now one of the three Safeguarding partners and is therefore a member of NTSCP Executive group, 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 Government’s 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 Workshops to Raise Awareness of PREVENT (WRAP) level 3 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 is our greatest asset and we 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 staff 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 on a sustainable basis. There is support for a learning culture so that practices can keep up to date, informing innovation and improvement, and enhancing care for patients and well-being of staff.
The offer, of monthly 90 minute education sessions for GPs, was well attended by most practices, and individual sessions evaluate well. However, the CCG took the opportunity during 2019/20 to undertake an analysis of the GP training as we wanted to evaluate such issues as the education topics, the quality of delivery and dissemination of learning throughout practices.

We also want to increase patient feedback as a source of learning. As a result of the feedback received, we have revised the training and education offer to GP Practices which is aimed at being more relevant and useful for practices in order to improve care for patients and support GPs and staff.

An analysis of the education needs of back office staff within GP practices was also undertaken, resulting in a new training programme being rolled out during 2019/20.

The CCG also offers other, ad hoc training offers for staff, coordinated by the transformation team, e.g. leadership schemes, and Microsoft training.

**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.

**Northern CCG Joint Committee**

In common with all CCGs in the region, we played an active role in the Northern CCG Joint Committee.

During 2019/20 the Joint Committee considered the following:

- North East and North Cumbria Prescribing Forum
- Individual Funding Requests (IFR) – A System Review Update
- Value Based Commissioning (VBC)
- North of England Commissioning Support (NECS) Annual Review and customer board reports
- Developing an Integrated Care System (ICS) in the North East and North Cumbria
- Developing a Lay Member Network
- Governance items
- Research and Evidence
- Flash Glucose Monitoring
The use of Avastin for the treatment of wet AMD
Cyber security
Specialised Commissioning
Breast Services Review
Use of antivirals for flu prophylaxis and treatment

A work plan for the Joint Committee for 2020/21 is currently being developed.

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

**Capacity Tracker**

The Secretary of State for Health and Social Care, Matt Hancock, has spoken about how better technology is vital for the NHS.

Leading the field in this area is the digital portal, Capacity Tracker, which is proving to be a valuable tool for individuals, care homes and health and social care staff across the North East and England as a whole.

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

It enables care homes to make their vacancies instantly visible to all discharge teams across England in real-time and is accessible from any desktop or mobile device.

This helps individuals make the right choice, ensuring they don’t stay in hospital any longer than is necessary when discharge to their own home is not possible. The simplified process reduces stress and anxiety for the individual and their families at a time when they need care and support.

Capacity Tracker has removed the requirement for hospital discharge teams to perform the time-consuming task of speculatively calling care homes to gather up-to-date vacancy information. Having the ability to rapidly access care home vacancies across England in real-time helps minimise avoidable Delayed Transfers of Care and frees up beds in acute settings for other patients.

As of March 2020, over 9,000 care homes across the country and around 13,000 users had signed up to the Capacity Tracker.

**NHS Mail secure emails in nursing & residential homes**

North Tyneside CCG have successfully supported all Nursing and Residential Care Homes across the North Tyneside locality with signup to the NHS Mail secure email service with is the
secure email service approved by the Department of Health and Social Care for sharing patient identifiable and sensitive information.

By signing up to NHS Mail, care homes can remove a reliance on inefficient paper based systems and, as a result, will see significant time savings allowing the care home staff to spend less time making phone calls and, instead, focus more on the core purpose of patient care. In addition, this will enable process efficiencies that allow quicker receipt of medical and prescription notes, test results and community psychiatric nurse (CPN) reviews. Further benefits include:

- Quicker receipt of accurate information
- Improved audit trail
- Increased patient safety

**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.

**Performance Measures**

<table>
<thead>
<tr>
<th>MRSA</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 2019/20 to date.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clostridium Difficile</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Diff cases have been updated to show the change in reporting for the CCG which is now to include all figures, we have split these into Hospital Onset and Community Onset however the CCG figure is the addition of both.</td>
<td></td>
</tr>
<tr>
<td>The CCG had 51 cases of Clostridium Difficile against an annual threshold of no more than 43 cases for 2019/20. The 43 case threshold was originally based on a reduction on the actual number of cases recorded in 2018/19 which was 44 cases.</td>
<td></td>
</tr>
<tr>
<td>During 2019/20, the HCAI Data Capture System was changed to include four different types of hospital and community onset healthcare associated infections, some of which were not previously reported in 2018/19.</td>
<td></td>
</tr>
</tbody>
</table>
Engaging People and Communities

Demographic monitoring is undertaken by the CCG to ensure wide participation across the borough and that the nine protected characteristics of the Equality Act 2010 are covered.

We can confirm that the annual report is a key part of the evidence the CCG will submit for review for the Oversight Framework indicator 50.

Developing the infrastructure for engagement and participation

In 2019/20, the CCG has adopted a new approach to demonstrating its duty and commitment to engaging people and communities. For the first time we have developed a separate patient and community involvement annual report, collating the range of activities we have undertaken with patients and the public during the year. We want to highlight examples of where we have reviewed public involvement activity across our providers and taken action in response to this.

The definition of what is included as hospital cases was also revised, resulting in a higher number of cases being reported compared to previous years. The 43 case threshold was not reassessed in 2019/20 to reflect these fundamental changes in the data.

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 in 2019/20.

Referral to treatment times

86.5% of patients waited less than 18 weeks to receive initial treatment in March 2020. This is below the national standard of 92%. However, to put this in context it should be noted that in February 2020 only two CCGs nationally achieved the standard, with the lowest performer at 68% and the national average at 80.1%.

The CCG has seen an 18% increase in the number of patients waiting to receive initial treatment from February 2019 to February 2020. The CCG has been working closely with provider trusts to increase capacity across the specialities which have contributed to this 18% increase.

The COVID-19 pandemic will impact upon achievement of the standard following NHSEI guidance on suspending routine activity.

Engaging People and Communities

Demographic monitoring is undertaken by the CCG to ensure wide participation across the borough and that the nine protected characteristics of the Equality Act 2010 are covered.

We can confirm that the annual report is a key part of the evidence the CCG will submit for review for the Oversight Framework indicator 50.

The CCG wants to listen to our patients and local communities and we want to hear your views about healthcare services so that we can take these into account in our commissioning decisions. We recognise this is underpinned by our legal obligation to offer opportunities to be involved at different stages of the commissioning process.

The CCG has a Communications and Engagement Strategy which is kept under constant review by our Communications & Engagement Committee to ensure it is fit for purpose and it underpins all CCG activity. It should be read in conjunction with other key documentation including the Equality Strategy, Operating Plan and Information & Technology Strategy.

We have a range of methods to ensure involvement and engagement which are summarised in this section. We have also taken the opportunity to demonstrate patient and public engagement and participation throughout this document in relation to specific initiatives and developments.

A key element of how we operate is providing information in accessible formats. The CCG continuously offers assistance for those who require communications or other support to enable them to engage. This may include translation into other languages, cover transport costs to engagement events to providing an independent external facilitator to capture their story.

We have also created an ‘easy read’ version of our previous annual report to make it more accessible for a wider audience. We asked for feedback from members of the Patient Forum, as well as an easy read specialist in health to ensure that the report was suitable before publishing it on the CCG’s website. NHS England highlighted our easy read annual report as an example of best practice in patient and public participation.

The CCG has also commissioned a number of videos to help us share information with patients and the community in an exciting and accessible way. These videos are played in a number of locations such as practice waiting rooms and CCG buildings to help us reach a wide audience.

The CCG also has a ‘Get Involved’ section on our website. This helps people to get more involved in the CCG’s work in a variety of ways. For example, people can find out more about the Patient Forum, various working groups, individual practice patient forums and the CCG’s meetings which are held in public.

We encourage people to get involved in these areas of work and have had members of the public contact us through these methods who have subsequently been involved in some specific areas of work, for example the CCG’s Cancer Plan.

Online forms are available for people to make complaints or to share compliments or comments about services or their experiences.
Every year the CCG produces a document describing its key priority areas for commissioning services. The Patient Forum takes the opportunity to influence the CCG’s priorities by considering its Commissioning Intentions document as well as receiving regular commissioning updates throughout the year. The commissioning intentions are also shared with Healthwatch North Tyneside and the Health and Well-Being Board as partners across the system.

The CCG attends the North Tyneside ‘Working With’ group – a council and voluntary sector collaboration which considers health and social care issues – to provide opportunities to debate the commissioning intentions document and suggest improvements.

**Patient Forum**

The Patient Forum is a constituted sub-committee of the CCG’s Governing Body. Patient and public involvement is reported to every meeting of the CCG Governing Body that is held in public. This provides evidence that the Governing Body is assured about public involvement activity and the difference it has made.

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 aim of the Patient Forum is to have membership from each of the 26 GP practices in North Tyneside who 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 2019-20 and were involved with a series of health discussions giving an opportunity to share their experiences of services in North Tyneside.

Topics for discussion, which have influenced commissioning decision-making, included NHS North Tyneside CCG commissioning intentions, Integrated Care System, North Tyneside’s Cancer Plan, Hear my Voice - an online opportunity for patients to share their views on their primary care experience - as well as ongoing dialogue about service planning and delivery.

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

- GP practice screens information
- Realistic Medicine
- Social prescribing
- Integrated Frailty Service
- Service visits to urgent care, ambulatory care and Care Plus
- Palliative care patient information
- Primary Care Networks
We would like to take the opportunity to acknowledge the excellent work of the NHS North Tyneside CCG Patient Forum. The Forum as a critical friend 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.

**Development sessions**

Each year, Patient Forum members have this additional session to reflect on their influence and impact on services and initiatives. The viability of the forum and working groups is discussed and reviewed at length with recommendations arising to ensure the groups are in line with the CCGs priorities and members expectations.

**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. These groups are outlined below.

**Mental health**

This group debates mental health service developments and take part in service visits to enhance members knowledge. For example, social prescribing in North Tyneside is provided and coordinated by First Contact Clinical, a North East based organisation describing themselves as a provider of ways to wellbeing.

There will be regular opportunities for members to discuss referrals and outcomes to this service.

**Communications**

Members support the CCG with matters relating to communications. This includes the CCG website, publications and the production of the Patient Forum newsletter.

The eighteenth issue of the newsletter has been produced and distributed across the borough, and aims to ensure as many patients as possible have the opportunity to read it.

**Future care**

This group comprises older people, urgent care and service areas identified in the Future Care Programme Board work plan. In addition, members of this group have service visits to Care
Plus, ambulatory care, urgent care services and the out of hours GP home visiting service to see first-hand how these services are delivered to patients.

Members have been involved in the planning of the proposed Integrated Frailty Service.

**End of life care**

Members support all end of life initiatives which include patient and carer information, shared patient records and palliative care services.

It was recognised that bereavement is often a forgotten symptom and it is important to embed similar processes across the services. Health professionals learn so much from bereaved families and this is fed back to primary care. Members of the Patient Forum were recently thanked for their input to a bereavement video which is in the process of co-production.

**Self-care and wellbeing**

Members are actively involved in health campaigns and initiatives as well as providing input to the production of apps and other materials relating to self-care.

Members have contributed to a self-care video and a medicine cabinet contents guide to display on GP practice screens.

**Innovations**

This newly formed group is actively involved and supports the CCG with IT and service developments. Members were invited to a presentation at the CCG about GP video consultations, which is a requirement for practices to offer to their patients in 2021.

Representatives from the provider organisation, LIVI, were in attendance to talk through the service and answer member questions before a pilot stage is arranged. Members will also have a demonstration of the app in due course.

**Healthwatch North Tyneside**

The CCG recognises the important role that Healthwatch North Tyneside plays in representing the views of our residents.

A Healthwatch representative is a key stakeholder in the CCG’s Future Care Programme Board, responsible for the system wide transformation programme for North Tyneside and is also a member of the CCG’s Communication & Engagement Strategic Group.

The CCG and Healthwatch agree a programme of work each year, focussing on the key areas that patients and the public have highlighted to Healthwatch and which link of transformation programmes being undertaken in the CCG. For example, during 2019/20, Healthwatch led a
piece of work to better understand what local people do when they fall ill, helping the CCG to understand the patient experience of accessing urgent and emergency work.

Healthwatch published reports on its findings and provided a presentation to the Future Care Board meeting in January 2020. A number of themes emerged from this work including a concern about access to GP appointments. Many people thought that advice about which service to access was confusing and also experienced difficulty with the booking system for the North Tyneside Urgent Treatment Centre.

This has led to further communications work to simplify the messages where we can about urgent and emergency care, keeping in line with national guidelines. We have also developed a joint action plan with the Northumbria Healthcare NHS Foundation Trust to improve access to the Urgent Treatment Centre.

**Hear My Voice North Tyneside**

We have referenced ‘Hear My Voice North Tyneside’ several times within this report. This is a new project launched by the CCG to help patients, family members, carers and staff to describe their experience of receiving and delivering health care.

The CCG has supported the project by purchasing a license to use SenseMaker, an online survey tool that collects quantitative and qualitative data, combining them to produce uniquely insightful information.

The project is one of the ways in which we can strengthen a culture of partnership and collaborative working, by integrating the feedback we receive into shaping and delivering services for the future.

Community and voluntary sector groups and patient Forum members have helped to shape, test and pilot Hear My Voice and test the website.

**Summary**

The impact that engagement and involvement has had on CCG planning and commissioning cannot be underestimated. We have many examples, which we describe throughout this document, of the influence that it has had on shaping services and how service are provided. Just some of the examples would include:

- The Hear My Voice North Tyneside initiative
- Development of the North Tyneside Cancer Plan described earlier in this report
- We have also referenced in this report the development of the integrated frailty pathway where patients and carers views are integral to the development of the new pathway
- Development of online GP appointments ahead of the national requirement
- The development of the North Tyneside Recovery College
We continue to strive to look for new and innovative ways to engage and involve patients, carers and the public and to maximise the methods of and opportunities for engagement and involvement.

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

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

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

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

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

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

Governance
Equality, Diversity and Health Inequalities is governed and reports into the Quality and Safety (Q&S) Committee.

The Q&S Committee ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity. It also 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.
Equality Strategy

Our Equality Strategy was refreshed in 2017, with minor updates made in 2019, and will be reviewed in 2020. The strategy 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 Equality 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 Q&S committee approved plans detailing actions we will take for 2019-20 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 the Department for Work & Pensions, we have maintained our ‘Level 2 Disability Employer’ status for 2020 - 2021 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.

The CCG assesses itself against the NHS Workforce Race Equality Standard (WRES) annually to ensure that:

- Data is collected and reviewed against the nine WRES indicators.
- An action plan is produced to close any gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and
- Board membership includes BME representation.

We are required to publish a WRES annual report and action plan to address any areas for improvement. The CCG is committed to the WRES and you can see our most recent report and action plan on our website.

**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 tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers, as well as including prompts.
for engagement with protected groups the tool also aids compliance with the Accessible Information Standard.

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 tool. 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 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.

Our CCG activity in relation to the AIS are 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 at: [www.england.nhs.uk/ourwork/accessibleinfo/](http://www.england.nhs.uk/ourwork/accessibleinfo/)

**Health inequalities**

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

We understand our local population and local health needs, through the use of joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.
The average life expectancy for the people of North Tyneside is 78 years for men and 82 years for women. Life expectancy is 11.9 years lower for men and 11.2 years lower for women in the most deprived areas of North Tyneside than in the least deprived areas.

The principal cause of premature death in North Tyneside is cancer, followed by cardiovascular disease (CVD). Smoking is the major cause of preventable death, with alcohol misuse the second biggest lifestyle health risk factor.

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.

For our CCG area, only 6.0% of hospitalisation records have an unknown ethnic group compared to the national England average of 6.6%.

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

We continue to monitor the health profiles and data available which detail the health challenges of our population including the Joint Strategic Needs Analysis (JSNA) Public Health Profile and RightCare Health Inequalities data.
Further information can be found at:

**Health profiles:** [https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e08000022.html?area-name=north%20tyneside](https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e08000022.html?area-name=north%20tyneside)

**Public Health England – Local Health:** [www.localhealth.org.uk](http://www.localhealth.org.uk)


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

NHSE sought daily assurances from CCGs and providers that effective arrangements were in place to ensure continuity of NHS services in the event of a ‘no deal’ EU Exit. The requirement for the CCG to provide these assurances ceased after the UK left the EU on 31 January 2020.
Accountability Report

Mark Adams
Accountable Officer
02 June 2020
Corporate governance report

Members’ report

Member profiles
Membership of the CCG Governing Body is summarised in table 6 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 26 GP practices in North Tyneside, as listed below:

**Table 4: List of GP practices in North Tyneside**

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

CCG Council of Practices
The Council of Practices comprises a nominated GP from each of the 26 GP practices that form the CCG. Its terms of reference require it to meet at least four times a year. In 2019/20 the Council of Practices met four 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 2019/20 is shown in table six.

Table 5: 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 OBE</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 6: 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 7: 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 OBE</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 8: 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>
<td>Executive Director of Nursing &amp; Chief Operating Officer</td>
<td>Dr Lesley Young-Murphy</td>
<td>Female</td>
</tr>
<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>Deputy Chief Finance Officer</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>
<tr>
<td>Senior Provider Management Lead</td>
<td>Mrs Kaye McEntee</td>
<td>Female</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/

Personal data related incidents
There were no Serious Untoward Incidents relating to data security breaches in 2019/20. No data incidents were reported to the Information Commissioner’s Officer during 2019/20.

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

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

As the Accountable Officer, I 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.

Mark Adams
Accountable Officer
02 June 2020
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 2019, 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 16, approved by NHS England on 13 May 2020, and is available here [www.northtynesideccg.nhs.uk/news-media/publications/constitution/](http://www.northtynesideccg.nhs.uk/news-media/publications/constitution/).

The CCG governance structure is shown in figure 7.

![North Tyneside CCG Governance Structure](image)

**Figure 7: 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.
**Council of Practices**

The 26 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 four times face to face and once ‘virtually’ in the 12 month period ending 31 March 2020.

During 2019/20, discussions at meetings of the Council of Practices included:

- Primary Care Networks
- Learning Disabilities
- Future Care
- Cancer
- Commissioning Intentions
- Covid-19

The Council of Practices reviewed its effectiveness by members completing an anonymous survey in January 2020. 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 2019 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 ending 31 March 2020, the CCG Governing Body has met nine times - five times in public, with papers posted in public in advance of the meeting and notices placed inviting public attendance. 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 25 June 2019.

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 2019/20 have included:

- Operating Plan and Commissioning Priority Areas
- Risk Assurance Framework
- Healthcare Acquired Infections (HCAI)
- Performance & Quality reports
- Finance Reports
- Reports from the Patient Forum
- Governance matters
- Winter Planning
- Communications & Engagement Strategy and Equality Strategy
In addition to the formal meetings held during the year, there have been three Governing Body development sessions covering:

- Integrated Care System & Integrated Care Partnership
- Joint development session with Northumberland CCG and Newcastle Gateshead CCG
- System Reform led by Professor Paul Stanton who commented:

  “I was impressed, throughout the day, by the extent to which all members shared a clear vision for the local community and by the depth and the rigour of the Public Health led analysis of the needs of the different constituent neighbourhoods of North Tyneside that underpins their commissioning intentions and actions.

  It was particularly encouraging to note that all members of the CCG Governing Body (not just the designated Lay Member with this named responsibility) shared a commitment to pro-active involvement of local people and of service users – not just in the diagnosis of community need but in their determination to work with and alongside the most disadvantaged communities and with partner bodies in a focused and persistent attempt to mitigate and (in time) to eliminate the hardship and multiple deprivation experienced by a number of local areas.

  I concluded that, unusually, so far as the CCG and the wider Integrated Care System was concerned, Patient and Public Involvement was built in (rather than bolted on) to their approach to whole system public sector commissioning, provision and transformation.”

The Governing Body completed a self-assessment of its operation and effectiveness in December 2019 consisting of an on-line questionnaire to all Governing Body members (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).

All members responded to the survey and in collective discussion when the results were presented, agreed no improvement actions were required.

**Audit Committee**

The Audit Committee is a committee of the Governing Body. It was in operation throughout the 12 month period ending 31 March 2020.
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 OBE
- CCG Deputy Lay Chair - Mary Coyle MBE DL
- One other member with the relevant skills and experience as nominated by the Governing Body - Dr Shaun Lackey

All three have been members of the Audit Committee for the whole year 2019/20.

The CCG’s internal and external auditors, Chief Finance Officer, Deputy Chief Finance Officer, and Head of Governance routinely attend the Audit Committee. The Chief Officer attends at least 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 2019/20 the Audit Committee met five times face to face and once ‘virtually’. On each of the face to face meetings, 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 (written) and the Finance Committee (verbal).

The Audit Committee’s main activities throughout 2019/20 have been:

- Overseeing the risk management processes across the CCG
- Approval and monitoring of the CCG’s audit plans
- Counter fraud (including a deep dive in to the CCG’s risk of 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 2019/20. In December 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 ending 31 March 2020.

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 OBE
- 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 during 2019/2020 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 three times during 2019/2020. 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 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 eight times in the period 1 April 2019 to 31 March 2020. The main items of business have included:

- Quality & risk updates
- Finance, Contracts, Performance
- Risk Assurance Framework
- Future Care
- Continuing health care
- Procurements
- Quality, innovation, productivity and prevention projects and schemes
- Commissioning intentions
- Operating plan
- Financial plan
- Better Care Fund
- Investments
- Voluntary Sector Grants
- Business Cases

The Clinical Commissioning and Contracts Committee completed a self-assessment of its operation and effectiveness during 2019/20. The self-assessment was
presented to the January 2020 committee. Members concluded that there were no particular areas where remedial action was necessary.

**Quality and Safety Committee**

The Quality and Safety Committee was in operation throughout the 12 month period ending 31 March 2020. 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 Officer - Dr Lesley Young-Murphy
- Deputy Director of Nursing, Quality and Patient Safety – Mrs Maureen Grieveson
- 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 eight times in the year from 1 April 2019 to 31 March 2020. 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 year 2019/2020 have been:

- Integrated Governance Report
- Integrated Quality and Performance Report
- Continuing healthcare (CHC)
- 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
- Policies for approval

The committee completed a self-assessment of its effectiveness in January 2020 and the collated results were reported to the March 2020 meeting. Committee members received the results of the self-assessment and agreed that the results were good.

**Patient Forum**

The Patient Forum was in operation throughout the 12 month period 2019/2020.

There have been six meetings of the patient forum between April 2019 and March 2020, 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 is facilitated by the North Tyneside Community and Health Care Forum. Dr Lesley Young-Murphy, 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 26 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 2019/20 is described in the Performance Overview: Engaging People & Communities section of this report.

Finance Committee

The Finance Committee was in place in April 2019 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 OBE
- 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 bi-monthly. The committee has met five times during the period April 2019 to March 2020 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

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 six times in public during the period April 2019 to March 2020 and continues to meet. The Chair was present at all meetings.

The principal items of business included:

- Operational update
- Primary Care networks
- Quality update
- GP Survey
- Extended access
- Practice Activity Scheme
- Prescribing Engagement Scheme
- GP Access
- Digitisation of GP records
- Boundary changes
- List Closures
- Finance update
- Future Care Programme Governance & Development
- Contract Baseline Report
- Strategy update
The committee completed a self-assessment of its effectiveness and the collated results were reported to the January 2020 meeting.

Committee members received the results of the self-assessment and agreed a number of actions to enhance committee performance.
## Attendance records for CCG Governing Body and committees

### Table 9: Attendance records for the Governing Body and committees for 2019/20

<table>
<thead>
<tr>
<th>Name</th>
<th>Post Held</th>
<th>No. of Meetings Held</th>
<th>No. of Attendances Held</th>
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<tbody>
<tr>
<td>Nick Bickford</td>
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<td>Jenny Clark-McGloed</td>
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<td>Sue Fairley</td>
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<td>Dr Lucy Huang</td>
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<td>Dr Ben Jones</td>
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<td>Dr Mary Lake</td>
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<td>Dr Sue Lynch</td>
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<td>Dr Vivian Clarke</td>
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<td>Dr Joanne Cooper</td>
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<td>Dr Paul Richardson</td>
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</tbody>
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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 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 their 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 escalated 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 (target 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 includes a frequent reporting cycle; the consolidation of the corporate risk register and assurance framework into one document, i.e. the RAF; the separate identification of strategic risks and corporate risks; the recording of target risk scores; and inclusion of the ‘three lines of defence’ assurance methodology in the RAF. Internal Audit provided substantial assurance in 2019/20 for the CCG’s Governance Structures and Risk Management Arrangements.

**Risk assessment**

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

Key corporate risks managed throughout 2019/20 are summarised as follows:

- Failure to support NHS & social care system to deliver appropriate care to the residents of North Tyneside throughout the Covid-19 pandemic
- Response to COVID 19 impacts on system’s ability to deliver healthcare to meet the needs of the population
- Risk of not being able to implement New Models of Care to meet the needs of the population
- Impact on morgues and homes because of a delayed transfer of deceased persons to a place of rest due to the Coroner advising undertakers not to remove a body until a death certificate has been signed
- Delayed transfer of primary care records and/or medical supplies
- Delayed ambulance handovers
- Contingency arrangements in the event of a no deal EU exit are not in place
- Inefficient processing as Outlook freezes, crashes or delays sending and receiving emails, resulting in unreliable communication chains and the potential to overlook items of significance or materiality
- Inconsistency with the quality and timeliness of electronic discharge summaries (EDSs) to GP practices and community teams
- Patients are prescribed contraindicated medications
• 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 CCG has effectively managed its risks in 2019/20. At the start of the year the CCG had four red risks. At year end, not including two risks relating to Covid-19 added in March 2020, the CCG had two red risks open.

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;
• 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;
• The Accountable Officer, working closely with the chair of the Governing Body, ensures 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; and

• Staff members who 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 policies. 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 for 2019/20. No issues were identified with the design of or compliance with the control framework in the areas reviewed.

This audit report was issued December 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 results of the Governing Body self-assessment survey in January 2020 showed that the significant majority of members agreed that the papers received by Governing Body have adequate information in the right format at the right time to make informed decisions.

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 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.

We have in place information risk assessment and management procedures and will continue to fully embed an information risk culture throughout the organisation against identified risks.

The CCG has submitted a compliant Data Security and Protection toolkit for 2019/20. This has been audited and substantial assurance provided.

**Business critical models**

The CCG has a Business Continuity Management Plan, approved by the Quality and Safety Committee in October 2019. 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 10: Third-party assurances**

<table>
<thead>
<tr>
<th>Assurance Source</th>
<th>Commentary</th>
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<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. Due to government restrictions imposed by Covid-19 some year-end transaction testing was restricted. Notwithstanding this, substantial assurance has been provided.</td>
</tr>
<tr>
<td>North of England Commissioning</td>
<td>The CCG outsources many of its support services to the North of England Commissioning Support Unit (NECS), hosted by NHS England, under a signed service level agreement.</td>
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<tr>
<td>Assurance Source</td>
<td>Commentary</td>
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<tr>
<td>Support Unit (NECS)</td>
<td>Assurance on the operation of certain financial and payroll controls has been provided by NHS England’s internal auditors, Deloitte LLP, via an ISAE 3402 Type II report issued on 30 April 2020 and covering the period from 1 April 2019 to 31 March 2020. 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, but provided reasonable assurance in relation to remaining controls that the related control objectives were achieved throughout the period 1 April 2019 to 31 March 2020.</td>
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<tr>
<td>The NHS Shared Business Service (SBS)</td>
<td>Assurance in respect of the operation of the finance and accounting services provided by NHS Shared Business Services (SBS) is provided by the NHS SBS’ auditors, PwC LLP, via an ISAE 3402 report issued on 1 May 2020. The report did note that as a consequence of Covid-19, auditors were unable to access the Service Organisation’s India sites due to lock-down requirements, and therefore were unable to obtain evidence in relation to certain controls for the months of February and/or March 2020. However, except for these exceptions, 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 2019 to 31 March 2020, 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 2019 to 31 March 2020.</td>
</tr>
<tr>
<td>Primary Care Support Services (Capita Business Services Limited)</td>
<td>Assurance in respect of the primary care support services provided from Capita Business Services Limited to NHS England and CCGs is provided by Capita’s auditors, KPMG LLP, on an annual basis. Reports issued for 2016/17 and 2017/18 identified significant control weaknesses. Improvements were noted in the two reports issued for 2018/19, although some control weaknesses remained. The report for 2019/20 was awaited at the time of writing this Annual Report.</td>
</tr>
<tr>
<td>NHS Business Service Authority (prescription payment process)</td>
<td>Assurance in respect of the operation of the prescription payments process provided by NHS Business Service Authority for 2019/2020 is provided by the NHS BSA’s auditors, PwC LLP, via an ISAE 3402 Type II report on an annual basis. The auditors have provided reasonable assurance</td>
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### Assurance Source

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<tr>
<td>Assurance Source</td>
<td>assurance that the controls related to the control objectives were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2019 to 31 March 2020 and customers applied the complementary controls; and that the controls tested, which, together with the complementary user entity controls, if operating effectively, were those necessary to provide reasonable assurance that the control objectives were achieved, operated effectively throughout the period from 1 April 2019 to 31 March 2020.</td>
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<tr>
<td>NHS GP Payment Service (NHS Digital)</td>
<td>Assurance in respect of the operation of the NHS GP Payment Service provided by NHS Digital for 2019/20 was provided by the NHS Digital’s auditors, PwC LLP, via an ISAE 3402 Type II report issued on 30 April 2020. The report gave a qualified opinion that provided reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2019 to 31 March 2020; 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 2019 to 31 March 2020, with the exception of one control tested. This exception, which resulted in the qualified opinion, related to the authorisation of system change implementations.</td>
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<tr>
<td>Local Counter Fraud Specialist</td>
<td>The CCG’s Local Counter Fraud Specialist is required to submit an annual Self-Review Tool (SRT) to the NHS Counter Fraud Authority (NHSCFA) 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 2019/2020 was reviewed and approved by both the audit committee chair and chief finance officer prior to submission by the deadline of 31 May 2020 (extended from 30 April 2020 due to Covid-19). The CCG has not been subject to an NHSCFA quality inspection in 2019/20.</td>
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<tr>
<td>Electronic Staff</td>
<td>The Electronic Staff Record (ESR) service is provided by</td>
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Assurance Source | Commentary
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Records (ESR) (McKesson) | IBM. An ISAE 3000 Type II report covering the operation of the national system is issued on an annual basis. The report for 2019/20 was awaited at the time of writing this Annual Report.

**Control issues**

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

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.

**Review of economy, efficiency & 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 2019/20 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.

The CCG was rated outstanding for the improvement and assessment framework for 2018/19 - details are available at the following link:

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

This is the latest information available.

The assessment framework for 2019/20 has changed to the Oversight Framework. We are awaiting our final rating for 2019/20.

**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.

During 2019-20, the Audit Committee undertook a ‘deep dive’ into the CCG’s approach to managing the risk of fraud.

There were no reported incidents of fraud during 2019-20.

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, governance and risk management 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 11: Assurance levels

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<thead>
<tr>
<th>Area of Audit</th>
<th>Level of Assurance Given</th>
<th>RAG</th>
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<tbody>
<tr>
<td>Governance Structures and Risk Management Arrangements</td>
<td>Substantial</td>
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<tr>
<td>Conflicts of Interest</td>
<td>Substantial</td>
<td></td>
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<tr>
<td>Data Security and Protection Toolkit (Draft Report)</td>
<td>Substantial</td>
<td></td>
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<td>Primary Medical Care Commissioning</td>
<td>Substantial</td>
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<tr>
<td>Contract and Performance Monitoring (Draft Report)</td>
<td>Substantial</td>
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<tr>
<td>Financial and Strategic Planning</td>
<td>Substantial</td>
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<tr>
<td>Key Financial Controls and QIPP Reporting (Draft Report)</td>
<td>Substantial</td>
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<tr>
<td>Continuing Healthcare (Draft Report)</td>
<td>Good</td>
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</tr>
<tr>
<td>Quality of Commissioned Services</td>
<td>Substantial</td>
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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.

**Conclusion**

The system of control described in this report has been in place in the CCG for the year ended 31 March 2020 and up to the date of the approval of the annual report and accounts.

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 organisation’s objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

Mark Adams
Accountable Officer
02 June 2020
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 OBE
- 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 2019/20 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.
<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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Richard Scott</td>
<td>Clinical Chair</td>
<td>65-70</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>10-12.5</td>
<td>75-80</td>
</tr>
<tr>
<td>Mr Mark Adams</td>
<td>Accountable Officer</td>
<td>30-35</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30-35</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>Executive Director of Nursing &amp; Chief Operating Officer</td>
<td>115-120</td>
<td>13</td>
<td>-</td>
<td>-</td>
<td>10-12.5</td>
<td>130-135</td>
</tr>
<tr>
<td>Mr Jon Connolly</td>
<td>Chief Finance Officer</td>
<td>65-70</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70-75</td>
</tr>
<tr>
<td>Dr Ruth Evans</td>
<td>Medical Director</td>
<td>80-85</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17.5-20</td>
<td>95-100</td>
</tr>
<tr>
<td>Dr Neela Shabde</td>
<td>Secondary Care Doctor</td>
<td>10-15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>Director of Contracting and Commissioning</td>
<td>90-95</td>
<td>65</td>
<td>-</td>
<td>-</td>
<td>47.5-50</td>
<td>145-150</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>80-85</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>Clinical Director</td>
<td>75-80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17.5-20</td>
<td>95-100</td>
</tr>
<tr>
<td>Dr Alexandra Kent</td>
<td>Clinical Director</td>
<td>50-55</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>22.5-25</td>
<td>70-75</td>
</tr>
<tr>
<td>Lay members:</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>3</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 OBE</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 2019/20:

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 21%. 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. The salary disclosed above shows North Tyneside CCG’s share of remuneration of 50%.

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.

Expense payments are shown in £00 and include lease car allowances and mileage claims.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
Staff sharing arrangement for senior manager remuneration 2019/20

Mr Mark Adams is employed by Newcastle Gateshead CCG and works for North Tyneside CCG and Northumberland 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 all CCGs in 2019/20 is shown below:

Table 13: North Tyneside CCG staff sharing arrangement 2019/20 (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>150-155</td>
<td>19</td>
<td>150-155</td>
</tr>
<tr>
<td>Mr Jon Connolly</td>
<td>Chief Finance Officer</td>
<td>135-140</td>
<td>15</td>
<td>135-140</td>
</tr>
</tbody>
</table>
### Senior manager remuneration (including salary and pension entitlements)

**Table 14: North Tyneside CCG remuneration report 2018/19 (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 (bands of £5,000)</th>
<th>Long-term performance pay and bonuses (bands of £5,000)</th>
<th>All pension related benefits (bands of £2,500)</th>
<th>TOTAL (bands of £5,000)</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>-</td>
<td>267.5-270</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>-</td>
<td>15-17.5</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>-</td>
<td>25-27.5</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>-</td>
<td>37.5-40</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>Head of Governance</td>
<td>60-65</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15-17.5</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>Clinical Director</td>
<td>75-80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85-87.5</td>
</tr>
<tr>
<td>Dr Alexandra Kent</td>
<td>Clinical Director</td>
<td>50-55</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95-97.5</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>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:

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.

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.

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 15: 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</th>
<th>Expense payments (taxable) to nearest £100</th>
<th>TOTAL</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>
### Pension benefits as at 31 March 2020

**Table 16: North Tyneside CCG senior officers pension benefits 2019/20 (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 2020 (bands of £5,000)</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1 April 2019 £000</th>
<th>Real Increase in Cash Equivalent Transfer Value £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2020 £000</th>
<th>Employer's contribution to stakeholder pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Richard Scott</td>
<td>0-2.5</td>
<td>-</td>
<td>15-20</td>
<td>45-50</td>
<td>286</td>
<td>8</td>
<td>304</td>
<td>-</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>30-35</td>
<td>95-100</td>
<td>726</td>
<td>31</td>
<td>775</td>
<td>-</td>
</tr>
<tr>
<td>Dr Ruth Evans</td>
<td>0-2.5</td>
<td>-</td>
<td>15-20</td>
<td>35-40</td>
<td>350</td>
<td>16</td>
<td>378</td>
<td>-</td>
</tr>
<tr>
<td>Mrs Anya Paradis</td>
<td>2.5-5</td>
<td>2.5-5</td>
<td>15-20</td>
<td>35-40</td>
<td>274</td>
<td>38</td>
<td>324</td>
<td>-</td>
</tr>
<tr>
<td>Mrs Irene Walker</td>
<td>0-2.5</td>
<td>-</td>
<td>5-10</td>
<td>-</td>
<td>65</td>
<td>15</td>
<td>88</td>
<td>-</td>
</tr>
<tr>
<td>Dr Shaun Lackey</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>40-45</td>
<td>299</td>
<td>12</td>
<td>325</td>
<td>-</td>
</tr>
<tr>
<td>Dr Alexandra Kent</td>
<td>0-2.5</td>
<td>-</td>
<td>10-15</td>
<td>-</td>
<td>94</td>
<td>8</td>
<td>109</td>
<td>-</td>
</tr>
</tbody>
</table>

**Notes for senior officer pension benefits 2019/20:**

Pensions information is provided by NHS Pensions

Cash equivalent transfer value at 1 April 2019 has been inflated by 2.4% in accordance with NHS Business Services Authority instructions.

The pension figures shown relate to the benefits that individuals have accrued as a consequence of their total membership of the scheme. Benefits and related Cash Equivalent Transfer Values do not allow for a potential future adjustment arising from the McCloud judgment.
## 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</th>
<th>Real increase in pension lump sum at pension age</th>
<th>Total accrued pension at pension age at 31 March 2019</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2019</th>
<th>Cash Equivalent Transfer Value at 1 April 2018</th>
<th>Real Increase in Cash Equivalent Transfer Value</th>
<th>Cash Equivalent Transfer Value at 31 March 2019</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Richard Scott</td>
<td>(bands of £2,500)</td>
<td>(bands of £2,500)</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Lesley Young-Murphy</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>15-20</td>
<td>45-50</td>
<td>70</td>
<td>200</td>
<td>279</td>
<td>-</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>-</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>-</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>-</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>-</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>-</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 McCloud judgment.
Cash equivalent transfer values

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

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

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

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation 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.

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

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

The CCG has not made any payment for compensation on early retirement or for loss of office in 2019/20.

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

The CCG has not made any payment to past members during 2019/20.
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 2019/20 was £115-120k (2018/19: £115-120k). This was 2.4 times (2018/19: 2.2) the median remuneration of the workforce, which was £49,578 (2018/19: £52,536).

In 2019/20, no employee (2018/19, no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £5,980 to £97,711 (2018/19: £1,256 to £86,867).

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 a consistent level in 2019/20. The decrease in median remuneration relates to marginal changes to the overall remuneration and number of the workforce in year.

<table>
<thead>
<tr>
<th>Band of Highest Paid Director's Total Remuneration (£'000)</th>
<th>2019/20</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Total Remuneration (£)</td>
<td>49,578</td>
<td>52,536</td>
</tr>
<tr>
<td>Ratio</td>
<td>2.4</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Staff Report

Number of senior managers

The CCG had 13 senior managers in post at 31 March 2020.

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 19: Staff Numbers and Costs (this has been subject to audit)

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of people employed</td>
<td>49.53</td>
<td>1.79</td>
<td>51.32</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,566</td>
<td>96</td>
<td>2,662</td>
</tr>
<tr>
<td>Social security costs</td>
<td>273</td>
<td>-</td>
<td>273</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>458</td>
<td>-</td>
<td>458</td>
</tr>
<tr>
<td>Other Pension Costs</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Staff costs</strong></td>
<td><strong>3,298</strong></td>
<td><strong>96</strong></td>
<td><strong>3,394</strong></td>
</tr>
</tbody>
</table>
Staff composition

The CCG staff gender profile at 31 March 2020 is based upon information relating to permanently employed staff as follows:

Table 20: 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>52</td>
<td>20</td>
<td>72</td>
</tr>
<tr>
<td>Total staff</td>
<td>54</td>
<td>21</td>
<td>75</td>
</tr>
</tbody>
</table>

* The Governing Body figures are provided as standalone figures, they do not contribute to the total figure for the whole CCG as some members are employed by other organisations.

Staff sickness absence

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

Table 21: Staff sickness absence

<table>
<thead>
<tr>
<th></th>
<th>2019 Number</th>
<th>2018 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>549</td>
<td>266</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>10</td>
<td>5</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 2019/20 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 2019/20 (2018/19, nil)

**Off-payroll engagements**

For all off-payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months:
Table 22: Off-payroll engagements longer than six months

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing engagements as of 31 March 2020</td>
<td>8</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></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>3</td>
</tr>
<tr>
<td>For between one and two years at the time of reporting</td>
<td>5</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>

New off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, greater than £245 per day and that last longer than six months:

Table 23: New off-payroll engagements longer than six months

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020</td>
<td>3</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>number assessed that fall under the remit of IR35</td>
<td>3</td>
</tr>
<tr>
<td>number assessed that do not fall under the remit of IR35</td>
<td>0</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number engaged directly (via personal service company contracted to department) and are on the entity’s payroll</td>
<td>3</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>
Off-payroll engagements of Board members and senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Table 24: Off-payroll engagements / senior official engagements

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</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.</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 2019/20.
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 2020, 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 adopted by the European Union, and as interpreted and adapted by HM Treasury’s Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

• give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its net expenditure for the year then ended;

• have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and

• have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Page 138 of 145
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.

Opinion on regularity

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

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

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 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. 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 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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 2020.

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 April 2020, 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 2020.

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.

Page 142 of 145
Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to issue:

- Our independent auditor’s statement to the Governing Body on the CCG Accounts Consolidation Template.


We are satisfied that these matters would not have a material effect on the financial statements or on our conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources.

Cameron Waddell
Key Audit 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 7.

An audit certificate and report is also included in this Annual Report at page 138.
Annual accounts
## CONTENTS

### The Primary Statements:

- Statement of Comprehensive Net Expenditure for the year ended 31st March 2020  
- Statement of Financial Position as at 31st March 2020  
- Statement of Changes in Taxpayers' Equity for the year ended 31st March 2020  
- Statement of Cash Flows for the year ended 31st March 2020  

### Notes to the Accounts

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<th>Page Number</th>
</tr>
</thead>
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<tr>
<td>Accounting policies</td>
<td>5-7</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>8</td>
</tr>
<tr>
<td>Employee benefits and staff numbers</td>
<td>8-9</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>10</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>11</td>
</tr>
<tr>
<td>Operating leases</td>
<td>11</td>
</tr>
<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>
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<tr>
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</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 2020

<table>
<thead>
<tr>
<th>Note</th>
<th>2019-20 £'000</th>
<th>2018-19 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other operating revenue</td>
<td>(323)</td>
<td>(178)</td>
</tr>
<tr>
<td>Total operating revenue</td>
<td>(323)</td>
<td>(178)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>3</td>
<td>3,394</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>4</td>
<td>365,079</td>
</tr>
<tr>
<td>Depreciation charges</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Other operating expenditure</td>
<td>4</td>
<td>157</td>
</tr>
<tr>
<td>Total operating expenditure</td>
<td></td>
<td>368,642</td>
</tr>
</tbody>
</table>

Comprehensive Net Expenditure for the year ended 31 March

<table>
<thead>
<tr>
<th></th>
<th>2019-20</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>368,319</td>
<td>350,997</td>
</tr>
</tbody>
</table>
## Statement of Financial Position as at 31 March 2020

<table>
<thead>
<tr>
<th>Non-current assets:</th>
<th>2019-20 £'000</th>
<th>2018-19 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>-</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current assets:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other receivables</td>
<td>1,403</td>
<td>1,739</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>337</td>
<td>96</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>1,740</td>
<td>1,835</td>
</tr>
</tbody>
</table>

| **Total assets**                        | 1,740          | 1,847          |

<table>
<thead>
<tr>
<th>Current liabilities:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>(24,312)</td>
<td>(22,554)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>(24,312)</td>
<td>(22,554)</td>
</tr>
</tbody>
</table>

| Assets less liabilities                 | (22,572)       | (20,707)       |

| **Financed by Taxpayers’ Equity**       |                |                |
| General fund                            | (22,572)       | (20,707)       |
| **Total Taxpayers’ Equity**             | (22,572)       | (20,707)       |

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 2nd June 2020 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

£'000

Changes in Taxpayers' Equity for 2019-20

Balance at 01 April 2019

(20,707)

Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2019-20

Net operating expenditure for the financial year

SOCNE (368,319)

Net Recognised CCG Expenditure for the Financial Year

(368,319)

Net funding

SCF 366,454

Balance at 31 March 2020

(22,572)

Changes in Taxpayers' Equity for 2018-19

Balance at 01 April 2018

(20,466)

Changes in NHS Clinical Commissioning Group Taxpayers' Equity for 2018-19

Net operating costs for the financial year

SOCNE (350,997)

Net Recognised CCG Expenditure for the Financial Year

(350,997)

Net funding

SCF 350,756

Balance at 31 March 2019

(20,707)

The financial statements on pages 1, 2 and 4 form part of this statement.
## Statement of Cash Flows for the year ended 31 March 2020

<table>
<thead>
<tr>
<th>Note</th>
<th>2019-20 £'000</th>
<th>2018-19 £'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>(368,319)</td>
<td>(350,997)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Increase / (decrease) in trade &amp; other receivables</td>
<td>8</td>
<td>336</td>
</tr>
<tr>
<td>Increase in trade &amp; other payables</td>
<td>10</td>
<td>1,758</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(366,213)</td>
<td>(350,746)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow before Financing</strong></td>
<td>(366,213)</td>
<td>(350,746)</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>366,454</td>
<td>350,756</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Financing Activities</strong></td>
<td>366,454</td>
<td>350,756</td>
</tr>
<tr>
<td><strong>Net Increase in Cash &amp; Cash Equivalents</strong></td>
<td>9</td>
<td>241</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>96</td>
<td>85</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the End of the Financial Year</strong></td>
<td>337</td>
<td>96</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 2019-20 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.

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 employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.6 Other Expenses

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

1.7 Property, Plant & Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost, irrespective of their individual or collective cost.

1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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.
Notes to the financial statements

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.
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. The Clinical Commissioning Group does not hold any finance leases.

1.9.1 The Clinical Commissioning Group as Lessee
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10 Cash & Cash Equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Cash, 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 Clinical Commissioning Group's cash management.

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

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

1.13 Financial Assets
Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
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 and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

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

1.13.2 Impairment
For all financial assets measured at amortised cost or at fair value 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 arms' 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 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 derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

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.

1.17.2 Sources of estimation uncertainty
The following assumption about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The main estimate in 2019-20 related to prescribing expenditure which is two months in arrears and is based on BSA profiling. The accrual within the accounts is for the month of March only this year and is £3.2 million compared with £5.4 million in the prior year.

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 2019-20.

- 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.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021-22 is currently impracticable. However, the CCG does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

- 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.
2 Other Operating Revenue

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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>Other non contract revenue</td>
<td>323</td>
<td>23</td>
<td>300</td>
<td>178</td>
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<tr>
<td>Total other operating revenue</td>
<td>323</td>
<td>23</td>
<td>300</td>
<td>178</td>
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</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>2019-20</th>
<th>2018-19</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent Employees</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,662</td>
<td>2,566</td>
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<tr>
<td>Social security costs</td>
<td>273</td>
<td>273</td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
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<td>458</td>
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<tr>
<td>Other pension costs</td>
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<td>1</td>
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<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
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</table>

<table>
<thead>
<tr>
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<th>2018-19</th>
<th>Permanent Employees</th>
<th>Other</th>
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</thead>
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<tr>
<td></td>
<td>Total</td>
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<td>£'000</td>
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<tr>
<td>Employee Benefits</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,485</td>
<td>2,386</td>
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<tr>
<td>Social security costs</td>
<td>248</td>
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<td>0</td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>286</td>
<td>286</td>
<td>0</td>
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<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,019</td>
<td>2,920</td>
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3.2 Average number of people employed

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<tr>
<th></th>
<th>Total Number</th>
<th>2019-20 Permanently employed Number</th>
<th>Other Number</th>
<th>Total Number</th>
<th>2018-19 Permanently employed Number</th>
<th>Other Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>51.32</td>
<td>49.53</td>
<td>1.79</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.nhbsa.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 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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 2019-20, employers’ contributions of £457,973 were payable to the NHS Pensions Scheme (2018-19: £286,127) at the rate of 20.68% of pensionable pay (14.36% in 2018-19). These costs are included in the NHS pension line of Note 3.
## 4. Operating expenses

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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Services from other CCGs and NHSE England</td>
<td>2,766</td>
<td>1,373</td>
<td>1,393</td>
<td>2,633</td>
<td>1,473</td>
<td>1,160</td>
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<tr>
<td>Services from foundation trusts</td>
<td>251,053</td>
<td>10</td>
<td>251,043</td>
<td>237,541</td>
<td>6</td>
<td>237,535</td>
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<tr>
<td>Services from other NHS trusts</td>
<td>239</td>
<td>0</td>
<td>239</td>
<td>258</td>
<td>0</td>
<td>258</td>
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<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>32,937</td>
<td>0</td>
<td>32,937</td>
<td>32,342</td>
<td>0</td>
<td>32,342</td>
</tr>
<tr>
<td>Purchase of social care</td>
<td>10,576</td>
<td>0</td>
<td>10,576</td>
<td>10,286</td>
<td>0</td>
<td>10,286</td>
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<tr>
<td>Prescribing costs</td>
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<td>34,505</td>
<td>32,431</td>
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<td>32,431</td>
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<tr>
<td>Pharmaceutical services</td>
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<td>0</td>
<td>97</td>
<td>919</td>
<td>0</td>
<td>919</td>
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<tr>
<td>GPMS/APMS and PCTMS</td>
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<td>0</td>
<td>30,509</td>
<td>29,268</td>
<td>0</td>
<td>29,268</td>
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<tr>
<td>Supplies and services – general</td>
<td>897</td>
<td>54</td>
<td>843</td>
<td>790</td>
<td>49</td>
<td>741</td>
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<td>Establishment</td>
<td>932</td>
<td>59</td>
<td>873</td>
<td>907</td>
<td>137</td>
<td>770</td>
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<tr>
<td>Transport</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Premises</td>
<td>416</td>
<td>195</td>
<td>221</td>
<td>282</td>
<td>172</td>
<td>110</td>
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<tr>
<td>Audit fees</td>
<td>41</td>
<td>41</td>
<td>0</td>
<td>41</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
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<td>11</td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Other professional Fees</td>
<td>63</td>
<td>63</td>
<td>0</td>
<td>85</td>
<td>85</td>
<td>0</td>
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<tr>
<td>Legal fees</td>
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<td>2</td>
<td>0</td>
<td>132</td>
<td>132</td>
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<td>Education, training and conferences</td>
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<td>14</td>
<td>14</td>
<td>28</td>
<td>23</td>
<td>5</td>
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<tr>
<td>Depreciation</td>
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<td>12</td>
<td>28</td>
<td>0</td>
<td>28</td>
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<td>Chair and Non Executive Members</td>
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<td>140</td>
<td>0</td>
<td>138</td>
<td>138</td>
<td>0</td>
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<tr>
<td>Clinical negligence</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>14</td>
<td>14</td>
<td>0</td>
<td>31</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td><strong>365,248</strong></td>
<td><strong>1,984</strong></td>
<td><strong>363,264</strong></td>
<td><strong>348,157</strong></td>
<td><strong>2,302</strong></td>
<td><strong>345,855</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 2019-20 including VAT, was £41k.

GPMS/APMS and PCTMS relates to Primary Care Commissioning.

Non-audit services are in respect of Mental Health Investment Standard assurance that NHSE requires CCGs to obtain from an independent reporting accountant, to demonstrate their investment in mental health expenditure rises at a faster rate than their overall published programme funding. This assurance was carried out by Mazars LLP.

The expenditure within Other Professional fees includes £54k for internal audit services provided by AuditOne (£50k in 2018-19).

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>
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<td></td>
<td></td>
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<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>4,367</td>
<td>75,056</td>
<td>4,208</td>
<td>75,351</td>
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<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>4,325</td>
<td>74,558</td>
<td>4,178</td>
<td>75,127</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>99.04%</td>
<td>99.34%</td>
<td>99.29%</td>
<td>99.70%</td>
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<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>1,660</td>
<td>253,508</td>
<td>1,695</td>
<td>239,964</td>
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<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>1,653</td>
<td>253,338</td>
<td>1,682</td>
<td>239,493</td>
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<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>99.58%</td>
<td>99.93%</td>
<td>99.23%</td>
<td>99.80%</td>
</tr>
</tbody>
</table>

6 Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
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<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payments recognised as an expense</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Minimum lease payments</td>
<td>-</td>
<td>164</td>
<td>2</td>
<td>166</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>164</td>
<td>2</td>
<td>166</td>
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</table>

In 2018-19 Operating Leases included charges for voids & subsidies (£55k).

Due to a change in NHSE/I subjective code mapping, voids and subsidies are no longer included within operating leases. The costs can be found within Premises in Note 4.

6.1.2 Future minimum lease payments

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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Land</td>
<td>Buildings</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payable:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>161</td>
<td>1</td>
<td>162</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>356</td>
<td>-</td>
<td>356</td>
</tr>
<tr>
<td>After five years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>517</td>
<td>1</td>
<td>518</td>
</tr>
</tbody>
</table>
### 7 Property, plant and equipment

#### Information technology

<table>
<thead>
<tr>
<th>Year</th>
<th>Details</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-20</td>
<td>Cost or Valuation at 01 April 2019</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Cost/Valuation at 31 March 2020</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Depreciation 01 April 2019</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Charged during the year</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Depreciation at 31 March 2020</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Net Book Value at 31 March 2020</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Purchased</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total at 31 March 2020</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Asset financing:

- **Owned**: 0
- **Total at 31 March 2020**: 0

#### 2018-19

<table>
<thead>
<tr>
<th>Year</th>
<th>Details</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost or Valuation at 01 April 2018</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Cost/Valuation at 31 March 2019</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Depreciation 01 April 2018</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Charged during the year</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Depreciation at 31 March 2019</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Net Book Value at 31 March 2019</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Purchased</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Total at 31 March 2019</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Asset financing:

- **Owned**: 12
- **Total at 31 March 2020**: 12

### 7.1 Economic lives

<table>
<thead>
<tr>
<th>Asset</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>
8 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2019-20</th>
<th>Current 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>NHS receivables: Revenue</td>
<td>309</td>
<td>746</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>804</td>
<td>781</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>54</td>
<td>61</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>124</td>
<td>95</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>87</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade and other receivables</strong></td>
<td><strong>1,403</strong></td>
<td><strong>1,739</strong></td>
</tr>
</tbody>
</table>

8.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2019-20</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>By up to three months</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>By three to six months</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>By more than six months</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>
9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2019-20 £'000</th>
<th>2018-19 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 01 April</td>
<td>96</td>
<td>85</td>
</tr>
<tr>
<td>Net change in year</td>
<td>241</td>
<td>11</td>
</tr>
<tr>
<td>Balance as at 31 March</td>
<td>337</td>
<td>96</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 337 96
- Cash and cash equivalents as in statement of financial position: 337 96

Balance at 31 March 2020: 337 96

10 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2019-20 £'000</th>
<th>Current 2018-19 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: Revenue</td>
<td>1,622</td>
<td>2,804</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>4,457</td>
<td>2,064</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>3,386</td>
<td>1,206</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>13,513</td>
<td>15,395</td>
</tr>
<tr>
<td>Social security costs</td>
<td>44</td>
<td>38</td>
</tr>
<tr>
<td>Tax</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>1,249</td>
<td>1,002</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>24,312</strong></td>
<td><strong>22,554</strong></td>
</tr>
</tbody>
</table>

Other payables and accruals includes £329,770 outstanding pension contributions at 31 March 2020 (£300k in 2018-19) - £53,616 for Clinical Commissioning Group employees (£46k in 2018-19) and £276,154 for Primary Care through Delegated Co-Commissioning (£253k in 2018-19).
11 Financial instruments

11.1 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets measured at amortised cost</th>
<th>2019-20 £’000</th>
<th>2018-19 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>324</td>
<td>573</td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>30</td>
<td>234</td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>91</td>
<td>5</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>337</td>
<td>96</td>
</tr>
<tr>
<td><strong>Total at 31 March 2020</strong></td>
<td><strong>791</strong></td>
<td><strong>908</strong></td>
</tr>
</tbody>
</table>

11.2 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities measured at amortised cost</th>
<th>2019-20 £’000</th>
<th>2018-19 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>141</td>
<td>308</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>12,175</td>
<td>10,046</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>11,910</td>
<td>11,115</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>1,002</td>
</tr>
<tr>
<td><strong>Total at 31 March 2020</strong></td>
<td><strong>24,226</strong></td>
<td><strong>22,471</strong></td>
</tr>
</tbody>
</table>

Due to a change in NHSE/I subjective code mapping, other financial liabilities is included in trade and other payables with external bodies for 2019-20.

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>2019-20 £’000</th>
<th>2018-19 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expenditure</td>
<td>16,604</td>
<td>15,834</td>
</tr>
</tbody>
</table>
### 13 Related parties transactions

Details of related parties transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Governing Body / Executive Member</th>
<th>2019-20</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Payments to Related Party</strong></td>
<td><strong>Receipts from Related Party</strong></td>
<td><strong>Amounts owed to Related Party</strong></td>
</tr>
<tr>
<td><strong>GP Practices</strong></td>
<td><strong>Party</strong></td>
<td><strong>£'000</strong></td>
</tr>
<tr>
<td>Marine Avenue Medical Centre</td>
<td>Dr Richard Scott</td>
<td>901</td>
</tr>
<tr>
<td>The Village Green Surgery</td>
<td>Dr Ruth Evans</td>
<td>1,632</td>
</tr>
<tr>
<td>The Priory Medical Group</td>
<td></td>
<td>1,903</td>
</tr>
<tr>
<td>49 Marine Avenue Surgery</td>
<td></td>
<td>704</td>
</tr>
<tr>
<td>Ashleysley Surgery</td>
<td></td>
<td>772</td>
</tr>
<tr>
<td>Battle Hill Health Centre</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Beaumont Park Medical Group</td>
<td></td>
<td>757</td>
</tr>
<tr>
<td>Beechlee Medical Centre</td>
<td></td>
<td>1,337</td>
</tr>
<tr>
<td>Bridge Medical</td>
<td></td>
<td>792</td>
</tr>
<tr>
<td>Collingwood Health Group</td>
<td></td>
<td>2,500</td>
</tr>
<tr>
<td>Earsdon Park Medical Practice</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Forest Hall Medical Group</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Garden Park Surgery</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Lane End Surgery</td>
<td></td>
<td>1,120</td>
</tr>
<tr>
<td>Mallow Medical Group</td>
<td></td>
<td>666</td>
</tr>
<tr>
<td>Monkswath Medical Centre</td>
<td></td>
<td>1,048</td>
</tr>
<tr>
<td>Nelson Medical Group</td>
<td></td>
<td>660</td>
</tr>
<tr>
<td>Northumberland Park Medical Group</td>
<td></td>
<td>1,110</td>
</tr>
<tr>
<td>Park Parade Surgery</td>
<td></td>
<td>550</td>
</tr>
<tr>
<td>Park Road Medical Practice</td>
<td></td>
<td>1,121</td>
</tr>
<tr>
<td>Portugal Place Health Centre</td>
<td></td>
<td>1,484</td>
</tr>
<tr>
<td>Redburn Park Medical Centre</td>
<td></td>
<td>754</td>
</tr>
<tr>
<td>Spring Terrace Health Centre</td>
<td></td>
<td>773</td>
</tr>
<tr>
<td>Stephenson Park Health Group</td>
<td></td>
<td>2,339</td>
</tr>
<tr>
<td>Swarland Avenue Surgery</td>
<td></td>
<td>1,054</td>
</tr>
<tr>
<td>Wellspring Medical Practice</td>
<td></td>
<td>818</td>
</tr>
<tr>
<td>West Farm Surgery</td>
<td></td>
<td>751</td>
</tr>
<tr>
<td>Whitley Bay Health Centre</td>
<td></td>
<td>1,468</td>
</tr>
<tr>
<td>Widesopen Medical Centre</td>
<td></td>
<td>1,918</td>
</tr>
<tr>
<td>Woodlands Park Health Centre</td>
<td></td>
<td>799</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 26 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 Earsdon 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.

On 1st July 2019 Forest Hall Medical Practice and Garden Park Surgery merged to form a new practice Stephenson Park Health Group.

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 the parent Department. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department which included Northumbria Healthcare NHS FT, Newcastle upon Tyne Hospital NHS FT, Cumbria, Northumberland, Tyne & Wear NHS FT, and the North East Ambulance Services NHS FT 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 £32.6m paid in 2019-20 (£31.0m in 2018-19).

TynHealth Ltd is a provider of healthcare services. Its members are the current 26 GP Practices in North Tyneside. There was £3,260k paid to it in 2019-20 (£1,860k in 2018-19).

The Clinical Commissioning Group has not 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>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>223H(1) Expenditure not to exceed income</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I(2) Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I(3) Revenue resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223J(1) Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223J(2) Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223J(3) Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>375,987</td>
<td>368,642</td>
<td>357,399</td>
<td>351,175</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.