West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Council Chamber, The Forum, Moat Lane, Towcester, NN12 6AF on Thursday 28 September 2023 at 1.00 pm

Agenda

1.	**Apologies for Absence and Notification of Substitute Members - Chair** (Verbal Report)
2.	**Notification of Requests to Address the Meeting - Chair** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest - chair** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements - Chair** (Verbal Report)
5.	**Community Training Partnership - Alex Copeland** (Verbal Report)
6.	**Minutes and actions from the previous meeting 27th July - Chair** (Pages 5 - 18)
7.	**Better Care Fund Quarterly Report - Stuart Lackenby** (Verbal Report)
8.	**Live your best life domains: Opportunities to be fit well and independent** (Pages 19 - 32) • Challenges – Presentation, Deborah Mbofana/Peter Cox • Northamptonshire Framework – Report and Presentation, Chris Holmes • Active Lives Strategy Development – Presentation, Peter Cox • Voluntary Sector Spotlight Nsport – Presentation, Chris Holmes • Active Quarter – Presentation, Scott Bradley

9.	**Joint Health and Wellbeing Strategy - Sally Burns** (Pages 33 - 68)
10.	**Introduction of Local Area Partnership Leads - Julie Curtis** (Verbal Report)
11.	**Health Protection Committee Annual Report - Sally Burns** (Pages 69 - 80)
12.	**Any Other Business - Chair** (Verbal Report)
13.	**Close the meeting**
14.	**Reports for information** (Pages 81 - 480) NHS Northamptonshire Integrated Care Board Annual Report 2022/2023

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Councillor Fiona Baker
Dr Jonathan Cox
Sally Burns
Colin Foster
Russell Rolph
Colin Smith
Dr Andy Rathbone
Professor Jacqueline Parkes
Dr Philip Stevens
Dr Santiago Dargallonieto
Heidi Smoult
Miranda Wixon
Chief Superintendent Rachel Handford
Councillor Jonathan Nunn
Anna Earnshaw
Naomi Eisenstadt
Stuart Lackenby
Toby Sanders
Michael Jones
Councillor Wendy Randall
Wendy Patel
Dr David Smart
David Maher
Robin Porter
carella Davies

Information about this Agenda

Apologies for Absence

Apologies for absence and the appointment of substitute Members should be notified to cheryl.bird@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
Members are reminded that any member who is two months in arrears with Council Tax must declare that fact and may speak but not vote on any decision which involves budget setting, extending or agreeing contracts or incurring expenditure not provided for in the agreed budget for a given year and could affect calculations on the level of Council Tax.

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Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

Tel: 07500 605450
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Or by writing to:

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WEST NORTHANTS
Health and Wellbeing Board
live your best life

WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 27th July 2023 at 1.00 pm
Venue: Council Chamber, The Forum, Towcester

Present:

Councillor Matthew Golby (Chair)	Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council
Carella Davies	Chief Executive, Daventry Volunteer Centre
Cllr Fiona Baker,	Cabinet Member, Childrens and Families, West Northants Council
Cllr Jonathan Nunn	Leader, West Northants Council
Cllr Wendy Randall	Opposition Leader, West Northants Council
Colin Smith	Chief Executive, LMC
Dr David Smart,	Chair Northampton Health and Wellbeing Forum
Miranda Wixon	Chair VCSE Assembly
Naomi Eisenstadt	Chair, NHS Northamptonshire Integrated Care Board
Polly Grimmett	Director of Strategy, Northampton General Hospital
Robin Porter via Teams	Assistant Chief Fire Officer, Northants Fire and Rescue
Sally Burns	Director of Public Health, West Northants Council
Stuart Lackenby	Deputy Chief Executive, West Northants Council
Toby Sanders	Chief Executive, NHS Northamptonshire Integrated Care Board
Wendy Patel via Teams	Healthwatch Northamptonshire

Also, Present

Alex Copeland, Chief Executive, Hope Centre
Ashley LeDuc, Assistant Director, Commissioning and Quality, West Northants Council
Cheryl Bird, Health and Wellbeing Board Business Manager
Jo Barrett, Assistant Director Housing and Communities, West Northants Council
Julie Curtis – Via Teams, Assistant Director PLACE Development, West Northants Council
Michael Hurt, Better Care Fund Service Manager, West Northants Council
Peter Doveston, Northants Streets Campaign
Rhosyn Harris, Consultant in Public Health, West Northants Council
Sarah Stansfield, Chief Finance Officer, NHS Northamptonshire Integrated Care Board

44/23 Apologies

Anna Earnshaw, Chief Executive, West Northants Council
David Maher, Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust

Dr Andy Rathborne, Primary Care Network
Dr Philip Stevens, GP, Chair Daventry and South Northants GP Locality
Dr Santiago Dargallonieto, Chair, Northampton GP Locality
Heidi Smoult, Chief Executive, Northampton General Hospital
Michael Jones, Divisional Director, EMAS
Professor Jacqueline Parkes, Professor in Applied Mental Health, University of Northampton
Rebecca Wilshire, Director of Childrens Services, West Northants Council
Russell Rolph, Chief Executive, Voluntary Impact Northamptonshire

45/23 Notification of requests from members of the public to address the meeting

A representative from Northants Streets Campaign addressed the Board to highlight how exercise can reduce serious illness, such as type 2 diabetes, coronary heart disease, stroke and cancers. This in turn would reduce the pressure on health and social care services. The representative also noted that evidence has shown that incorporating exercise into people's daily lives is key to improving mental health and wellbeing. Encouraging active travel such as cycling helps to reduce carbon emissions and improve air quality, with evidence showing that adding cycle lanes into town centres has increased cycling.

The Director of Public Health advised that the Joint Health and Wellbeing Strategy (JHWBS), is focusing on the wider determinants of health and prevention to create an environment where residents can live as healthy as possible. There are a number of strategies that underpin the JHWBS including active travel plans and active travel strategy. One of the Live Your Best Life ambitions contained within the strategy discusses getting residents more active.

46/23 Declaration of members' interests

None received.

47/23 Minutes and actions from the previous meeting 25th May 2023

RESOLVED that:

- **The minutes from the previous meetings held on the 25th May were agreed as an accurate record.**
- **All actions from the previous meeting have been completed.**

48/23 NHS Northamptonshire Integrated Care Board Joint Capital Resource Plan

The Chief Finance Officer, ICB presented the NHS Northamptonshire Integrated Care Board Joint Capital Resource Plan (JCRP) and highlighted the following:

- The JCRP is a new statutory arrangement following implementation of the Health and Care Act 2022 and is an operational plan for the healthcare system, outlining how local NHS organisations will spend their capital allocation for 2023/2024.
- The majority of the allocations come from internally generated capital from NHS organisations and awards from NHS England national programme funds.
- The majority of the internal capital is being spent on business as usual, maintenance and estates. This will include refresh of medical equipment over the next 5 years, due to significant aging with some of the medical equipment.

- There are 2 national awards coming into the health system over the next few years:
  - Digital improvements and set up of and electronic patient record for NGH.
  - Planning for the development of community diagnostic centres.

The Chief Executive ICB noted the ICB are completing a Estates Strategy, which will take into consideration the local population growth with the quality of the existing NHS estates, capacity, primary care facilities, community healthcare facilities and whether there are sufficient modern premises to deliver health services from. Community diagnostics will be a vital component of improving capacity across the county and reducing waiting times.

RESOLVED that:

- **The NHS Estates Strategy to come to a future Board meeting.**
- **The board note the planned expenditure and funding set out in the report.**

49/23 Voluntary Sector Spotlight – Hope Centre

The Chief Executive, Hope Centre gave an overview of the work completed by the Hope Centre and highlighted the following:

- The Hope Centre is a charity working across the whole of Northamptonshire but primarily based in West Northamptonshire providing:
  - Crisis support to the homeless which rebuilds lives and helps those in need to access and maintain secure accommodation.
  - Food and training to members of the community who are hungry and unable to support themselves or their family.
  - Community outreach which empowers personal development, supports independent living and prevents homelessness.
- The Hope Centre is a registered charity, with an enterprise CIC enabling commercial work to be completed to support the charity. There are separate Boards for the Charity and CIC.
- Hope Enterprise CIC delivers a food larder network consisting of 12 food larders across West Northamptonshire providing crisis food to those most in need. These larders are supporting approximately 4000 people every week. The Food Larders are also trying to create community welfare hubs to build trust and offer wrap around services, with 2 full time debt/finance advisors provided by community Law Services working in the food larders.
- For 2022/2023 the Hope Centre had a turnover of approximately £1 million, as well as approximately £1 million received in food donations. There are approximately 400 volunteers, with 50-60 being full time with lived experiences.
- Hand up is a day centre looking after the homeless, sofa surfers, sex workers and those in temporary accommodation. Approximately 50-60 people come into the service every day to receive support, meals and showers.
- One of the aims of the Hope Centre is to bring partners together to make a sustainable change for those who are homeless and move out of homelessness, by treating the underlying issues of people who are homelessness to get them of the street and supported. This includes providing drug and alcohol support, a mental health nurse, GPs and dentists.
- The Hope Centre works closely with housing teams, reviewing the Homeless Strategy and having a representative sitting on the Housing Board.
- The Warm Space Café is open Monday to Friday providing a free breakfast and a warm space targeting those in social isolation, on low incomes and struggling.
- Those attending the Hope Centre suffer from major health inequalities with average life expectancy of approximately 50 years. A Homeless life expectancy is approximately 35/36 years.

- The Hope Centre provide over 50 training courses a week, ranging from physical, emotional social wellbeing to employability, debt and finance, with over 30 peer mentors and paid staff through lived experience.
- The Hope Centre have been commissioned by Public Health to deliver Cook Grow Eat programme in deprived communities to teach about food, working with community champions, along with providing toothbrushes and toothpaste across deprived communities as part of the Oral Health work.
- The Hope Centre also undertakes Household Support Fund function delivering over 300k vouchers to those in greatest need.
- The Community Training Partnership will deliver free courses to front line workers.
- The Hope Centre host the Sustainable Food Place, which is collective of like-minded individuals and organisations who want to reduce food waste and ensure we can get food to people living in hardship.
- The Chief Executive, Hope Centre sits on the Five Wells Board, looking at how we can reintegrate prisoners and reduce the likelihood of them ending on the street following release.
- The Hope Centre also attend the Mental Health Collaboration to ensure the join up of community services for those suffering with poor mental health.
- Currently the biggest challenge is the increased numbers of those needing help, if support can be provided earlier if might prevent an escalation into crisis.
- Providing support for those in rural areas is currently a real challenge, the Hope Centre have a network of volunteers who are able to go out to those needing help, providing food etc.

RESOLVED that the Board noted the update.

50/23 Live your best life domains: Housing that is affordable, safe, and secure in places that are clean and green

The Live Your Best Life thematic theme for this meeting is Housing that is affordable, safe, and secure in places that are clean and green.

Disabled Facilities Grants

The Assistant Director for Housing and Communities presented to the board the Disabled Facilities Grant (DFGs) Annual Report 2022/2023.

- DFG's are mandatory grant of up to £30k for adaptations in residential properties to enable people to stay independent for longer and at home for longer. West Northants Council (WNC) can also provide a discretionary element of £15k for an individual case.
- The WNC DFG budget for 2022/2023 was £2.5 million, the same as 2011/2022, which is a challenge as demand remains high and construction works are increasing.
- It can take a few months for a DFG to be delivered, as there is an application process, occupational therapists specify the works and appoint a contractor. At the end of the financial year there are commitments where works are approved but will not be completed until the next financial year.
- During 2022/2023 397 mandatory grants and 61 discretionary grants were approved and completed.
- DFG spend is higher in rural areas with an aging population, with Rural West Local Area Partnership (LAP) having double the number of DFGs compared to other LAP areas across West Northamptonshire.
- DFGs are for all ages, being significantly but not exclusively linked to the older population.

WNC Housing Function

The Assistant Director for Housing and Communities gave an overview of WNC Housing function and highlighted the following:

- The housing function sits within the Communities and Opportunities directorate of WNC, working closely with colleagues in regulatory services, adult social care and public health.
- The Communities and Opportunities Directorate Service Plan has mapped where the different functions within the team align to WNC Corporate plan and Live Your Best Life ambitions.
- The Housing and Communities team are responsible for community safety engagement and resettlement, housing solutions, housing strategy and partnerships, private sector housing.
- Housing solutions includes providing advice and assistance to customers who are threatened with or have become homeless as well as maintaining the WNC Housing Register where residents can apply to access social housing. Work is also taking place to reduce the number of rough sleepers by providing appropriate housing solutions and support.
- The key Priorities for the Housing Solution Service are to:
  - Bring together the legacy teams for the previous district and borough councils into one single team.
  - Re-shape how we provide temporary accommodation when a household is homeless. As homeless levels are increasing the cost of the provision is increasing, so we need to re-shape how we deliver this provision with more cost-effective solutions for temporary accommodation. A service health check has been commissioned around WNC statutory homeless service, with the aim to shift to a prevention approach rather than dealing with households at crisis point.
  - Work is taking place on implementing a single allocations housing scheme to replace the 3 schemes from the legacy district and borough councils. This is currently out to consultation. This will help us award a higher priority to households as part of the prevention stage.
  - Redesign and commission a new Rough Sleeper Pathway.
- There is a WNC Housing Strategy which is an overarching document that aligns with other strategies such as the JHWBS, work is taking place with partners to deliver work sitting under the sub strategies. There is a Housing Partnership Board which drives delivery of the Housing Strategy.
- WNC owns approximately 12k homes, with the management of these outsourced to Northamptonshire Partnership Homes (NPH). Damp mould and condensation is a big issue in social housing and is driving some of the social housing regulatory changes. WNC is working with NPH to develop more affordable housing which will include the consideration of community spaces. The Housing Strategy and Partnership Team also work with housing associations.
- Priorities for the Housing Strategy and Partnership are to develop a WNC Homeless and Rough Sleeping Strategy, remodelling and commissioning a new single homeless rough sleeper pathway, to push for an to increase in the provision of affordable housing which is challenging with the increased construction costs.
- WNC have an active property acquisition programme to provide a cost-effective alternative to expensive nightly-paid temporary accommodation as well as delivering properties for families from Ukraine and Afghanistan through the Local Authority Housing Fund programme.
- The Private Sector Housing Team oversee housing enforcement where action is taken against private landlords who are not meeting the required standards.

- The travellers site in Ecton Lane is owned by WNC, who have received significant capital to invest in this site over the next 2 years. NPH mange the site on behalf of WNC and are working with residents to inform them of the improvement plan.
- A working group has been created in response to public concerns around shared housing and Houses of Multiple Occupancy (HMOs). Discussing with local businesses, Landlords Forum, letting agents, University of Northampton (UoN) and local residents their concerns regarding HMOs. Following this consultation an action plan was presented to WNC Cabinet on 11th July with the key themes of improving issues with litter and rubbish, reviewing policies for HMOs and to drive up the standards by reviewing how WNC issue HMO licences. Article 4 is applied when a property owner wants to convert a family house into a HMO and there are certain restrictions on the concentration of HMOs in an area. HMO's are mapped by wards with the top wards being Abington & Phippsville, Castle and St George.
- There are strict conditions around the use of S106 monies, which has to be related to a specific development. The community infrastructure levy represents an opportunity for development of community spaces.
- WNC has commissioned a housing stock condition survey this year, which will take a representative sample of all tenures, owner occupied and private rented. Results from this survey is expected at the end of 2023, and will be used to inform future service delivery.
- There is a challenge for social housing landlords around net zero targets and wider stock improvements.

<u>Homelessness and Rough Sleeping</u>

The Assistant Director Housing and Communities gave an overview of findings from the Homeless Review and highlighted the following:

- WNC has a statutory duty to review homelessness in their area every 5 years. Deadline for the Homelessness Review and for adoption of a new Homelessness and Rough Sleepers strategy is by April 2024.
- 4951 approaches were made to the Housing Options Service in 2022/23, an increase of 14% on the previous year.
- Between April – December 2022, 576 calls, an average of 58 calls per month, were made to the Out of Hours (OOH) team, mainly from within Northampton. Customers who approach the service after 4pm are signposted to the OOH team.
- The main reasons for people presenting as homeless was friends and family asking them to leave, ending of assured short hold tenancy, domestic abuse, ending of supported housing.
- West Northants have lower levels of prevention than regional and national averages, but a higher level of relief. More emphasis needed on earlier intervention to avoid dealing with people at crisis point.
- There were 483 main duty acceptances in 2022/23, compared to 321 in 2021/2022. Despite current challenges, the service improved performance around prevention and relief outcomes, with 896 successful outcomes in 2022/23 compared to 870 in 2021/22.
- Homeless acceptances increased by 162 (50 %) while the number of successful prevention and relief outcomes also increased, demonstrating increased demand, year on year.
- Of applicants who applied during 2022/23, over two-thirds (69%) owed a prevention duty, were single adults/ households without dependent children, as were two thirds (66%) owed a relief duty. WNC only has a statutory duty to assist single adults if they have a high level of vulnerability (priority need). Almost a quarter of all approaches originate within Northampton Central LAP (23% in 2021/22 and 25% in 2022/23). Followed by Northampton East, generating 13% of approaches in 2021/22 and 11% in 2022/2023.

Northampton North LAP generating 12% of approaches in 2021/22, rising to 16% in 2022/23. Showing that most of the need is coming from more deprived areas.

- Every year WNC complete a rough sleeping annual snapshot supported by voluntary and statutory partners. In November 2022 there was a count of 25 rough sleepers which was an increase from the previous year. Also as the cost of living starts to take effect numbers of rough sleeping have started to increase with an average of 15 a night.
- Department for Leveling Up Housing and Communities (DLUHC) require us to identify those most likely to be unable to sustain a tenancy over the short-medium term, known as the Target Priority Group (TPG). The definition includes individuals who have been seen sleeping rough in two or more years out of the last three, and in two or more months out of the last 12, as well as those who have made historical presentations.
- Within our current TPG cohort:
  - 16% are female, all aged 25+
  - Majority of men are in the 25-49 year age group
  - Most are British; with a small proportion are EU/ non-EU nationals.
- WNC and the Hope Centre work with International Lighthouse to try and get foreign nationals to their relevant embassy to get papers sorted to apply for settled status.
- The Housing and Communities Team and Public Health jointly commissioned PPL to conduct research covering an independent assessment of the need of people sleeping rough, including the current customer journey, existing accommodation and support.
- The PPL research reviewed estimated current need for accommodation-based or housing-related support for people at risk of, or experiencing, rough sleeping. The current supply within the single homelessness pathway
- Results from the needs assessment identified the following as working well:
  - 'Strong operational and multi-agency support taking place at an individual level within the pathway'
  - Targeted approaches - NHTT and dedicated Homelessness Mental Health Practitioner
  - Street Services Team work closely with NHTT to offer collaborative, assertive outreach to start and maintain engagement with health and social care.
  - Dedicated staff working on discharge and support transition between hospital, prison and care leaver transitions
- With the needs assessment identifying the following as needing improvement:
  - Better move on
  - Unmet need and gaps in support provision
  - Better access to advice, prevention and assessment, generally
  - Improved access to the PRS
  - Improved oversight of accommodation and support, across provision
  - 'Treatment first' approach remains prevalent. We continue to talk about 'tenancy/ housing readiness'. Training on Housing Led/ Housing First approach needed.

The Board discussed the update and the following was noted:

- Statutory services complete the most work with vulnerable adults within the Northampton Central LAP area.
- The draft needs assessment will be shared with the Board once the additional data is included.
- Service user engagement was positive about care received from the acute trusts and there is a need to look at whether presentations at the acutes could have been avoided.
- There are currently 7 sites in Northampton and 1 in Towcester undergoing air quality monitoring, all being in high traffic areas. Results from this monitoring could be mapped against numbers of respiratory illness.
- During the JHWBS engagement process with communities the main issue raised is the state of their environment. There is a Cleaner Communities Campaign being completed by the Environmental Enforcement Teams.

- There is a need to ensure the public know how to alert WNC of illegal HMOs and how community spaces can be developed to tackle isolation. Northamptonshire has seen a huge growth in housing, which has not been matched by the growth in community spaces.
- The WNC Local Plan is being refreshed setting policy around planning, with a workshop being held on architectural design to highlight examples of good practice. The Planning Policy Team are already looking at incorporating Building Healthy Life into the local plan.
- NPH has an apprenticeship programme and the contractors they use also have apprenticeships programmes. Anchor institutions include large housing providers and we can ask what apprenticeship opportunities are being offered to residents in the most deprived communities to ensure there is equity of access.
- Grand Union Housing presented at the National Chartered Institute of Housing conference on how housing associations and registered providers can contribute towards health and wellbeing.

RESOLVED that:
- **Feedback from the Homelessness Needs Assessment to be circulated to the group.**
- **Slides from the thematic item to be circulated to the group.**

51/23 Better Care Fund

The Assistant Director Commissioning and Performance gave an overview of the Better Care Fund (BCF) Plan 2023-2025 and highlighted the following:
- The BCF Plan 2023-2025 meets all the national conditions.
- The value of the BCF scheme for 2023/2024 is £54 million, with the key changes in the schemes being:
  - Addition of the Adult Social Care Discharge fund to commission solutions which demonstrate better value for money and support people to remain as independent as possible for as long as possible.
  - 3 year funding to focus on admission avoidance and prevention services.
  - Ageing Well scheme has been included to provide more focus on transformation services to reduce hospital admissions.
- The Integrated Care Across Northamptonshire (iCAN) programme has been removed from the BCF schemes and is now business as usual focusing on out of hospital services.
- A BCF Executive Board has been introduced which includes senior representatives from WNC, ICB and NHFT to provide oversight of the BCF schemes.
- There will be groups focusing on data to ensure accurate and timely reporting against BCF metrics.
- A BCF Delivery Board will look at the schemes associated with the BCF, to provide an opportunity to consider additional schemes that could drive integration of services.

The Board discussed the update and the following was noted:
- The BCF Executive Board will provide an opportunity for shape and structure around the BCF schemes. In section 5 of the draft Terms of Reference for the BCF Executive Board it discusses the forum being a single commissioning body for West Northamptonshire. It is advisable for collaborative working to be acknowledged. Northamptonshire ICB and WNC are the 2 main organisations within the BCF and there needs to be recognition of the roles there representatives will have.
- Northamptonshire ICB are keen to have additional input into this BCF Executive Board rather than reviewing just financial details, particularly with clinical and medical routes.

- There is a need to ensure the BCF receive influence from the Peoples Board as the VCSE sector can play an increased role in delivery of the BCF schemes, particularly in rural communities.
- The golden thread for BCF plans in future years is to align the 5YFP and JHWBS on a county footprint as well as a PLACE and community footprint.

The Assistant Director for Commissioning and Performance responded to the feedback and noted:

- Attendees at the inaugural BCF Executive Board meeting were tasked with identifying commissioners and additional members to join the Board.
- The new governance arrangements will start to drive the pooled budget arrangements and integration of services. A quarterly report will come to this Board highlighting the effectiveness of existing schemes, with the BCF end of year report providing context in overall effectiveness of the BCF schemes.
- Representatives from primary care will be invited sit on the BCF Executive Board, Primary Care Networks have already been involved in the work of the Executive Board. GPs are heavily engaged with the Aging Well program, and the Aging Well teams will work closely with the LAPs.

RESOLVED that the Board:

a) Noted delegated authority to submit the plan before board approval was provided by the Chair of the Health and Wellbeing Board in an email dated 9th June 2023.
b) Noted that detailed plans have been submitted to NHS England for moderation.
c) Noted that West Northamptonshire Council have undertaken a review of the schemes to align the BCF to the Aging Well programme, and this has been agreed by the Northamptonshire ICB.
d) Noted that additional funding to support hospital discharge has been included within the planning template. Details of the schemes are also included.
e) Agreed the new BCF governance

52/23 Joint Health and Wellbeing Strategy

The Director of Public Health presented to the Board the draft JHWBS and highlighted the following:

- Health and Wellbeing Boards have a statutory duty to produce a JHWBS to highlight priorities and how will work with partners to reduce inequalities in their local area.
- If the Board agrees the draft JHWBS it will be go out for 6 weeks public consultation. Feedback from this consultation will be incorporated into the final JHWBS which will be presented to the Board for approval at the next meeting.
- The JHWBS sits underneath the Integrated Care Northamptonshire Strategy and aligns to the 5YFP.
- The JHWBS also aligns to the Live Your Best Life ambitions and sets out how these can be delivered at a PLACE level.
- The following sections are included in the JHWBS:
  - Summary page,
  - Foreword by the Chair,
  - Vision which aligns with the vision of the ICN Strategy.
  - Describing what makes us healthy and happy, working on wider determinants of health, 10 keys for happiness.
  - Discuss JSNA, health inequalities work and assets referred to in the Strategy.
  - Approach on tackling health inequalities, taking an evidence based approach working at a PLACE level, through the Health and Wellbeing Forums (HWBFs) and LAPs. Highlighting co-production with the voluntary and community sectors.

  - Listing each of the ambitions, providing an introduction, where we are now, what we want to achieve, what are the inequalities of services and how are we going to measure progress. This will also include what are we going to measure, how will we measure.
  - The final page introduces members of the Board.
- The strategy will be delivered in partnership using the resources available.
- The draft Strategy has been presented to the Town and Parish Councils, residents forums, HWBFs and LAPs.

The Board discussed the update and the following was noted:

- Data on exclusions needs to include ethnicity and gender indicators.
- Detailed scorecards will sit behind the Live Your Best Life ambitions.
- This Board needs to monitor progress towards the Live Your Best Life ambition outcomes.
- Strategy Directors across the system should meet on a monthly basis review strategies and how they can align to the JHWBS.

RESOLVED that the Board agree the draft Joint Local Health and Wellbeing Strategy for wider consultation with partners, stakeholders, communities and residents.

53/23 Local Area Partnership Re-designation

The Chair presented a proposal for the LAP names to change from numbers to a name that will be recognisable to residents, whilst not making communities feeling excluded.

- Daventry and South Northants LAPs to be named:
  - DSN1 Rural North
  - DSN2 Rural West
  - DSN3 Rural South
  - DSN4 Rural East
- Northampton LAP will be named:
  - N1 Northampton East
  - N2 Northampton South
  - N3 Northampton West
  - N4 Northampton Central
  - N5 Northampton North

RESOLVED that the Board agreed to the proposal.

54/23 Any Other Business

The Chief Executive NHS Northamptonshire ICB, advised there is a national and local shortage of access for NHS dental treatments. The ICB has taken on responsibility for commissioning NHS Dental services and in recent months 3 dental practices in Northamptonshire have taken the decision to stop offering NHS services. The ICB Dental Team are working with dental practices in the surrounding area of these practices to ask for expression of interest from dental practices for capacity to take on additional NHS patients. There has been a good response and soon patients at the affected practices will be written to with information on the practices that are taking on additional patients.

The Chief Executive, NHS Northamptonshire advised there has been national media coverage around changes in mental health provision where the police will not routinely attend mental health incidents and looking for other health partners to fill this gap. In

Northamptonshire, NHFT have been working closely with Northants Police through the Mental Health Learning Disability Autism Collaborative to have a number of service provisions to ensure those suffering a mental crisis will be attended to and supported

RESOLVED that an update on the collaboration work between NHFT and Northants Police to come to a future Board meeting.

There being no further business the meeting closed at 3.20 pm.

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West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action
270723/02	Feedback from the Homelessness Needs Assessment to be circulated to the group	Rhosyn Harris		

Actions completed since the 27th July 2023

Action No	Action Point	Allocated to	Progress	Status of Action
270723/01	Presentations from the meeting 27th July to be circulated to the Board	Cheryl Bird	Circulated 28th July.	Completed

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

Health and Wellbeing Board

live your best life

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

28th September 2023

Report Title	**Move Northamptonshire: A Framework For Active Lifestyles In Northamptonshire2023 to 2028**
Report Author	**Chris Holmes, Jackie Browne NSport** **(In partnership with the Northamptonshire Physical Activity Network)**

Contributors/Checkers/Approvers		
Other Director/SME	Sally Burns	19th September 2023

List of Appendices

Appendix A Move Northamptonshire Framework

1. Purpose of Report

1.1. To seek Board approval for 'Move Northamptonshire', the local system wide Framework for Active Lifestyles that will help shape workplans and strategies involving increasing physical activity across communities.

2. Executive Summary

2.1 Living an active lifestyle and moving more within our everyday lives matters. The health benefits of physical activity, exercise and sport are well evidenced, supporting both our mental and physical health, our social connections, the strength of our local communities and the development of our local economy.

2.2 Physical activity plays an important part in meeting the 'Live Your Best Life' strategy, in particular the 'opportunity to be fit, well and independent' ambition, but also having a part to play in achieving many of the other LYBL ambitions.

2.3 'Move Northamptonshire' is a system wide Framework, created with input from over 200 individuals and organisations, outlining a strategic approach to helping active lifestyles become integral to all people's lives, irrespective of background, age, race, gender or geography. It's intent is to act as the needle that threads active lifestyles through the whole of the system in Northamptonshire – through strategies, policies, approaches and actions.

3. Recommendations

3.1 The Health and Wellbeing Board approve 'Move Northamptonshire' as the key system-wide Framework for active lifestyles, physical activity and sport across the county.

4. Report Background

4.1 'Move Northamptonshire' renews the previous countywide Framework ('Northamptonshire More Active More Often') covering a five year period up until 2028.

4.2 It is a system wide Framework, for all organisations to be a part of - it is not one organisation's Framework. The work to create it has been led by Northamptonshire Sport, with a small steering group consisting of Public Health, the Unitary Authorities and the ICB.

4.3 It maps out a long-term Shared Ambition (Vision) and outlines the six Key Enablers that will be critical in achieving that Ambition. The choice of the word 'Framework' rather than 'Strategy' is deliberate – giving the sense of all parts of the system connecting in to the degree and depth that suits their objectives.

4.4 The agreed Shared Ambition is that *"by 2028 healthy active lifestyles will be integral to ALL people's lives in Northamptonshire, irrespective of background, age, gender or geography".* The implication is that certain communities, areas demographic groups will need more support than others to get active and that it will take the lifespan of this Framework (5 years) to start making the changes across the whole system that will be needed.

4.5 Those changes are summarised in the six Key Enablers, mapped out across a lifecourse, indicating that different things will be needed at different stages through people's lives;

Great Start : Our early years have a profound effect on the rest of our lives. A great early experience of physical activity, sport and play can set us up for a sustained healthy active lifestyle

Tailored Choices : Understanding that people's circumstances are ever changing and we all need bespoke, easy to access, opportunities that suit our current situation and life stage

Active Environments : We need housing development, local neighbourhoods, transport options, built infrastructure, green and blue assets networks that make the choice to be active the easier option.

Integrated Offers : Integrating physical activity into other services, systems and places will avoid it being seen as an add-on. If being active is embedded into how our workplaces, our health services and our education provision function then we can make being active daily much easier

First Rate Communication : The benefits of active lifestyles are well understood, even if it's not enough to change social norms. To transform this understanding into sustained behaviour change our messaging, campaigns, marketing and 'calls to action' need be excellent.

Active Ageing : The benefits of staying active into later life will help achieve the best possible health and wellbeing outcomes for older adults and support them to stay independent for as long as possible.

4.6 **Consultation**

4.6.1 Over 200 people have helped to create 'Move Northamptonshire', the process having helped to identify the challenges, barriers, ideas and vision for what a more active Northamptonshire could look like.

4.6.2 A five stage process has been followed;

Insight Development : 1-2 months understanding data, trends, strategic context and local intelligence.

Open Conversations : 3-4 months holding open-ended discussion with residents, communities, networks and stakeholders through meetings, online platforms and presentations.

Emerging Themes : 3-4 months summarising, aggregating and analysing the common themes, exploring them in more depth through workshops and seminars

Shaping Priorities : 2-3months curating, drafting and refining the themes and issues into a draft Framework before open online consultation with the public and partners.

Launching : 2-3 months mandating, endorsing and bringing the Framework to life.

4.7 **Community Impact**

4.7.1 The Framework will impact across the whole population. However, as is implicit in the Shared Ambition, there are certain communities, areas demographic groups will need more support than others to get active and that it will take the lifespan of this Framework (5 years) to start making the changes across the whole system that will be needed.

5. Background Papers

5.1 Framework Attached

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MOVE NORTHAMPTONSHIRE

A Framework For Active Lifestyles In Northamptonshire **2023 to 2028**

MoveNorthamptonshire.org

Active lifestyles and moving more matters

Introduction

‘Move Northamptonshire’ is a system-wide framework for developing more active lifestyles in Northamptonshire.

It’s been created through conversations with over 200 people and organisations, providing their ideas about how to support more people to be active, especially those who face the greatest barriers.

You’ll see the terms ‘movement’ and ‘active lifestyles’ being used throughout, these are the collective terms for the other words we commonly use, including sport, physical activity, exercise, recreation and leisure. It’s a call to action, to work collaboratively to make active lifestyles a central part of people’s lives in Northamptonshire

The framework will only make a difference if everyone plays their part. To create sustainable change the framework needs public, voluntary and private sector support. It is a call to action, to work collaboratively to make active lifestyles a central part of people’s lives in Northamptonshire

What will this framework do?

As well as outlining a shared ambition (vision) this framework will also:

- **Connect movement and active lifestyles into other strategies** ✓
- **Guide investment and capacity** ✓
- **Co-ordinate resources more effectively** ✓
- **Lever external resources** ✓
- **Develop greater collaboration and buy-in** ✓
- **Support sharing of best practice** ✓
- **Raise the profile of movement and active lifestyles** ✓

#MoveNorthamptonshire

Active lifestyles and moving more matters

With active lifestyles playing such an important part in people's overall health and wellbeing, an integration with the health system in Northamptonshire is vital. The NHS Long-Term Plan commits to moving upstream, a shift towards prevention, and recognises the vital role that active lifestyles can play.

Integrated Care Northamptonshire brings together our Unitary Councils, the NHS and the VCSE sector to work collaboratively in meeting people's health and care needs. The 10-year ICN Strategy 'Live Your Best Life' (LYBL) sets out the ambition to help people benefit from equitable opportunities to live their best life, whoever they are and wherever they live in Northamptonshire.

This Framework, 'Move Northamptonshire', is informed by LYBL and aims to ensure that active lifestyles are a fundamental way of helping people to live their best life. It also aims to thread active lifestyles throughout the 'system' in Northamptonshire, providing a voice for movement and physical activity as partners consider their strategies, policies, approaches and actions.

Active lifestyles and moving more matters

Moving more and having an active lifestyle matters. It supports our physical and mental health, our social connections, the strength of our local communities and the development of our local economy. Increasingly, it also plays a part in our environmental sustainability.

Being active regularly, at a level that raises our heart rate and causes us to feel out of breath:

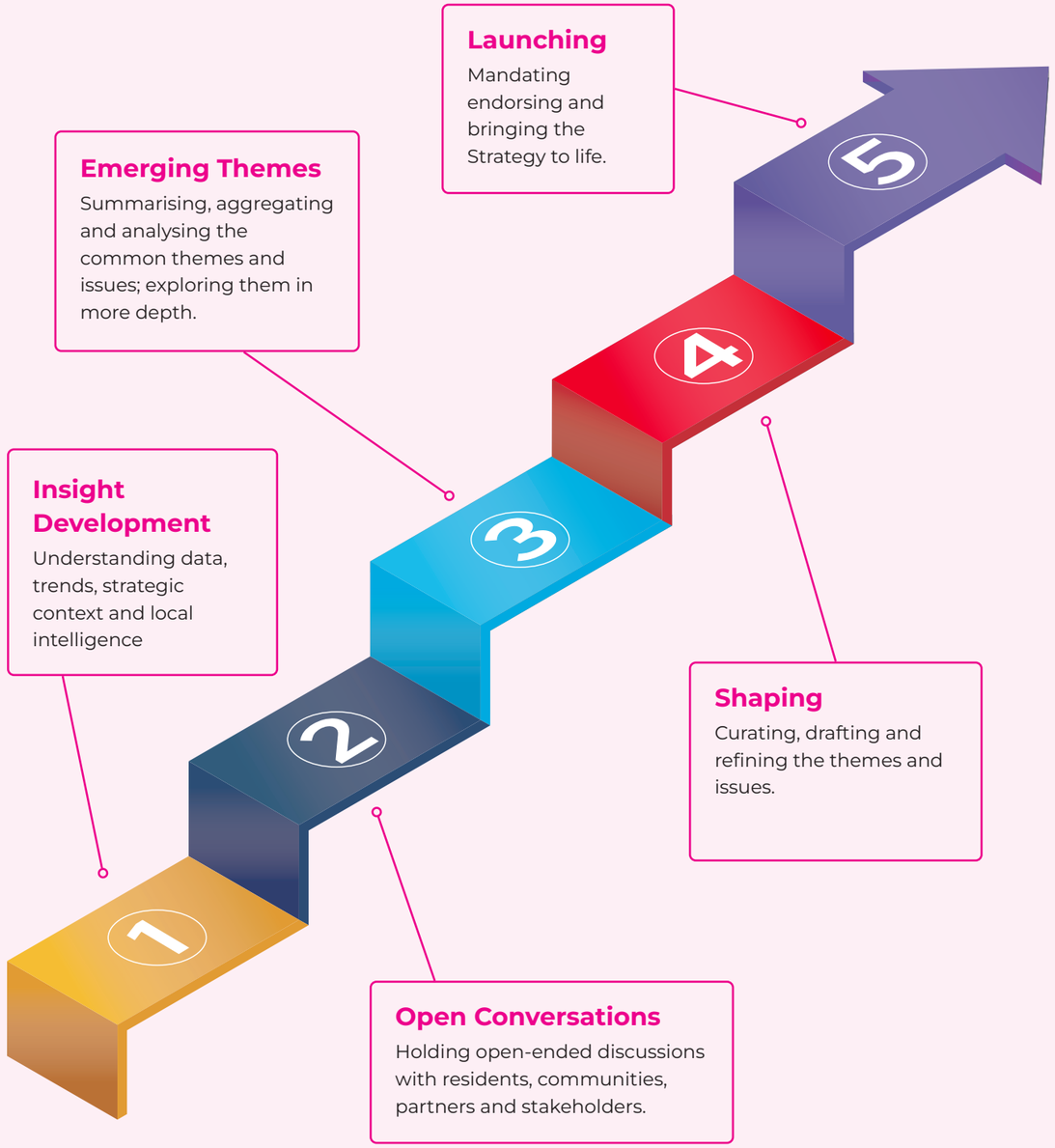
- **Reduces our risk of heart diseases, stroke and respiratory illness by up to 25%**
- **Reduces our risk of depression by 48%**
- **Lowers all-cause mortality by 30%**
- **Minimises risk of bone fractures by 66%**
- **Generates £4 for society for every £1 spent**

This framework believes that everyone should experience these benefits, regardless of their age, gender, race, ability or background. However, despite these benefits being well evidenced and understood, we know there are barriers that make the choice to be active more challenging, especially for certain groups and communities in Northamptonshire:

- **26.9% of the adult population (753,000 adults) are inactive.**
- **Disabled adults are almost twice as likely aS non-disabled people to be physically inactive (42.4 % vs 22.6%).**
- **People from low income households are 20% less likely to be active than those from higher income households.**
- **Over half of children and young people are not achieving the recommended 60 'Active Minutes' per day.**
- **Over 50% of adults aged 75+ are inactive, with this age group to grow significantly in future years.**
- **People from ethnically diverse communities are half as likely to be active as those from white British backgrounds.**

How did we get here?

Over **200** people have helped create 'Move Northamptonshire', the process has helped to identify the challenges, barriers, ideas and vision for what a more active Northamptonshire could look like.



What does a more active Northamptonshire look like?

Shared Ambition

"By 2028 healthy active lifestyles will be integral to ALL people's lives in Northamptonshire, irrespective of background, age, race, gender or geography."

To make this aim a reality certain communities, demographics and people living certain places will need more support than others to get active. It will take the lifespan of this framework to deliver the transformation, by the end of it, you will see that:

- ✓ People are moving more and leading more active lifestyles for at least 150 minutes per week.
- ✓ Inequality gaps are reduced.
- ✓ More children are active for at least 60 minutes per day.
- ✓ Everyone's wellbeing and happiness increases.

How do we define inactive?

- Adults: Doing less than 30 minutes of moderate intensity activity per week.
- Children: Doing less than 60mins of moderate intensity activity per day.

The UK Chief Medical Officer guidelines recommends:

- Adults should do at least 150 mins of moderate intensity physical activity or 75 mins of vigorous physical activity or a combination of both each week.
- Children should do at least 60 mins of moderate intensity physical activity each day.

#MoveNorthamptonshire

What do we need to do to realise this ambition?

Making this shared ambition a reality within the next five years requires concerted effort from all. It will take sustained, co-ordinated and innovative approaches, as well as changes in how we do things. This includes, greater collaboration, sharing learning, pooling resources and joint accountability.

At the heart of the Framework is the fact that people's circumstances change. Our lives don't stay the same.

Work gets busy, young families divert us and older parents need caring for. Life continuously alters and what keeps you active at 22 is unlikely to be the thing that keeps you active in your 70s. Therefore, the 'ways we support' activity need to be adapted, as we move through life. The Framework refers to these ways we work as 'Enablers'; the areas to focus on that could impact people throughout their lifetime.

Active Ageing

The benefits of staying active into later life will help achieve the best possible health and wellbeing outcomes for older adults and support them to stay independent for as long as possible.

Great Start

Our early years have a profound effect on the rest of our lives. A great early experience of physical activity, sport and play can set us up for a sustained healthy active lifestyle.

Tailored Choices:

Understanding that people's circumstances are ever changing and we all need bespoke, easy to access, opportunities that suit our current situation and lifestage.

Active Environments

We need housing development, local neighbourhoods, transport options, built infrastructure, green and blue assets networks that make the choice to be active the easier option.

Integrated Offers

Integrating physical activity into other services, systems and places will avoid it being seen as an add-on. If being active is embedded into how our workplaces, our health services and our education provision function then we can make being active daily much easier.

First-rateCommunication

The benefits of active lifestyles are well understood, even if it's not enough to change social norms. To transform this understanding into sustained behaviour change our messaging, campaigns, marketing and 'calls to action' need be excellent.

Exploring the enablers

Great Start:

Our early years have a profound effect on the rest of our lives. A great early experience of physical activity, sport and play can set us up for a sustained healthy active life.

To make this happen the stakeholders aim to...

- Embed active play within all early years settings.
- Support all schools to offer '60 Active Minutes' a day.
- Make all PE lessons inspiring and motivating for all children and young people.
- Sustain a confident and capable workforce within schools.
- Create easy pathways from school to community provision.
- Support 'whole school' approaches around healthy active lifestyles (including school meals, family involvement, active travel and staff wellbeing).

First-rate Communication:

The benefits of active lifestyles are well understood by people, even if it has not been enough to change social norms. To transform this understanding into sustained behaviour change our messaging, campaigns, marketing and 'calls to action' need be first-rate.

To make this happen the stakeholders aim to...

- Establish system-wide consistency in language and terminology.
- Co-ordinate regular and system-wide campaigns that inspire more people from every background to be active.
- Commit to the 'Open Active' data standards, publishing information in an open and consistent way.
- Build and support a team of 'Move Northamptonshire' champions to advocate for physical activity within their setting, this could be a community, workplace or interest group.
- Maximise the opportunity to use digital platforms and IT solutions to make finding out about and participating in physical activity opportunities easier.

Tailored Choices:

Understanding that people's circumstances are ever changing and we all need bespoke, easy to access, opportunities that suit our current situation and lifestage.

To make this happen the stakeholders aim to...

- Support the core network of clubs, leagues, events and competitions to continue their recovery from the pandemic and tackling the cost of living pressures.
- Provide opportunities for people who need extra support post-pandemic and those most effected by the cost of living pressures.
- Deepen our understanding and insight around physical activity inequalities.
- Prioritise resources more carefully, targeting those that need the greatest support.
- Support communities to build their own capacity to be active.
- Work hand-in-hand with people in considering and creating the opportunities that will support active lifestyles.
- Broaden the diversity of the professional, voluntary and community workforce, at all levels.
- Explore ways of reducing cost for those who can least afford activities.

Exploring the enablers continued...

Integrated Offers:

Integrating physical activity into other services, systems and places will avoid it being seen as an add-on. If being active is embedded into how our workplaces, our health services and our education provision function then we can make being active daily easier.

To make this happen the stakeholders aim to...

- Embed physical activity and movement into the health offer locally, working with Public Health, the Integrated Care System, Primary Care Networks and voluntary sector providers to address wider health needs.
- Deepen the integration of physical activity and movement into social prescribing networks and referral pathways making opportunities inclusive and easy to access.
- Utilise physical activity within wider local government objectives and services around anti-poverty, levelling up, community engagement, regeneration, economic development and the green agenda.
- Embed movement and active lifestyles into the Active Ageing work in Northamptonshire.
- Review leisure provision to ensure it is sustaining existing activity levels and increasing take-up by those who can least afford it.
- Support the incorporation of physical activity into workplaces, supporting employers to provide the facilities, incentives, policies and programmes to improve the wellbeing of their staff.

Active Ageing:

Staying active in later life will help achieve the best possible health and wellbeing outcomes for older adults and support them to stay independent for as long as possible.

To make this happen the stakeholders aim to...

- Embed physical activity into whole system community approaches that support improved outcomes for older adults, including models of social prescribing across the county.
- Create stronger connections with health and adult social care providers to build an integrated offer for older adults.
- Apply insight and person-centred approaches to better understand older adults and provide opportunities and activities to benefit them.
- Collectively promote and advocate the benefits of maintaining an active lifestyle, including strength and balance into later life.

Active Environments:

We need housing development, local neighbourhoods, roads, transport options, leisure facilities, green and blue assets that make the choice to be active the easier option.

To make this happen the stakeholders aim to...

- Transform local planning policy and processes to better support active lifestyles.
- Designate a series of 'Active Zones / Quarters' across the county, where priority effort and additional resource is directed into increasing use for physical activity.
- Accelerate the construction of new, safe, routes for cycling and walking.
- Create 'Healthy Streets' across the county, bringing together communities and local authorities, to increase the amount of cycling, walking and playing in our local areas.
- Ensure we have a built facility infrastructure that meets community need and insight, especially those groups where inactivity is greatest.
- Reduce the impact of climate change by identifying more sustainable ways of operating leisure and sport facilities, working towards a carbon neutral target by 2030.

How will we work?

If the whole ‘system’ around us is better aligned to active lifestyles and less fragmented in approach, the likelihood of successfully embedding physical activity as the social norm is greater. For movement and active lifestyles to become innate we need the policies, strategies, services and approaches of public, voluntary and private sectors to unite in the ambition.

To make this happen the stakeholders aim to...

- ✓ Pledge their support for the Shared Ambition, aligning themselves to it within the context of their own circumstances and overall objectives.
- ✓ Work together to measure the impact of the framework.
- ✓ Establish a set of shared measures used by all to shape individual, organisational and collective future approaches
- ✓ Put the needs of the local communities at the centre of future decisions and actions.
- ✓ Work even more collaboratively with each other and our communities in the co-design of opportunities.
- ✓ Listen and learn even more from each other about what works and what doesn’t.

What does success look like?

If our Shared Ambition is for “healthy active lifestyles to be integral to ALL people’s lives in Northamptonshire” then the ultimate measure of success has to be the Chief Medical Officer recommendations for adults and children/young people (adults - 150 mins a week; children/young people - 60 mins a day).

Because of the specific intent to achieve this “irrespective of background, age, race, gender or geography” we must also look at the more detailed data as it applies to our least active communities.

Whilst an improvement in physical activity levels is the ultimate measure, we can also measure other changes that will lead to greater physical activity levels:

Changes in the System: With the strength of relationships, levels of trust, alignment of strategies and creation of policies.

Changes in Satisfaction: With the quality, choice and accessibility of opportunities to be active.

Changes in Attitudes: With people’s motivation, confidence, social norms and positivity towards physical activity.

Activating the framework

However, to really empower this collective effort the mandate of key structures and organisations is important. Positioning this framework effectively and gaining appropriate endorsements of the public, voluntary and private sector – will assist in delivering the Ambitions.

Truly activating the ambition within this framework requires a ‘movement of many’ - of individuals, organisations, networks and systems. There are many people with the energy and passion to make a difference and it will be through these efforts that this Strategy will succeed. This doesn’t require ‘governing’ or ‘overseeing’ in any formal sense.

‘A movement of many’

Getting Involved

Activating the framework requires the collective efforts of the many. Only by combining a multitude of major and minor actions will we create the ‘movement’ necessary to achieve the Ambition. Everyone and every organisation can play their part in some way.....

- Find the time in the day to be active yourself.
- Encourage others around you – family, colleagues, customers and partners to do the same.
- Read this framework (you’ve done that if you’ve reached this far!) and start thinking about the ways you, or your organisation can ‘plug in’.
- Tell others about the framework, persuade them that they can be a part of the movement too.
- Take part in the Activation Sessions - bring your energy and your ideas.
- Think about how your own organisation’s delivery can shift to align even better with the ambitions.
- Share your learning and your stories.
- Help to grow the movement by promoting #movenorthamptonshire

West Northamptonshire Health and Wellbeing Board

28th September 2023

Report Title	**Joint Health and Wellbeing Strategy**
Report Author	**Sally Burns, Director of Public Health, West Northants Council**

List of Appendices

Appendix A – Joint Health and Wellbeing Strategy

1. Purpose of Report

1.1 This report presents the final draft West Northamptonshire Local Health and Wellbeing Strategy to Board members for endorsement and support.

2. Executive Summary

2.1 The Health and Care Act 2022 requires all Health and Wellbeing Boards to develop and deliver a Joint Local Health and Wellbeing Strategy. This strategy will complement and contribute to the system wide strategy, 'Integrated Care Northamptonshire' – Live Your Best Life, which was adopted by the Integrated Care Board in December 2022.

2.2 The Draft Strategy has been developed over the last year, with progress updates reported to the Board on 23 March and 25 May 2023 particularly focused on local engagement gathered to inform the strategy and priorities against the 10 Live Your Best Life ambitions.

2.3 Following endorsement by the Board on the 27th July the draft strategy went for wider formal public consultation including the key priority outcomes to jointly deliver and focus its ambition to ensure local people Live Their Best Life.

3. Recommendations

3.1 It is recommended that the Board approve the Draft West Northamptonshire Joint Local Health and Wellbeing Strategy.

4. Reason for Recommendations

4.1 Delivery of the Strategy underpins the Board's wellbeing responsibilities as set out in the Care Act 2014

4.3 The Draft West Northamptonshire Joint Local Health and Wellbeing Strategy is aligned to the Corporate Plan and associated strategies.

5. Report Background

5.1 The Health and Care Act 2022 changed the leadership architecture around the Health and Care system. An Integrated Care Board and Partnership was established in Northamptonshire including membership from West and North Northamptonshire Councils and other key system partners.

5.2 Health and Wellbeing Boards continue to be responsible for assessing the health and wellbeing needs of their population and publishing a Joint Strategic Needs Assessment and a Joint Local Health and Wellbeing Strategy.

5.3 The Draft West Northamptonshire Local Health and Wellbeing Strategy sets out the priorities for improving the health and wellbeing of West Northamptonshire, highlights how the identified needs will be addressed, including addressing health inequalities. The Strategy reflects the evidence of need and feedback from local people.

5.4 The Strategy will directly inform the development of joint commissioning arrangements (see Section 75 of the National Health Service Act 2006) in West Northamptonshire and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans.

5.5 Work on the development of the draft strategy started in January working closely with system wide colleagues and extensive engagement with stakeholders and local people.

6. Next Steps

6.1 Work is also underway to embed the agreed high level outcomes framework and progress the delivery plans for each of the ambitions in the Strategy.

6.2 A Local Area Partnership engagement plan is being developed to facilitate community feedback alongside updated evidence from the Joint Strategic Needs Assessment enabling it to be reviewed and updated as necessary.

7. Implications

7.1 Resources and Financial

7.1.1 There are no immediate financial implications as a result of this report but the strategy sets out the priorities for the Health and Wellbeing Board and therefore it is anticipated that all organisations support, align and focus their resources towards these priorities.

7.2 Legal

7.2.1 Health and Wellbeing Boards have a statutory responsibility for assessing the health and wellbeing needs of their population and publishing a joint Strategic Needs Assessment and a Joint Local Health and Wellbeing Strategy. The draft strategy sets out the priorities for improving the health and wellbeing of West Northamptonshire

7.3 Risk

7.3.1 Work is underway to produce delivery plans behind each of the ambitions in the health and Wellbeing Strategy, this includes risk identification and risk management.

7.4 Consultation and Communications

7.4.1 Extensive consultation has taken place so far with partners, stakeholders and with communities. Further wider consultation is planned and the delivery approach is based on consultation and co-production.

7.5 Consideration by Overview and Scrutiny

7.5.1 The strategy has not been considered by overview and scrutiny however there have been three all member workshops so far as part of the progression of this work.

7.6 Climate Impact

7.6.1 There are positive implications and the impact of climate change and adaptation to climate change clearly has important implications for the health and wellbeing of our residents. Through the delivery of the strategy we will have a positive impact.

7.7 Community Impact

7.7.1 The Local Area Partnership and place delivery model which underpins the draft Joint Health and Wellbeing Strategy will help focus on reducing health inequalities across both geographical communities and communities of interest.

8. Background Papers

8.1

a) West Northamptonshire Health and Wellbeing Strategy Engagement overview

b) Northamptonshire Joint Strategic Needs Assessment Refresh

Joint Strategic Needs Assessment (JSNA) | West Northamptonshire Council (westnorthants.gov.uk)

c) Integrated Care Northamptonshire Strategy

Integrated Care Northamptonshire Strategy (icnorthamptonshire.org.uk)

d) Five Year Forward View Strategy

NHS Northamptonshire Integrated Care Board Five-Year Joint Forward Plan (icnorthamptonshire.org.uk)

DRAFT

Joint Local Health and Wellbeing Strategy

2023-2028

Please note, this is a draft version subject to consultation feedback, final proofing and accessibility checks

DRAFT

Contents

Summary of our strategy

Our shared vision

We want to work better together to create a place where people are active, confident and enjoy good health and wellbeing. A West Northamptonshire where people can see and feel a bright future for quality support and services when they need help.

Across the life course we are committed to

Starting Well

Living Well

Ageing Well

Our approach

1. Prevention as a priority
2. Tackling health and wellbeing inequalities
3. The importance of 'Place' and delivery through our Local Area Partnerships and Local Area Forums
4. An evidence-based and community insight led approach
5. Co-production

Summary of our strategy

Ambition	Key outcomes	Available system priority metrics
Best start in life	Women are healthy and well during and after pregnancy. Children are healthy from birth. All children grow and develop well so they are ready and equipped to start school. Children in care are healthy, well and ready for adulthood.	% achieving good level of development at age 2-3
Access to best education and learning	Children and young people perform well at all key stages. SEND education meets the needs of children locally. Schools serve all children and young people well and nobody misses out on learning. Adults have access to learning opportunities which supports employment and life skills.	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	Adults are healthy and active, and enjoy good mental health. People experience less ill-health and disability due to lung and heart diseases.	9% of adults currently smoke' (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps you and your families out of poverty	More adults are employed and receive a 'living wage'. Adults and families take up benefits they are entitled to.	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Good access to affordable, safe, quality, accommodation and security of tenure. The local environment is clean and green with lower carbon emissions.	Number of households owed a prevention duty under Homelessness Reduction Act
Safe in your homes and when out and about	People are safe in their homes, on public transport and in public places. Children and young people are safe and protected from harm.	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to families and friends	People feel well connected to family, friends and their community. Connections are helped by public transport and technology. Improving outcomes for those who are socially excluded.	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Homeless people and ex-offenders are helped back into society. People have good access to support for addictive behaviour and take it up.	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	Timely access to all health and social care services when they need across life course from conception to end of life. People are supported to live at places of their residence and only spend time in hospital to meet medical needs. Services to prevent illness (all health screening and vaccinations) are easy to access with quality service provision. People are treated with dignity and respect in all care provisions including end of life.	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible adults with learning disability/ severe mental illness receive annual health check
To be accepted and valued simply for who you are	Diversity is respected and celebrated. People feel they are a valued part of their community and are not isolated or lonely. People are treated with dignity and respect.	Metrics to be developed

Foreword

I am delighted to introduce the West Northamptonshire Joint Local Health and Wellbeing Strategy for 2023 to 2028. This challenging new plan sets out how, in West Northamptonshire, we will work together as a partnership and with residents to improve health outcomes for local people.

We do this at a time of significant pressures on public services post pandemic, and on people nationally due to unprecedented cost of living challenges, exacerbated by the conflict in Ukraine and the impact of climate change.

In 2022 changes to the health system architecture and leadership led to the development of 'Integrated Care Northamptonshire' a system wide strategy for the county and a fundamental shift in health and care organisation.

An Integrated Care Board (ICB) replaced the former Clinical Commissioning Group and both West and North Northamptonshire Councils are key partners on this board alongside local healthcare leaders. 'Integrated Care Northamptonshire' has been developed around 10 ambitions, to enable people living and working in the area to Live Their Best Life.

The West Northamptonshire Health and Wellbeing Board will play a significant role in the delivery of 'Integrated Care Northamptonshire' over the next 5 years. These ambitions are the starting point for us as we shape our own Joint Local Health and Wellbeing Strategy (JLHWS).

This document explains how the Health and Wellbeing Board intends to play its part to improve the health and wellbeing of people living in West Northamptonshire; and how we will do this by engaging and enabling our local communities through a 'place' based approach.

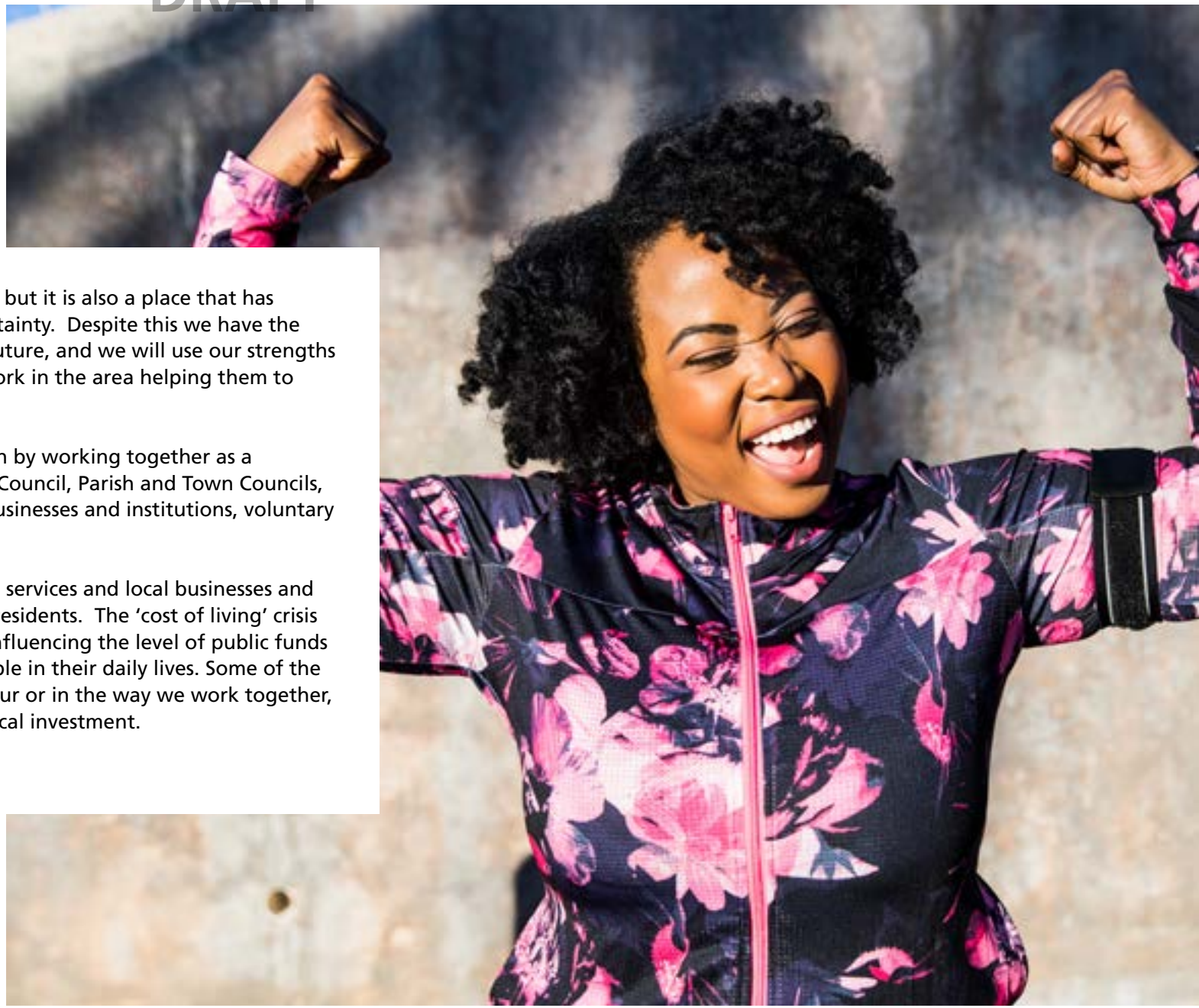
This is our health and wellbeing commitment to the people of West Northamptonshire for the next five years. We will regularly review and report back on our progress and develop an open two-way dialogue with our local communities to ensure we deliver what is important to residents. It is intentionally ambitious to ensure we can turn the tide of growing demand on health and care services enabling them to have the space to improve.

Our starting point is prevention, through education and by empowering local people to take responsibility for their own good health and wellbeing. To achieve this, we are committed to tackling health inequalities in some of our communities.

Our mission is to ensure the people of West Northamptonshire are supported and able to live their best life. I hope you agree that this exciting strategy will help us get there.

Cllr Matt Golby,
Cabinet Member for Adult Social Care and Public Health

Introduction



West Northamptonshire is a great place to live but it is also a place that has challenges and like all areas, faces some uncertainty. Despite this we have the opportunity and potential to create a bright future, and we will use our strengths to improve the lives of people who live and work in the area helping them to 'Live their Best Life'.

We can shape our own journey and destination by working together as a partnership between West Northamptonshire Council, Parish and Town Councils, NHS, primary care, emergency services, local businesses and institutions, voluntary sector and our community partners.

The pandemic put an enormous pressure upon services and local businesses and has left a challenging personal legacy for our residents. The 'cost of living' crisis adds to this challenge nationally and locally; influencing the level of public funds available and the pressures faced by local people in their daily lives. Some of the challenges we face require changes in behaviour or in the way we work together, some will require considerable national and local investment.

Our shared vision

Together, with our partners, we share a vision for health and wellbeing:

We want to work better together to create a place where people are active, confident and enjoy good health and wellbeing. A West Northamptonshire where people can see and feel a bright future for themselves and their families, take personal responsibility for their own health, but can reach out to quality support and services when they need help.

Through Integrated Care Northamptonshire we have agreed 10 challenging ambitions to enable local people to Live Their Best Life. Our West Northamptonshire Joint Health and Wellbeing Strategy brings vision this to life at a place level.

Many of these ambitions require us to address the wider determinants of health and this is where all partner organisations in West Northamptonshire can add the greatest value.

Our 10 ambitions reflect what local people need to have or be to help them Live their Best Life.

These are:

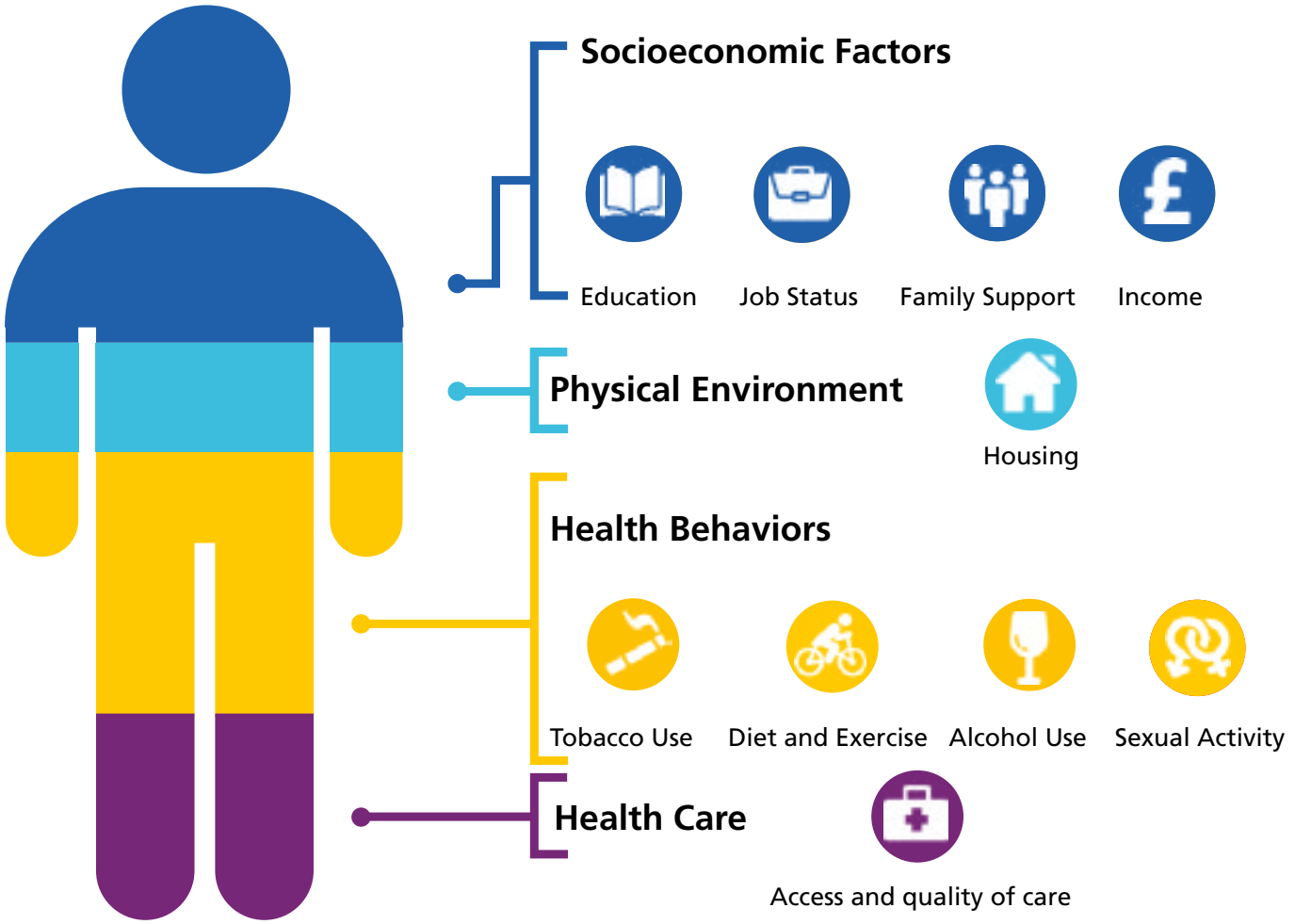
- The best start in life
- Access to the best available education and learning
- Opportunity to be fit, well and independent
- Employment that keeps you and your family out of poverty
- Good housing in places which are clean and green
- Safe in your homes and when out and about
- Connected to friends and family
- The chance of a fresh start when things go wrong
- Access to health and social care when they need it
- Accepted and valued for who you are

Our understanding of what makes us healthy and happy

Impacts of the wider determinants of health - Robert Wood Johnson model

Health and wellbeing is a complex interaction between individual behaviours (such as lifestyle including smoking, diet and exercise, alcohol use and sexual activity), social and economic factors (such as education, job status, family support, income), the physical environment (where we live) and access to quality healthcare.

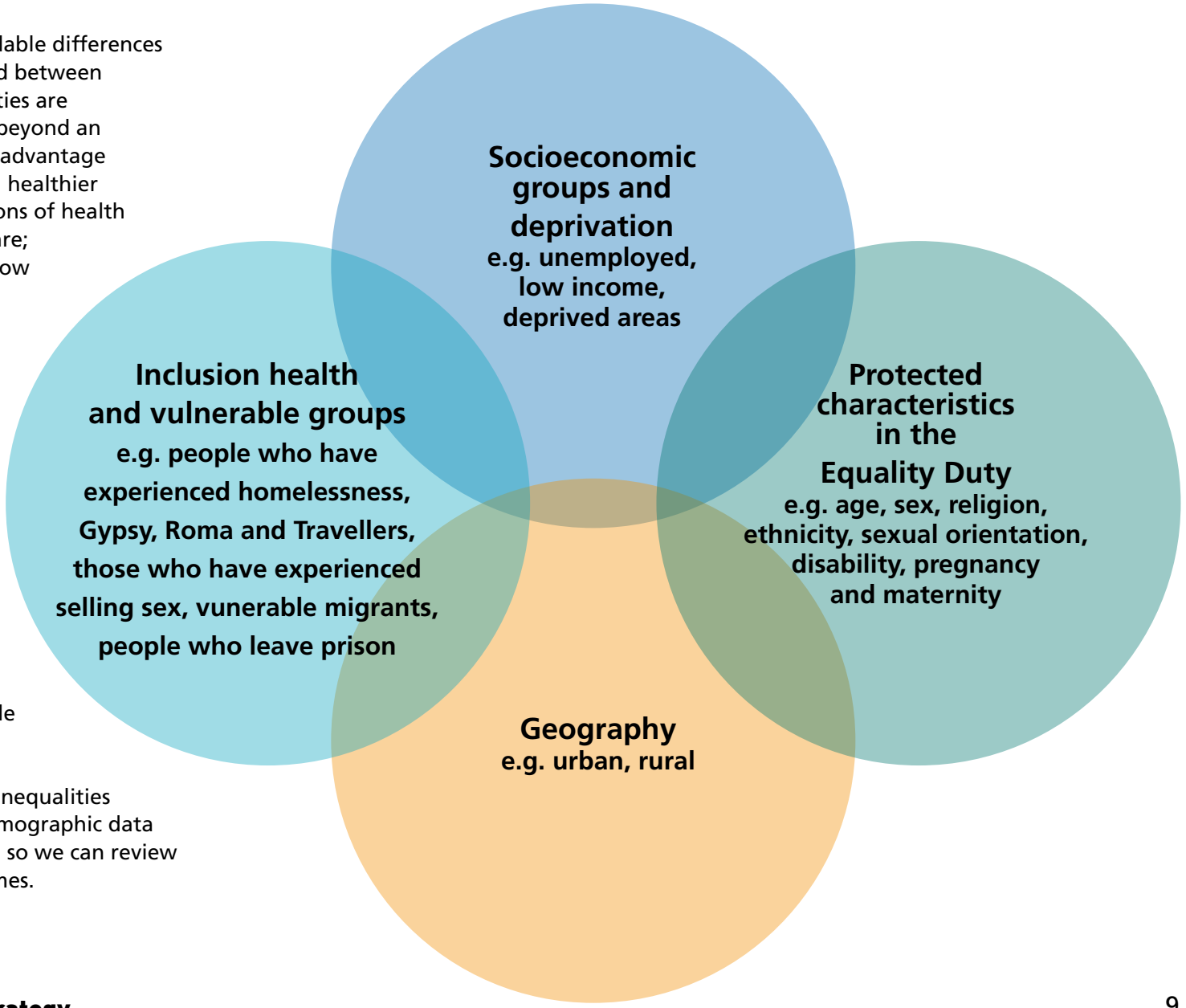
The diagram shows that the physical environment contributes to 10% of health outcomes; healthcare contributes to 20%; health behaviours 30% and social and economic factors 40%. Therefore, a holistic approach to health and wellbeing is needed, which takes all of these characteristics into account and encourages people to take charge of their own health and wellbeing. If we focus solely on healthcare it will not address all health problems, and we need to work together as a system to address all of these factors, with a greater focus on the wider determinants of health, because health starts long before illness, it starts in our homes, schools and jobs.



Drivers of inequalities

The overlapping dimensions of health inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Health inequalities are determined by social circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives. The Venn diagram shows the dimensions of health inequalities and how these overlap. These are; socioeconomic groups and deprivation i.e. low income / unemployment, people living in deprived areas; protected characteristics in the Equality Duty such as age, sex, ethnicity; geography i.e. urban / rural; and inclusion health and vulnerable groups such as people experiencing homelessness, those who have experienced selling sex. Many people fall into more than one of these groups and experience multiple disadvantage. Inequalities can lead to marginalisation of individuals and groups, who experience discrimination, barriers to accessing services, as well as worse outcomes and experiences of services. Providing universal services with targeted support for vulnerable groups is effective at reaching all of those that need them by ensuring that there are fewer or no barriers. To better understand inequalities all services need to commit to collecting demographic data (as a minimum postcode, age and ethnicity) so we can review inequities in access, experiences and outcomes.



Key factors for health and happiness

There are a number of key factors that impact on a persons health and happiness as highlighted by Marmot and recognised in the 10 keys to happiness below. These are:

Giving
Do kind things for others

Relating
Connect with people

Exercising
Take care of your body

Awareness
Live life mindfully

Trying out
Keep learning new things

Direction
Have goals to look forward to

Resilience
Find ways to bounce back

Emotions
Look for what's good

Acceptance
Be comfortable with who you are

Meaning
Be part of something bigger

Credit source: Action for happiness (www.actionforhappiness.org)

Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. Available from: www.gov.uk/research-for-development-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-healthinequalities-in-england-post-2010

Our current position in West Northamptonshire

The diagram (right) explains the population of West Northamptonshire and highlights a number of key statistics, including 6,600 households are considered overcrowded in terms of bedrooms, 11,3000 are lone parents with dependent children, 81.7% are in employment and nearly 101,000 of our residents are aged between 0 to19.

Key health challenges that we face

- Our key health challenges are informed by our joint strategic needs assessment (JSNA) and supporting themed fact sheets. www.westnorthants.gov.uk/health-and-wellbeing-board
- Social determinants and poverty set a pattern of poor lifestyle behaviours that compound poor health.
- We must take a preventative approach to poor health and tackle the social determinants whilst supporting people to have positive behaviours.

Nearly **72,700** residents are aged **65** and over

Nearly 9,000 are aged 85 and over

2.7%
Aged 16 and over are LBGT+

29.4%
are not White British

81.7%
In Employment

14,400
students are taught on UoN campus in Northampton with 6,100 taught off-campus.

101,000
residents are aged 0-19 (23.7%)

Over 25,000
state their life is limited a lot by a long term physical or mental health condition or illness

Over **9,000** people provide over 50hrs unpaid care per week

425,725
people live in West Northamptonshire

13.5% increase in a decade

… they mostly live within

172,643
households

… while **6,500** people live in communal establishments

Nearly **5,000** households are deprived in 3 or 4 of the Census deprivation dimensions

6,600 households are considered overcrowded in term of bedrooms

11,300 are lone parent households with dependent children

Health and Wellbeing in West Northamptonshire

This page sets out the challenges residents face through their lives. The symbols in red show where West Northamptonshire is performing worse than the England average. If we look into the data further to look at outcomes for different communities (both geographic and communities of interest) it will show that there are inequalities in these outcomes, with people from some communities experiencing a higher number of worse outcomes. We will use this data and insight to target our activities to address inequalities.

Start Well

- 4,647 babies were born in 2021.
- 12.3% of mothers smoked at the time of birth in 2020/21. This is worse than the England average.
- The population of West Northamptonshire was 425,700 in 2021.
- 72% of children achieved a good level of development at the end of reception class in 2019.
- 14% of children aged under 16 lived-in low-income families in 2020/21. This is better than the England average.
- 21% of children in reception class were overweight or obese in 2019/20. This is better than the England average.*
- 30% of children in Year 6 were overweight or obese in 2019/20. This is better than the England average.*
- 73% of young people gained a standard pass (4) in English and Maths GCSEs in 2021.
- The Chlamydia detection rate was 1,417 per 100,000 in 15- to 24-year-olds in 2020 This is below the national target range.
- There were 10 pregnancies in females aged under 18 per 1,000 girls aged 15 to 17, in 2020. This is lower than the England average.

Live Well

- A 2018 based projection estimated there were 170,103 households in West Northamptonshire in 2021.
- The average salary (persons) in 2020 was £32,467. This was an increase of 2% compared to 2019.
- 78% of adults were employed in 2020/21. This is similar to the England average.
- 9% of households experienced fuel poverty in 2018.
- There were 374 new sexually transmitted infections per 100,000 population in 2020. This is lower than the England average.
- 63% of adults were physically active in 2020/21. This is worse than the England average.
- 52% of the population aged 16+ ate their "5-a-day" in 2019/20. This is worse than the England average.
- 69% of adults were overweight or obese in 2020/21. This is worse than the England average.
- There were 467 alcohol related hospital admissions per 100,000 population in 2020/21. This is similar to the England average.
- 15% of adults smoked in 2019. This is similar to the England average.
- There were 8 suicides per 100,000 population in 2018-2020. This is lower than the England average.
- There were 297 hospital admissions for self-harm per 100,000 population in 2020/21. This is worse than the England average.
- There were 3 deaths from drug misuse per 100,000 population in 2018-2020. This is lower than the England average.
- 42 people were killed or seriously injured on roads per 100,000 population in the 2016-2018. This is similar to the England average.
- There were 26 deaths from preventable cardiovascular diseases per 100,000 population in 2017-2019. This is similar to the England average.
- There were 20 deaths in under 75s from preventable respiratory diseases per 100,000 population in 2017-2019. This is similar to the England average.
- There were 54 deaths from preventable cancers per 100,000 population in 2017-2019. This is similar to the England average.

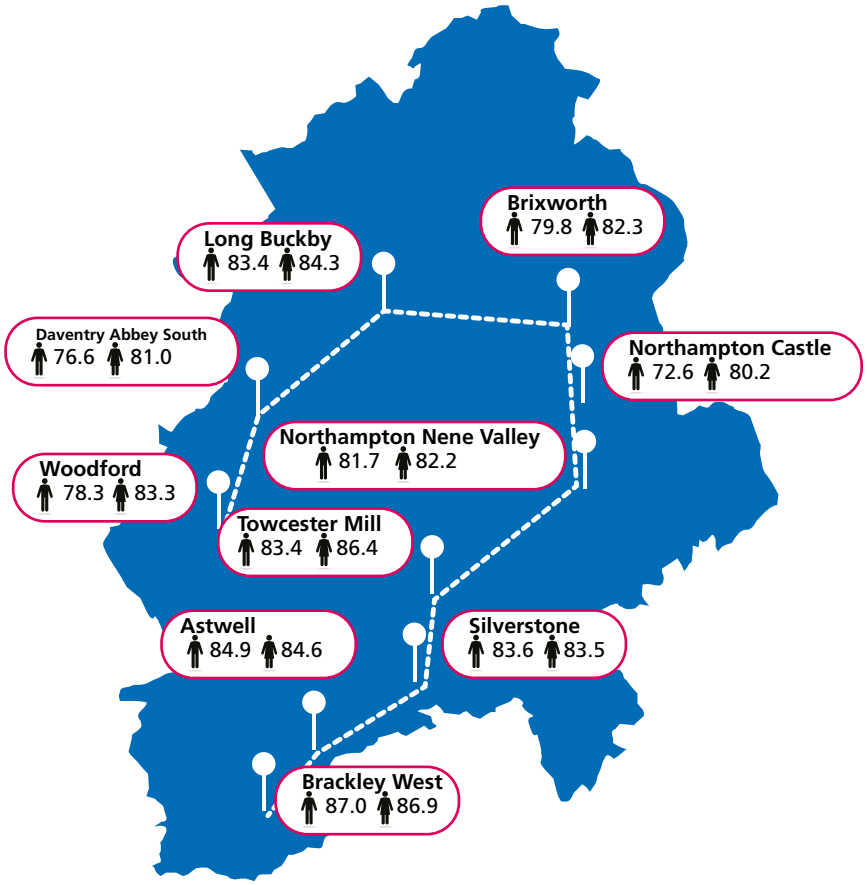
Age Well

- There were 2,727 hospital admissions due to falls in people aged 65+ per 100,000 65+ population in 2020/21. This is worse than the England average.
- The average male life expectancy was 79.8 in 2018-2020. This is better than the England average.
- The average female life expectancy was 82.8 in 2018-2020. This is worse than the England average.

better than England average | worse than England average | similar to England average | no comparison data available

* Please note that figures on childhood excess weight should be interpreted with caution due to low 2019/20 NCMP participation.

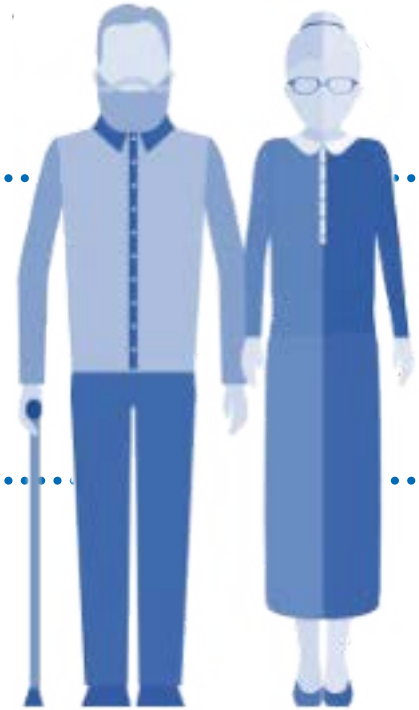
Life expectancy in West Northamptonshire



Following a 'bus route' in each unitary, demonstrates that communities that only live a few miles apart can have stark differences in life expectancy.

Average life expectancy at birth for men is 79.8

Men living in the more affluent 20% of the West can expect to live 9 years longer than those in the 20% most deprived areas



Average life expectancy at birth for women is 82.8

Women living in the more affluent 20% of the West can expect to live 8 years longer than those in the 20% most deprived areas

Healthy life expectancy (the average number of years a person would expect to live in good health) for men and women in Northamptonshire ranges between 63 and 65 years of age meaning that most people will start their retirement with some degree of poor health.
Source Data : Fingertips 2018-2020

Our approach

Through our services and policies, we can make the greatest impact within the partnership by focussing our efforts on improving outcomes within the wider determinants of health including; housing, air quality, community cohesion and social improvements in places and communities which we live.

Five key approaches will shape our strategic health and wellbeing ambitions.

1 - Prevention as a priority

National and local resources to support health and wellbeing are critically stretched because of high demand often due to lifestyle and environmental pressures on people of all ages. Preventing poor health and wellbeing is more important than ever.

Local data suggests that there is more we can do on prevention in West Northamptonshire – supporting people to make good lifestyle choices, picking problems up earlier and creating local environmental conditions that support good health; thereby taking pressure off primary and acute services.

Generally, people want to be in control of their lives and not rely on services to put things right. We will support them by providing help in preventing health problems and enabling people to manage their lives in a way that can lead to a happy, healthier future. We are also committed to ensuring local communities are great places to live with a culture of wellbeing.

The Health and Wellbeing Board is well placed to support preventative interventions through; housing and environment, children's and adults, leisure and cultural services, highways and footways and community safety.

Our approach

2 -Tackling health and wellbeing inequalities

We recognise that there are people in our communities who experience greater health and care challenges or are not always visible to the services that can support them.

Health inequalities are preventable, unfair, and unjust differences in health between groups, populations, or individuals. These arise from unequal social, economic, and environmental conditions which in turn, can determine the risk of people getting ill, their ability to prevent sickness, or their chance to get treatment when health or care needs occur.

In short, inequalities mean that some people do not have the same chances to be healthy. The disproportionate impact of COVID further highlighted long-standing health inequalities on different groups and communities particularly highlighting ethnic inequalities.

We know from data and feedback where these inequalities occur locally and through this strategy, we will target those most in need or seldom heard. In everything that we do we will ensure that we collect the right data to understand where the inequalities are and target services to better meet those needs.

The Integrated Care Northamptonshire Health Inequalities Plan describes how we will work with communities so that everyone has the chance to thrive and to access quality services providing excellent experiences and the best outcomes for all. The Joint Health and Wellbeing Strategy will adopt the principles of the Health Inequalities Plan to enable us to achieve this aim.

To read the full ICN Health Inequalities plan follow the link below:
Northamptonshire Health Inequalities Plan 2022/23-2025/26 (icnorthamptonshire.org.uk)

Our approach

3-The importance of 'place' and local assets

We need to take very local action to address specific problems in some communities that prevent good health and wellbeing. To do this we need to work side by side with local people and community leaders. Our place model for West Northamptonshire includes the development of nine Local Area Partnerships (LAPs) supported by two Health and Wellbeing Forums.

The model is reliant on all partners working together to identify local priorities, improve outcomes and reduce inequalities for residents and their communities.

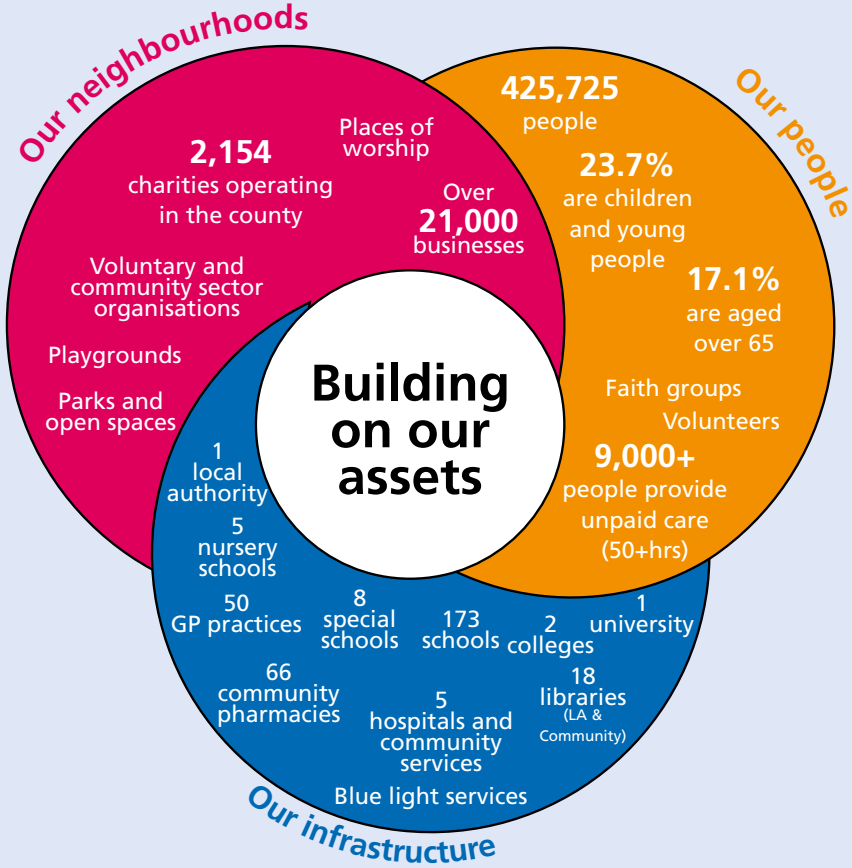
The initial functions of the Local Area Partnerships are to:

- represent local areas and give a voice to residents, translating strategy into local action
- empower residents to co-produce new services and solutions locally with partners
- contribute to system-wide priorities by utilising evidence-based information and local insight from frontline services and communities
- empower local leaders to take accountability for local action.

Each Local Area Partnership has a core membership that brings together leaders who work closely within their community and understand the local landscape.

For more information about the Place delivery structures including our Health and Wellbeing Forums and the LAPs please see www.westnorthants.gov.uk/health-and-wellbeing-board.

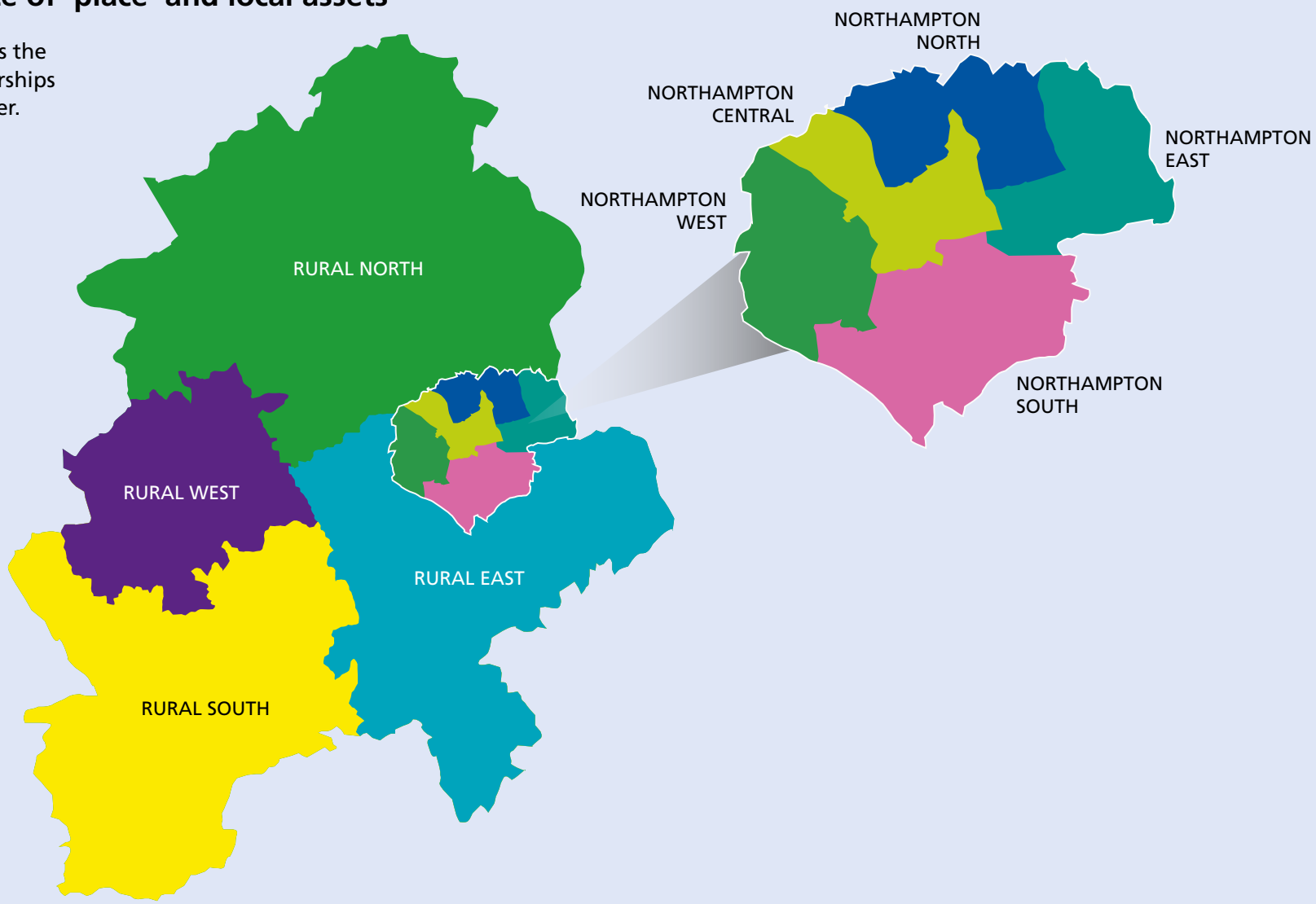
As shown in the diagram (below), our assets are made up of our neighbourhoods, people and infrastructure. For example our neighbourhoods include places of worship, charities, voluntary and community sector organisations and playgrounds to name a few. Our people show the number of people living in West Northants and the population of children, young people, over 65's and those providing unpaid care. Our infrastructure highlights our GP practices, libraries, schools and anchor institutions as assets that can create a positive impact on our local area through working in partnership and offering targeted opportunities.



Our approach

3-The importance of 'place' and local assets

The map (below) shows the nine Local Area Partnerships and the areas they cover.



Our approach

4 - An evidence-based and community insight led approach

The Joint Strategic Needs Assessment (JSNA) is a summary of data related to health and wellbeing across Northamptonshire that provides a view of local health and wellbeing information alongside national data. This data informs our priorities and performance focus. We have used this valuable resource to shape our priorities, identify where we need to improve and allocate our resources.

Enriching that knowledge, we have also taken on board insights from our local communities. These may be geographic communities a defined local area, for example a Local Area Partnership or Parish, or communities of interest. It can also be a cross cutting community, for example young people across West Northamptonshire. Insight from across our area has already been built into the development of this strategy and we will continue to work in this way to support its further development. We are particularly keen to build on our Well Northants asset-based model of community engagement.

The West Northamptonshire Health and Wellbeing Board values this insight from local people and has listened to a wide range of local voices including our community forums in developing this strategy. There were many common themes which have helped us to focus on what matters most locally. We will continue to listen to local voices as we roll out delivery plans and fine tune our priorities.

5- Co-production

Passion for the place, experience, assets, and skills are abundant in our local communities. This is often an untapped resource when designing and commissioning services locally. Our fantastic community and voluntary sector are a critical part of our co -production and are our secret weapon locally. Co-production is a way of working were service providers and service users work together to reach a shared outcome. This approach is value driven and built on the principle that those who are affected by a service are best placed to help design it. It contributes to a sense of shared identity and purpose locally. The 'Place' approach outlined above creates the right environment for this to work well; and local insight sets the context for the creative development of services designed together.

Our ten ambitions set out to support residents in West Northampton to 'Live Your Best Life'

Each ambition has a set of metrics that have been agreed by the Integrated Care Northamptonshire Partnership as metrics we as a county will be working together to improve. The Health and Wellbeing Board will use these metrics to monitor our progress and are essential in ensuring that we are moving forward and delivering the ten 'Live Your Best Life' ambitions. Alongside this, we will create a detailed delivery plan for each ambition and performance metrics that we will monitor as part of the delivery of this strategy.

Ambition
The best start in life
Access to the best available education and learning
Opportunities to be fit well and independent
Employment that keeps you and your family out of poverty
Good housing in places which are clean and green
Safe in your homes and when out and about
Connected to friends and family
The chance for a fresh start when things go wrong
Access to health and social care
Accepted and valued for who you are

DRAFT

Ambition 1 - The best start in life

Introduction

In West Northamptonshire we are committed to give children the best start in life to grow happy and healthy, flourish and succeed in life. With the current cost of living crisis long lasting impacts of the COVID-19 pandemic, children and families are facing huge challenges to receive the support they need when they need it, leading us to pick up issues at crisis point. We want to ensure we develop an integrated support offer for families and children to meet their needs at the earliest point of identification, and enable them to access local, timely and welcoming services to prevent problems from escalating. We want to ensure we give children the best start for life to flourish and live a healthy adulthood.

Where we are now

- Risks of birth complications and poor health in new-born children is higher than it ought to be due to high levels of smoking and obesity in pregnancy.
- Children in care in Northamptonshire have poorer access to regular health and dental checks than other areas.
- Not enough children are starting school with the skills they need to succeed.
- There is a lack of youth provision for young people.
- Too many young people have poor mental wellbeing and this is increasing.
- The severity of poor mental health in adolescence is also increasing resulting in high rates of admission to hospital for self-harm and eating disorders.

What you have told us

- The community want locally based support services for families and young people.
- The community would like a 'drop in' service with tailored support for young parents.
- We want more support for children with special needs and their parents.

What is the inequalities focus

We need to focus on children and families in the 20% most deprived areas, families from ethnic minorities, children in care, young parents, children with special needs and children with long term conditions.

What we want to achieve

- Women are healthy and well during and after pregnancy.
- Children are healthy from birth.
- All children grow and develop well so they are ready and equipped to start school.
- Children in care are healthy, well and ready for adulthood.

How we will achieve our ambition

- We will develop a supportive, integrated and consistent offer to support women from pre-pregnancy stage to postnatal stage by working with the Local Maternity System prevention group and wider partners across the system.
- We will work to increase the uptake of free early education entitlement for all three and four years old. We will work with the 0-19 service to increase the integrated aged 2-2.5 reviews and expand the universal and targeted support for parents to ensure that all children are ready to start school and able to flourish and live a healthy adulthood.
- We will develop an early help universal offer to support families in need at the earliest point of identification and to prevent issues from reaching crisis point.
- We will develop the family hubs programme building on existing services and community assets and strengthen integrated services across local authority, Northamptonshire Integrated Care Board, Children Trust, and the voluntary community sector to improve outcomes for children and young people across West Northants.
- We will increase access to specialist care and support services for at risk children and their parents.

Ambition 2 - Access to the best available education and learning

Introduction

In West Northamptonshire we are committed to giving all children access to the best education and learning. We want all children to attend safe, inclusive and aspirational schools, settings and providers. We want to all educational establishments to be at least 'Good' in all areas and to deliver an innovative, carefully planned curriculum that promotes personal development and provides a high quality, inclusive and diverse education.

We will work together to provide a robust multi-agency approach to support all children and young people to have access to the best educational provision, which meets their needs and enables them to thrive and fulfil their potential. Our aim is to ensure that we provide an appropriate, high quality, sustainable Education service. In doing so, we will improve life chances of all children and young people and enable them to flourish into adulthood as valued citizens.

Where we are now

- 91% of primary schools are good and outstanding
- 82% of our secondary schools are good and outstanding
- Our school attendance across is 92.5%
- 5,569 incidents of suspension linked or related to 2005 pupils, and 93 permanent exclusions in 22/23
- 63% of eligible 2 year olds access free education and childcare for 2-year-olds
- 60% of 3 and 4 year olds access the free universal funded early education entitlement
- 53% of eligible 3 and 4 year olds currently accessing the universal entitlement,

We know there is limited access to activities for young people outside of school

What you have told us

- Schools and other settings need to be more inclusive.
- Children and young people need 'safe spaces' outside of school.
- More support for children with special needs and their parents is needed.

What is the inequalities focus

We need to focus on children and families in the 20% most deprived areas, families from ethnic minorities, children in care, children with special needs and children who are vulnerable or those who are disadvantaged.

What we want to achieve

- Children and young people perform well at all key stages.
- SEND education meets the needs of children locally.
- Schools serve all children and young people well and nobody misses out on learning.
- Adults have access to learning opportunities which supports employment and life skills.

How we will achieve our ambition

- We will ensure all families have access to the best education and can access educational settings to meet their children's needs.
- We will ensure that all children, including those with SEND or vulnerabilities are able to develop resilience and independence.
- We will work to Increase the uptake of free early education entitlement for all two, three and four years old.
- We will work with all education partners to identify children at risk of exclusion, and develop packages of support to enable children to remain in appropriate education settings.
- We will work with all education partners to provide sufficient education places to meet need of all children, including those with SEND.
- We will develop a West Northants youth offer to provide children with safe spaces out of school.

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Ambition 3 - Opportunities to be fit well and independent

Introduction

The ability of our residents to live well, be fit and independent is hugely shaped by the circumstances in which they live their lives. To enable residents to live healthy lives, prevent ill health and promote wellbeing, people need the right information, services and support, with targeted interventions for those who need it most.

By working together as a system, and taking a life course approach, we can make sure that local people in West Northamptonshire have the opportunities to be fit, well and independent.

Where we are now

- Over one in four adults in West Northants are classified as physically inactive, and almost two thirds are classified as overweight or obese.
- Smoking is the single greatest risk factor for death and disability in West Northants with 11.5% of adults being current smokers.
- West Northants has growing older population and with people living in poor health.
- There are high rates of respiratory, diabetes and cardiovascular disease conditions with higher rates of mortality.
- Admissions for self-harm is higher than the England average.

What you have told us

- Bring people together by offering local activities and events to support healthier lifestyles that are affordable.
- The opportunity to receive care in our own homes to support independence is something that is important to us.
- We would like to see better communication, so we can stay informed and up to date on what is going on, as well as having a clear understanding of where to go for support.

What is the inequalities focus

- We know that people from certain communities are more at risk of poorer health, exposed to risk factors, and may not access services to improve their health and wellbeing.
- We need to make sure all of our services take into account needs of different communities and target them to ensure good uptake, experiences and outcomes. In particular, we will focus on supporting people living in areas of deprivation, people from ethnic minorities and marginalised groups.

What we want to achieve

- Adults are healthy and active, and enjoy good mental health.
- People experience less ill-health and disability due to lung and heart diseases.

How we will achieve our ambition

- We are developing a more joined up approach to the way we deliver services to support people to live healthy lives and improve their physical and mental health – taking an asset based community development approach to better understand communities and develop targeted offers to within local communities.
- We will support people as they age to stay well for longer, by working with individuals and communities to understand their concerns, and using the best available evidence to enable them to stay active and healthy.
- Through the Mental Health and Learning Disability Collaborative, and the Mental Health Prevention Action Plan, we are working together across the system to promote emotional wellbeing and mental health.
- We will enhance opportunities for active travel through the development and implementation of the Council's new Local Transport Plan, due for adoption in 2024/25. Additionally, through the development of Local Cycling and Walking Infrastructure Plans across West Northamptonshire.

Ambition 4 - Employment that keeps you and your family out of poverty

Introduction

The causes and consequences of poverty are often complex. There is no single cause, but a range of factors contribute to people's risk of experiencing poverty. Over half of those living in poverty live in working households, where work does not provide enough income to meet basic needs or people fall into poverty due to circumstances beyond their control. Low pay and low wage growth is a key cause of poverty, and we have seen a significant rise in part-time contracts. There is still a strong association between unemployment and poverty. It is clear that our young people are particularly impacted

Where we are now

- We have relatively high rates of employment across the area as a whole but there are significant disparities at a more local level.
- There are large gaps in employment for vulnerable communities such as those with serious and enduring mental illness and those with learning disabilities.
- Cost of living crisis and resulting poverty having particular impact on health and wellbeing of residents. There are particular concerns regarding fuel and food costs.
- Many people and families are not claiming financial support they are eligible for.

What you have told us

- The community would like local outreach employment support services including skills training, financial and benefits advice, support for business start-ups and social enterprises.
- Increase the number of apprenticeships for residents of all ages.
- Improved rural transport is needed to support local working people to access jobs.

What is the inequalities focus

We need to address gaps in employment for vulnerable communities such as ethnic minorities, those with serious and enduring mental illness and learning disabilities, care leavers and those living in areas of deprivation.

What we want to achieve

- More adults are employed and receive a 'living wage'.
- Adults and families take up benefits they are entitled to.

How we will achieve our ambition

- We will continue to deliver the Anti-poverty Strategy and work on the sustainability of cost-of-living support.
- We will support the West Northants Sustainable Food Network to address food poverty.
- We will develop our financial information and advice offer, especially in considering the needs of under-served communities.
- We will work with education settings, employers and recruiters to ensure there are meaningful and sustainable employment opportunities with targeted hyper-local support for vulnerable groups and those in groups who are under-employed to access jobs and remain in employment.
- The Northamptonshire Anchor Institutions Network will support provision of inclusive employment opportunities, particularly with under-served groups such as care leavers.

Ambition 5 - Good housing in places which are clean and green

Introduction

A stable and secure home is one of the foundations of a good life. The condition and nature of homes, including factors such as stability, space, tenure and cost, can have a big impact on people's lives, influencing their wellbeing and health. A secure, comfortable home enriches our lives and supports our mental and physical health. But high costs and a shortage of affordable homes means many people have to live in poor, overcrowded conditions, fall into debt because costs are too high, move frequently, or may face repossessions or evictions. This all creates further instability and stress, with a significant impact on people's health and wellbeing.

As well as housing, the places we live can also impact physical and mental health. Having access to clean and green spaces is important for wellbeing and promoting a healthy life, as well as can enable people to build social connections.

Where we are now

- The population of West Northamptonshire has grown by over 13.5% in the last decade which represents among the highest growth in the country.
- During 2022/23, 2275 households were owed a homelessness prevention or relief duty by WNC under the Homelessness Reduction Act 2017
- While the area is largely green and rural, with much of land usage agricultural, access to green spaces for people who live in our urban centres requires improvement.
- Air quality in some areas of Northampton requires improvement.

What you have told us

- More affordable rental accommodation is needed that is well maintained by landlords.
- It's very important that the environment around housing is clean, green safe and well maintained.
- We need to tackle shortage of housing and enable all people to access good housing, and considering the need for car parking spaces, open spaces and recreational land.

What is the inequalities focus

- We need secure and safe access to accommodation for vulnerable groups including care leavers and migrants.
- We need to prevent homelessness.
- People living in areas of deprivation are particularly affected by a lack of access to quality green spaces and air pollution.

What we want to achieve

- Good access to affordable, safe, quality, accommodation and security of tenure.
- The local environment is clean and green with lower carbon emissions.

How we will achieve our ambition

- We will support the priorities of the Housing Partnership Board and contribute to the WNC Housing Strategy to; deliver homes people need and can afford, improve the quality, standard and safety of homes and housing services, support residents, and sustainable communities.
- Through our Parks Strategy, we will ensure our green spaces are equally accessible for all and provide the opportunity to participate in activities. Local Area Partnerships will enable us to develop community led approaches to improving our local environment.
- We will support the development and implementation of air quality action plans through a collaborative working group.
- As Anchor Institutions we will support the work of the Sustainability Local Innovation Partnership Agenda Hub (SLIPAH) and the commitments in the Northampton Sustainability Accord.

Ambition 6 - Safe in your homes and when out and about

Introduction

Feeling safe, whether at home, in the street or at work has an effect on quality of life and enabling people to pursue and obtain the fullest benefits from domestic, social and economic lives without fear or hindrance from crime and disorder. The factors that affect community safety include higher levels of deprivation, estate design which favours criminality and youth involvement in anti-social behaviour, drug criminality and violence. Involvement in drug criminality has been linked to missing persons, and children are often exploited, increasing the risk of serious or sexual violence against vulnerable persons. Women and girls do not feel safe on our streets as a result of sexual harassment, and misogyny has become more prevalent online, with websites and chatrooms encouraging sexual violence against women.

Where we are now

- The age of youths engaging in drug related violence/weapons and violence against women and girls (VAWG) criminality is decreasing and commonly commences from pre/ early teenager years.
- Those dependent on drugs are often closely associated to neighbourhood crime to fund their addictions. The Home Office estimates 50% of all neighbourhood crime is committed by drug users, mainly heroin and crack users.
- Drug criminality analysis indicated that around 30% of Northamptonshire acquisitive crime was committed by individuals associated with drugs.

What you have told us

The majority of worries and concerns are about; youth violence and drug dealing, anti-social behaviour and knife crime, road safety, home safety, burglary and theft, which means we are scared to go out at night or use certain areas.

What is the inequalities focus

- There is a clear link between deprivation and crime, with focus needed on high need areas.
- Particular groups disproportionally affected by crime, including women and girls and those who have experienced selling sex.
- We particularly want to focus on supporting young people who are more vulnerable to exploitation.

What we want to achieve

- People are safe in their homes, on public transport and in public places.
- Children and young people are safe and protected from harm.

How we will achieve our ambition

- We will increase partnership outreach, promoting wellbeing and safety in our communities focused on contextual safeguarding, working with schools and those who are most vulnerable.
- We will develop of collaborative programmes and pathways for support, training and education.
- We will work through the Local Area Partnerships to develop place-based community approaches to priority neighbourhoods and vulnerable locations to ensure people are safe.
- We will develop of environmental improvements at neighbourhood level that design out crime will be delivered through the safer streets programme.
- We will promote of Fire and Rescue service home safety checks, and use of online home hazard checklist to help prevent falls and other accidents.
- We will increase early intervention and youth provision offer to ensure young people are safe and protected from harm – establishing and working with the youth collaborative.
- We will support the work of Trading Standards in relation to scams, doorstep crime and rogue traders

Ambition 7 - Connected to families and friends

Introduction

The assets within communities, such as the skills and knowledge, social networks and community organisations, are building blocks for good health. Community life, social connections and having a voice in local decisions all underpin good health, however too many people experience the effects of exclusion or lack social support.

The internet and digital technology is at the heart now of how public, economic and social life functions. It has transformed how we work, communicate, consume, learn, entertain and access information and public services. However, the spread of access and use is uneven, and many people remain digitally excluded. Those who are excluded can be limited or unable to participate fully in society.

Where we are now

- Many of our neighbourhoods score poorly compared with the national average in measures of connectivity to key services, digital infrastructure and isolation.
- While lots of learning and positive action has been taken from the COVID-19 pandemic, social isolation remains an issue including for younger people in deprived urban centres.

What you have told us

- You would like to see better communication, so you stay informed and up to date on what is going on.
- Bring people together by offering local activities and events to support healthier lifestyles and to connect with others.
- People in rural communities can feel isolated and lack of community transport affects our ability to get out and about.

What is the inequalities focus

- Some groups experience social exclusion, such as those mental health conditions, Gypsy Roma Traveller community, people who are homeless, migrants, sex workers.
- Older people and people with disabilities.
- There is huge variation in digital exclusion across the county with high rates of exclusion both in our most deprived communities as well as less deprived rural communities.

What we want to achieve

- People feel well connected to family, friends and their community.
- Connections are helped by public transport and technology.
- Improving outcomes for those who are socially excluded.

How we will achieve our ambition

- We will work through our place approach to ensure the right services are in the right place and joined up to enable people to feel well connected to their communities taking into account the different needs of rural and urban places.
- We will communicate in a variety of ways to ensure communities are aware of what is happening in their local communities and how to access support.
- We will continue to develop our Welcoming Spaces Initiative and ensure delivery of sustainable wrap-around services in local trusted settings.
- We will continue to develop One Stop Shops in communities.
- We will support the development and implementation of the Council's new Local Transport Plan, due for adoption in 2024/25 to support connectedness across West Northamptonshire.
- The Integrated Care Northamptonshire Digital Transformation Strategy will enable us to join up health and social care services and provide more digital access, through the creation of the Northants Care Record and single digital front door.
- We will develop projects to improve access to digital technology and the skills to use it.

Ambition 8 - The chance for a fresh start when things go wrong

Introduction

As well as ensuring that, as far as is possible, we prevent "deep social exclusion" which includes combinations of homelessness, substance misuse, history of offending and 'street culture' activities (such as begging and street drinking). We also want to ensure that people who have these experiences have a "fresh start in life".

Our West Northamptonshire housing strategy commits to tackling homelessness and rough sleeping in a way that delivers positive long-term outcomes for each individual.

In addition to this, our county-wide Combating Drugs Partnership Strategic Plan recognises the strong connections between addressing aspects of social exclusion in order to improve chances of recovery. This means ensuring access to housing and employment opportunities for those trying to make a fresh start.

Where we are now

- Too many people in the county have experiences associated with 'deep social exclusion' – namely, homelessness, substance misuse, history of offending and 'street culture' activities (such as begging and street drinking).
- Too many preventable and early deaths happen due to drug and alcohol use or in people experiencing rough sleeping.

What you have told us

- Drugs dealers target young people in our area and it is worrying.
- People who have experienced homelessness or rough sleeping or who have been released from prison are helped back into society
- More investment in support services for those released from prison, for both physical and mental issues.
- Concern re increasing number of rough sleepers who are asylum seekers with no recourse to public funds.

What is the inequalities focus

- People who experience deep social exclusion are an inequalities group in and of themselves.
- Inequity of access to current services still requires further exploration but we believe affects those in rural communities, Ethnic minority groups communities and vulnerable women.

What we want to achieve

- Homeless people and ex-offenders are helped back into society.
- People have good access to support for addictive behaviour and take it up.

How we will achieve our ambition

- We will deliver a new homelessness and rough sleeping strategy by April 2024.
- We will increase numbers of people in drug and alcohol treatment services by improving service promotion, address gaps in geographical access, as well as access for under-served groups.
- We will Improve successful completion of treatment by improving treatment for co-existing mental ill health and substance use.
- We will increase the capacity and capability to respond to increasing complexity and Improving quality of care, including particularly for young adults, and transition to adult services, and older people.
- We will strengthen the harm reduction offer and improve quality of treatment by reviewing and learning from deaths.

Ambition 9 - Access to health and social care

Introduction

In West Northamptonshire we want to ensure our residents are able to access the most appropriate health and social care services to meet their needs. We know we need to work with our partners and communities to provide easy and timely access to all health services including primary, secondary and specialist care. As well as access to social care support in places of residence including care homes, nursing homes, specialist centres, or homes. We want our services to be of be good quality, to ensure all people have positive experiences and get the same outcomes, regardless of who they are.

Where we are now

- There is delay in access to health services for medical, surgical or mental health interventions.
- Demand of service provision is exceeding current capacity including primary care, accident and emergency, acute services and social care and people are not accessing the right services at the right time.
- Delays in access to health screening and vaccinations is creating delays in early detection and diagnosis of diseases and protecting less people from vaccine preventable illnesses.
- Access to primary care services such as GP, dentists, opticians, podiatry and pharmacy is a challenge, especially for those with learning disabilities due to changing consultation methods.
- There is an inadequate social care bed capacity for patients with changing mental health status.
- There is a delay in timely processing of discharge plans due to medically unfit people not being able to return to a suitable place of residence.

What you have told us

- Health care hubs needed in our local communities with walk-in access for a range of services all on one site.
- People with language or communication difficulties find accessing primary care services a challenge.
- Migrants with no access to public funds find it hard to register with a GP, so have to present in crisis to A&E
- More investment is needed in social care services
- The transition from Children and Adolescent Mental Health Services to adult mental health services is not good enough and causes delay in treatment and stress to the family.

What is the inequalities focus

- Reaching out to residents not accessing health and social care services through community outreach services.
- Improving accessibility to health and wider services for the vulnerable groups i.e., people from ethnic minority groups, people who have experienced homelessness or rough sleeping, people with experience of substance misuse, unregistered migrant workers, people with learning disabilities or mental health, carers and asylum seekers/ refugees, vulnerable women.

What we want to achieve

- Timely access to all health and social care services when they need across life course from conception to end of life.
- People are supported to live at places of their residence and only spend time in hospital to meet medical needs.
- Services to prevent illness (all health screening and vaccinations) easy to access with a quality service provision.
- People are treated with dignity and respect in all care provisions including end of life.

How we will achieve our ambition

- We will use health equity assessments to understand inequality and inequities in access, experience and outcomes and develop targeted programmes to address the gaps.
- We will take a collaborative approach to develop a consistent model of 'outreach' and 'in-reach' provision of services with a better mobilisation of resources to improve access.
- We will redesign existing care pathways by including additional provisions with the help of alternate providers to help deliver the services for people who need it closer to home with appropriate use of the better care fund plan.
- We will work collaboratively to support people to have timely access to services and triage people through appropriate pathways to overcome delays in health and social care support.
- We will work to take a collective system approach to resolve bed capacity issues for people with changing mental health status.

Ambition 10 - To be accepted and valued simply for who you are

Introduction

It is well known that people get a sense of belonging if they are part of a vibrant, welcoming community which can also provide support during difficult times. In West Northamptonshire we want to promote this sense of wellbeing in both rural and urban areas and across all ages and communities. We want everybody who lives in West Northamptonshire to feel valued, to celebrate diversity and the good things this brings to life in our area.

We will continue to work together and with our local communities to ensure living here is a great experience regardless of who you are and how you choose to live, what you believe or how you appear.

Promotion of understanding, tolerance and celebrating what we share, and our differences will support a happy, healthier Northamptonshire which in turn can set a great example to other parts of the country.

Where we are now

- The 2021 census showed an increase in the population in West Northamptonshire by 13.5% to 425,700 people - across all ages with growth greater than the England average 30.3% (20.1% in England).
- We are an increasingly diverse population with 24.9% identifying as non-White British an increase from 8.8% in 2001.

What you have told us

- We want more cultural events to support community cohesion.
- Welcome packs and newsletters at a community level would support community unity.
- We need more intergenerational activities locally to promote inclusivity.
- Some ethnic minority communities feel marginalised from representation in civil and public life .
- LGBTQ accessibility schemes should be promoted and LGBTQ community involved in shaping services.
- Ensure investment and resources are available in rural communities.
- Involve local communities in decision-making and service design.

What is the inequalities focus

- Seldom heard and ethnically diverse communities.
- Marginalised communities e.g. women/ those who have experienced selling sex, Gypsy, Roma and Travellers, People who have experienced homelessness or rough sleeping.
- People living in the most deprived areas.

What we want to achieve

- Diversity is respected and celebrated.
- People feel they are a valued part of their community and are not isolated or lonely.
- People are treated with dignity and respect.

How we will achieve our ambition

- We will take a community-based approach to shape the ambition and actions in partnership with identified groups and communities using the Well Northants asset-based community development model.
- We will acknowledge and challenge the impact of structural racism, or fear of it, on health equalities.
- We will ensure our extensive community engagement framework established is built on and maintained, and that it is reflective of our communities.
- We will implement equality standards and strategies across system organisations.
- We will ensure our extensive community engagement framework established is built on and maintained, and that it is reflective of our communities.
- We will increase access to activities and community events to develop inclusion and participation and celebrate diversity.

Our governance - making things happen

Leadership

Our Health and Wellbeing Board plays a key statutory role in facilitating joint working across the system and setting the strategic direction to improve local health and wellbeing in West Northamptonshire.

It provides a forum where political, clinical, professional and community leaders from across the system come together to improve the health and wellbeing of their local population and reduce health inequalities.

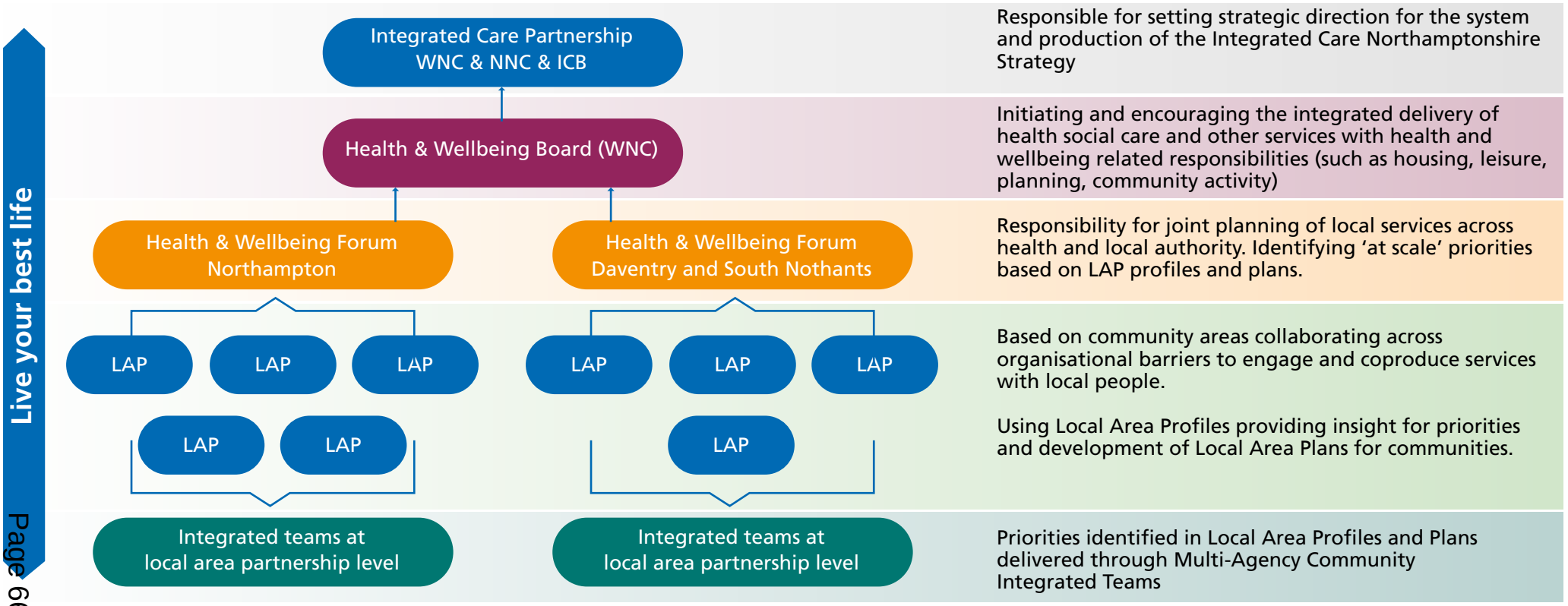
The strategy is strongly linked with many wider strategies and strategic delivery boards for example the Community Safety Partnership, Combatting Drugs Partnership and Housing Delivery Board to name a few.

Governance

A strong model of accountability is in place to ensure this strategy is driven forward and that performance against key outcomes is measured, monitored, and reported.

Reporting progress

It is the intention of the Health and Wellbeing Board to regularly review progress against the key outcomes in this strategy aligned to our 10 Live Your Best Life ambitions. We intend to share this progress with our communities in West Northamptonshire on a regular basis and if necessary, adjust our trajectory and resourcing.



Our performance framework

Ambition	Available system priority metrics
Best start in life	% achieving good level of development at age 2-3
Access to best education and learning	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	% of adults currently smoke (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps them and their families out of poverty	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Number of households owed a prevention duty under Homelessness Reduction Act
People feeling safe in their own homes and when out and about	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to their families and friends	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible adults with Learning disability/Severe mental illness receive annual health check
To be accepted and valued simply for who they are	Metrics to be developed

Having a set of metrics which we can use to monitor our progress is really important in ensuring that we are moving forward and delivering the ten 'Live Your Best Life' ambitions.

The metrics outlined in this performance framework have been agreed by the Integrated Care Northamptonshire Partnership as metrics we as a county will be working together to improve.

There will be many other detailed performance metrics that we will be monitoring as part of the delivery of this strategy but the performance frameworks outlines those metrics that are key priorities for us as a partnership and these will be reported to the HWB.

Members of the West Northamptonshire Health and Wellbeing Board

WEST NORTHANTS
Health and Wellbeing Board
live your best life

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

28 September 2023

Report Title	**Annual Health Protection Report 2022-23**
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Other Director/SME	Sally Burns Director Public Health	**21/09/2023**

List of Appendices

Appendix A Northamptonshire Health Protection Joint Committee Annual Report 2022/2023

1. Purpose of Report

This report is brought to the West Northants HWBB meeting to inform members about outcome of actions delivered in the year 2022-23 to tackle the health protection priorities identified within the 2022-2024 Northamptonshire Health Protection Strategic Plan and the actions recommended to address the gaps identified for the year 2023-2024.

Executive Summary:

Health protection involves planning, surveillance and response to outbreaks and incidents; it prevents and reduces the harm caused by communicable diseases and mitigates the impact on health from environmental hazards such as chemicals and radiation. Health protection also involves the delivery of major programmes such as national immunisation programmes and the provision of health services to diagnose and treat infectious diseases.

The strategic priorities for health protection are delivered by the relevant member organisations within Northamptonshire Health and Social care system, and quarterly assurance is sought by the Health Protection Committee as part of a statutory responsibility to ensure that appropriate arrangements are in place to protect population health. The nine strategic priorities are: Immunisation; Screening; Infection Prevention and Control; Tuberculosis; Blood Borne Viruses; Outbreak Management; Environmental Health; Training and Campaigns; and Addressing Health Inequalities.

Achievements against the strategic priorities have included performance of the national immunisation programmes, either close to meeting and/or exceeding national targets. All non-

cancer screening programmes have also seen an improvement. There has been a decline in sexually transmitted infection rates, some hospital acquired infections, chronic infectious diseases including Tuberculosis incidence, and newly diagnosed cases of HIV and Hepatitis B. 363 incidents and outbreaks have been managed, the majority of which involved COVID-19.

Gaps in the delivery of the strategic priorities have included a decline in seasonal flu in 2–3-year-olds, pregnant women and other adult at-risk groups. There was a reduction of cervical cancer screening amongst 24–49-year-olds. The rates of C Diff increased in both Acute Trust Hospitals. HIV testing rates were lower than the national average, and the late diagnoses of HIV is above the national and regional averages. There was a reduction in the commencement of timely treatment for people diagnosed with Tuberculosis. In addition there was an increase in Hepatitis C rates, and mortality rate from Hepatitis C related liver disease / cancer remains higher than the regional and national averages.

2. Recommendations

That the West Northants Health and Wellbeing Board adopt the recommendations in the Northamptonshire Health Protection Joint Committee: Annual Report (April 2022 to March 2023).

3. Report Background

The Local Authorities Regulations (2013) states that the Director of Public Health (DPH) is responsible for the local authority's contribution to health protection matters, including its role in planning for, and responding to, incidents that present a threat to the health of the public.

Northamptonshire Health Protection Strategic Plan has been delivering actions against the 2022-2024 nine strategic priorities. Results of actions delivered had positive outcomes with their performance better than England and East Midlands in all childhood and adolescent immunisation indicators. The coverage of adult vaccination programmes for Shingles, Pneumococcal and Pertussis in pregnant women, have shown an improvement. The uptake of the seasonal flu vaccination in people aged 65 and COVID-19 in all eligible cohorts are similar to the national averages.

All non-cancer screening programme including Antenatal and New-born Screening, Diabetic Eye screening (DES) and Abdominal Aortic Aneurysm (AAA) have improved, but DES and AAA screening are lagging behand the national target. Of all the national cancer screening programmes, only breast cancer screening has shown an improvement in uptake.

Sexually transmitted infection rates have improved for Syphilis, Gonorrhoea, and Chlamydia and are lower than EM and England averages. The 3-year average of TB incidence has also decreased. Latent TB screening programme for people from high-risk countries has been commissioned and implemented in Northamptonshire. The county has improved its HIV testing coverage, with a decrease in the number of new diagnoses in people aged 15 and above with HIV, the percentage of HIV late diagnosis has reduced, but still remains higher than the East Midlands and England averages. Acute Hepatitis B rates have improved and show a reduction; however, Hepatitis C detection rate has increased suggesting there was a rise in new cases.

Hospital Acquired infection rates due to MRSA bacteraemia (Methicillin Resistant staphylococcus Aureus), MSSA bacteraemia (Methicillin-Sensitive Staphylococcus Aureus), and E-Coli bacteraemia have fallen and shown improvement in acute trust hospitals. However, C Diff (Clostridium Difficile) infection rates had gone up in both of our acute trust hospitals.

The Health Protection Team has responded to and have supported the management of 363 incidents and outbreaks reported between 1st April 2022 and 31st March 2023, which were due mainly to COVID-19, but also included Gastrointestinal, Streptococcal, Chicken pox, E-Coli, Scabies and M Pox infections.

In the same time period, the Community Infection Prevention and Control (IPC) team undertook 181 IPC risk assessments and follow up assurance visits to support social care and other high risk community settings. It also delivered 144 IPC training and 92 quality improvement audits of high risk residential and nursing home settings.

To address inequality experienced by most of the underserved population residing or arriving in Northamptonshire (including rough sleepers, homeless, people in refuge centres, unregistered seasonal migrant workers, asylum seekers, refugees, and undocumented migrants), the team engaged and provided outreach clinical health interventions.

The HP team also provided public health specialist input for a safe and hazard free delivery of 134 events applications submitted to the Northamptonshire Safety Advisory Group (SAG) and successfully delivered 11 health protection media campaigns.

4. Issues and Choices

4.1 Issues

The issues in the Northamptonshire Health Protection Joint Committee: Annual Report 2022 - 2023 include:

- A decline in childhood vaccinations including seasonal flu vaccination in 2- and 3-year-olds, preschool boosters, and HPV in 12–13-year-old females, which were below national targets.
- Seasonal flu vaccination local coverage reduced in all adult cohorts apart from pregnant women. In addition, Shingles and all seasonal flu adult cohorts, except over 65s, were below the national targets.
- There was a drop in the take up of cervical screening amongst 24–49-year-olds.
- Cervical and Breast screening did not meet the national targets.
- The uptake of Bowl screening reduced.
- AAA and DES are below the national targets.
- There was an increase in C Diff rates in both Acute hospitals.
- There was a small increase in the Syphilis diagnosis rate.
- There was a reduction in starting the timely treatment for Tuberculosis. The number of people diagnosed with Tuberculosis offered HIV testing is lower than the national average.
- HIV testing rates are lower than the national average. In addition the late diagnoses of HIV is above the national and regional averages.
- There was a rise in hospital admissions due to Hepatitis B related liver disease/cancer, and a reduction in people entering drug misuse treatment accepting Hepatitis B vaccination.

- There was an increase in Hepatitis C rates. Furthermore, the mortality rate from Hepatitis C related liver disease / cancer remains higher than the regional and national averages.
- Mortality due to air pollution is higher than national and regional averages.

In addition, the ongoing impact of COVID-19 on the system as a whole, and the challenges in resources and capacity within organisations, affected the workforce and delivery capability of services during 2022-23.

4.2 Recommendations

Strategic Priority (SP) 1 Immunisation

Support the system to increase uptake in the childhood and adult immunisation programmes across the county area, including:

- Seasonal flu in 2 and 3 years.
- Preschool boosters.
- Shingles immunisation in over 70s.
- All seasonal flu adults cohorts.
- Maintain COVID-19 vaccination rates.

SP2 Screening

Support the system to increase uptake in the screening programmes across the county area, including:

- Cervical screening programme amongst 24–49-year-olds.
- AAA and DES screening.

SP3 Infection, Prevention and Control

Support the system to:

- Continue delivery of consistent IPC compliance, risk assessment and training in high-risk settings.
- Reduce rates of C Diff in both Acutes.
- Contribute a further reduction in the diagnosis rates of Syphilis.
- Contribute to initiatives and measures that support the reduction of COVID-19 cases, including good COVID-19 vaccination uptake.

SP4 Tuberculosis

Support the system to:

- Improve the proportion of people starting treatment for Tuberculosis within 4 months of diagnosis.
- Deliver the countywide latent screening programme to people from high-risk countries who have lived in the county for the last 5 years.

SP5 Blood Borne Viruses

Support the system to:

- Maintain improvements to HIV testing and diagnoses to prevent the increase in late diagnoses rates and to support achieving regional and national averages.
- Improve Hepatitis B vaccination uptake in people under substance misuse treatment.

- Support work that contributes to reducing hospital admissions due to Hepatitis B and Hepatitis C.
- Prioritise follow up care of people newly diagnosed with Hepatitis C to contribute to reducing mortality rates from Hepatitis C related disease/cancer.
- Reduce rates of Hepatitis C.

SP6 Outbreak Management

Support the system to:

- Update and localise the systemwide Outbreak Management Plan which are sufficiently resourced.
- Review the MoU between LHRP partners and the local authorities, to include the management of cross border incidences.

SP7 Environmental Health

Support the system to:

- Carry out an air quality health needs assessment to identify issues in poor air quality areas.

SP8 Training and Campaigns

- Continue to work with organisations and groups representing high-risk groups, delivering education and media campaigns that improve immunisation and screening across the system, and deliver professional updates to the workforce.

SP9 Addressing Health Inequalities

- Continue to address inequalities by engaging with groups with poor health and social outcomes in deprived areas, high-risk populations and those experiencing inaccessibility.

5. Implications (including financial implications)

5.1 **Resources and Financial**

None

5.2 **Legal**

None

5.3 **Risk**

There are no significant risks arising from the proposed recommendations in this report.

5.4 **Consultation**

Not applicable

5.5 **Consideration by Overview and Scrutiny**

Not Applicable

5.6 **Climate Impact**

None

5.7 **Community Impact**

None

6. Background Papers

6.1 Northamptonshire Health Protection Joint Committee: Annual Report (April 2022 to March 2023).

Northamptonshire Health Protection Joint Committee: Annual Report (April 2022 to March 2023)

Authors: Dr Annapurna Sen, Elton Myftari and Julia Partridge on behalf of the Directors of Public Health for North and West Northamptonshire Councils.

This report updates on output and outcome of actions delivered to meet the strategic priorities mentioned in our county wide "Joint Health Protection Plan."

Strategic Priorities 2022-24

The 2022 - 2024 strategic health protection priorities for the Health Protection Committee area (Northamptonshire) are as follows:

Strategic Priority 1: Immunisation

- Ensure the delivery of childhood and adult immunisation programmes in accordance with national and local targets.

Strategic Priority 2: Screening

- Ensure the delivery of cancer and non-cancer screenings in accordance with national and local targets.

Strategic Priority 3: Infection Prevention and Control

- Ensure infection prevention and control arrangements within organisations delivering health and social care services and other high-risk settings, to support a reduction in the number of healthcare acquired infections and other notifiable infections, including COVID-19.

Strategic Priority 4: Tuberculosis

- Ensure the local implementation of the recommendations of the national TB Strategy and NICE 2016.

Strategic Priority 5: Blood Borne Viruses

- Ensure that local service provision is in line with the national strategies for HIV, Hepatitis B and Hepatitis C.

Strategic Priority 6: Outbreak Management

- Ensure effective outbreak planning and response arrangements are in place within NHS and non-NHS partner organisations including Environmental Health teams.
- To ensure the coordinated delivery of the COVID-19 outbreak plan and pandemic response and recovery phase.

Strategic Priority 7: Environmental Health

- Ensure measures are in place to identify, manage and mitigate environmental health hazards including elevated levels of air pollution and environmental noise.

Strategic Priority 8: Training and Campaigns

- Ensure appropriate training and learning opportunities are available to educate professionals and the public in relation to health protection priorities.

Strategic Priority 9: Addressing Health Inequalities

- Ensure that in each of the Health Protection Priorities health inequalities and inequities are understood and plans are developed to address them, engaging with communities to understand their needs and coproduce solutions.

2022-23 Performance

Immunisation

Childhood Immunisation

- Northamptonshire outperformed England and East Midlands in all childhood immunisation indicators; most uptake was either close to meeting the national target and/or exceeded it. Preschool boosters which included the DTaP/IPV booster and MMR for two doses did not meet the national target, although performance was improved in comparison to the previous year.
- The seasonal flu vaccination coverage in children aged 2- and 3- years and school aged children from Reception to Year 9 showed a decline and did not meet the national target.
- Though there was an improvement in Northamptonshire and uptake exceeds the regional and national averages, the HPV vaccination coverage for one dose (females 12-13 years old) did not meet the national target of 90%.

Adult Immunisation

- The seasonal flu immunisation uptake dropped for people aged 65 and above, people aged under 65 and at-risk groups; nonetheless, the uptake in pregnant women showed an improvement.
- The only cohort that met the national target of 75% for seasonal flu vaccination was people aged 65 and above. All cohorts performed better than the regional and national averages.
- The vaccination uptake for Pertussis in pregnant women increased.
- Vaccination coverage for Shingles in those aged 70 years improved, but did not meet the national target of 50-60%.
- COVID-19 vaccination uptake improved in comparison to the previous year, across all doses in all cohorts, and was similar to the national average.

Screening

Antenatal and New-born Screening

- All indicators in antenatal (HIV, Hep B, Syphilis and Sickle cell and Thalassemia) and new-born screening (Hearing and Physical examination) reached the acceptable national target of 95%.
- New-born blood spot coverage stayed similar to the previous year and achieved the national acceptable target of 95%.

Cancer Screening

- Cervical screening coverage in the Northamptonshire area reduced in 24–49-year-olds by 2% and remained statistically similar for 50–64-year-olds, but both cohorts did not meet the national target of 80%.
- Bowel screening coverage dropped by 2% although it exceeded the national target.
- Breast screening coverage showed an improvement of around 2% and performed better than the national average but did not meet the national target.

Non-cancer Screening

- Abdominal Aortic Aneurysm (AAA) screening coverage significantly improved (increasing from 16% in the previous year to 41%) and performed noticeably better than the national average. This is below the national target of 85%.
- Diabetic Eye Screening (DES) improved by 2.5% but was below the national target of 75%.

Infection Prevention and Control (IPC)

IPC Compliance:

- 137 initial Infection Prevention and Control assurance visits and 44 follow-up IPC assurance visits were carried out to support high risk community and social care settings including care, residential and nursing homes, supported living, assisted living and domiciliary care settings.
- 144 IPC training (face to face) sessions were delivered to social care staff working in care, residential and nursing homes, supported living, assisted living, rehabilitation centres and domiciliary care settings.
- 92 quality improvement audits were completed for high-risk care and nursing home settings.

Prevention and Control of Health Hazards:

- Specialist Public Health input was provided for the safe and hazard free delivery of 134 events applications submitted through the Northamptonshire Safety Advisory Group network.

Healthcare Acquired Infection

- The C Diff (Clostridium Difficile) infection rate increased in both Acute Trust Hospitals.
- MRSA bacteraemia (Methicillin Resistant staphylococcus Aureus) rates fell, showing an improvement in both of the Acute Hospitals.
- The rate of MSSA bacteraemia (Methicillin-Sensitive Staphylococcus Aureus) declined overall, showing a reduction in Northampton General Hospital and increasing in Kettering General Hospital, but both rates were lower than the national average.
- E-Coli bacteraemia rates showed a decline, improving in both Acute Hospitals.

Sexually Transmitted Infections

- The number of new STI diagnoses decreased and was lower than the regional and national averages.
- The diagnoses rate of Syphilis showed an increase of 1% per 100,000 population but remained better than the regional and national averages.
- Gonorrhoea diagnoses rates decreased by 3% per 100,000 population and remained better than the regional and national averages.
- Chlamydia detection rates in people aged 15-24 years decreased and was better than the regional and national averages.

COVID-19

- The COVID-19 case rate in Northamptonshire for the week ending 31 March 2023 was 42 per 100,000 population.
- There was a total of 426 deaths reported in Northamptonshire where COVID-19 was mentioned as one of the causes on the death certificate.
- There was a total of 3,304 COVID-19 hospital admissions across the Acute and Community Hospitals.

Tuberculosis

- The 3-year average of TB incidence decreased and was lower than the regional and national averages.
- Northamptonshire showed a reduction in the proportion of pulmonary TB starting treatment within 4 months of diagnosis (timely treatment) although performed better than the regional and national averages.
- The proportion of Tuberculosis cases offered a HIV test saw a slight improvement but was lower than the national average.
- Latent TB screening programme for people from high-risk countries was commissioned and implemented in Northamptonshire.

Blood Borne Viruses

HIV (Human Immunodeficiency Virus)

- Northamptonshire improved its HIV testing coverage by 6% which was significantly better than the regional average but 2.5% lower than the national average.
- New diagnoses in people aged 15 years and above with HIV, decreased showing an improvement. However, this is lower than the regional average but better than the national average.
- The percentage of HIV late diagnosis showed an improvement but remained higher than the regional and national averages.

Hepatitis B (Data lag – comparisons have been made using published datasets)

- Acute Hepatitis B rate decreased showing an overall improvement.
- The number of hospital admissions due to Hepatitis B related liver disease/cancer increased.
- There was a decline in the number of people entering drug misuse treatment who were offered and accepted a Hepatitis B vaccination as a proportion of all eligible clients in treatment.

Hepatitis C (Data lag – comparisons have been made using published datasets)

- Hepatitis C detection rates increased, suggesting there was a rise in the number of new cases.
- The mortality rate of people aged under 75 years due to Hepatitis C related liver disease/cancer fell but remained higher than the regional and national averages.
- The number of hospital admissions due to Hepatitis C related liver disease/cancer remained similar to the previous year.
- The percentage of people receiving a Hepatitis C test in drug misuse treatment improved by 5%, which was above the national average.

Outbreak management

- The local Health Protection Team responded to and managed 299 COVID-19 related outbreaks.
- The Team also supported the management of 26 Gastrointestinal outbreaks.
- The local Health Protection Team worked alongside the regional UKHSA Team to manage 25 outbreaks in educational settings that included Streptococcal-A, Scarlet Fever, Chickenpox, E-Coli, diarrhoea and vomiting, and a case of Meningitis.
- The local Team also managed a number of Scabies outbreaks and incidents in asylum seeker/refugee settings.
- Support was also provided to the regional and local system partners to manage 11 incidents of Mpox.

Environmental Health

- Mortality of annual deaths attributable to air pollution in Northamptonshire stayed similar to the previous year (5.4%) but was slightly higher than both the national (5.1%) and regional (5.3%) averages.

Training and Campaigns

- The local Health Protection Team engaged with high-risk population sub-groups, in collaboration with community and voluntary organisations who worked with these groups, to deliver health education sessions to improve immunisation and screening uptake and other prevention initiatives.
- 11 health protection media campaigns took place.

Addressing Health Inequalities

- To address inequality experienced by some of the underserved population residing or arriving in Northamptonshire (including rough sleepers, homeless, people in refuge centres, unregistered seasonal migrant workers, asylum seekers, refugees and undocumented migrants). Health

intervention sessions included screening for communicable and non-communicable diseases, immunisation and health and wellbeing interventions. Collaboration with other agencies to provide social support, included the Housing and Revenues and Benefit Teams.

Recommendations

Following the analysis of individual datasets, these recommendations are to facilitate North and West Northamptonshire Public Health Teams to prioritise and develop their action plans for 2023-2024.

Strategic Priority 1: Immunisation

- Improve the uptake of preschool booster vaccinations (MMR and DTaP-Diphtheria, Tetanus, and Pertussis).
- Improve seasonal flu immunisation in children aged 2 and 3 years old, and all adult at risk cohorts, including pregnant women.
- Improve COVID-19 vaccination take-up.

Strategic Priority 2: Screening

- Improve cervical cancer screening coverage in women aged 24-49 years.
- Improve AAA and DES screening rates.

Strategic Priority 3: Infection Prevention and Control

- Reduce incidence of Clostridium Difficile (C Diff) as a health care acquired infection.
- Support social care settings and special educational settings by carrying out regular risk assessments and ensure consistent IPC training is delivered across all settings.
- Support the reduction in the number of Syphilis diagnosis.
- Contribute to the reduction in COVID-19 cases.

Strategic Priority 4: Tuberculosis

- Improve the number of people starting treatment within 4 months of diagnosis.
- Deliver the latent TB screening programme to people coming from listed high-risk countries and who have lived in Northamptonshire in the last 5 years.

Strategic Priority 5: Blood Borne Virus

- Continue improving HIV testing to prevent late diagnoses.
- Improve Hepatitis B vaccination uptake in people under substance misuse treatment.
- Support work that reduces hospital admissions due to Hepatitis B and Hepatitis C.
- Prioritise the follow up care of people newly diagnosed with Hepatitis C.

Strategic Priority 6: Outbreak Management

- Update and localise the systemwide Outbreak Management Plan.
- Review the Memorandum of Understanding (MOU) with Local Health Resilience Partnership (LHRP) agencies for managing outbreaks within both local authority areas as well as cross-border.

Strategic Priority 7: Environmental Health

- Undertake an air quality Health Needs Assessment to identify issues in poor air quality areas.

Strategic Priority 8: Training and Campaigns

- Collaborate with organisations and groups to deliver education and media campaigns that improve screening and immunisation uptake amongst the population and provides professional updates to the workforce.

Strategic Priority 9: Addressing Health Inequalities

- Engage with groups with poor health and social outcomes in deprived areas across the county, high risk cohorts and those experiencing inaccessibility.

The Actions to support these priorities will be detailed in the 2023-2024 Health Protection Plan.

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

28th September 2023

Report Title	**Northamptonshire ICB Annual Report and Accounts and Northamptonshire CCG Annual Report and Accounts**
Report Author	**Hannah Cruickshank, Senior Communications Manager, Northamptonshire Integrated Care Board (ICB)**

List of Appendices

Appendix A – Northamptonshire ICB Annual Report and Accounts 2022-2023 -
https://www.icnorthamptonshire.org.uk/documents?media_folder=2583&root_folder=Northamptonshire%20ICB%20Annual%20Reports

Appendix B – Northamptonshire CCG Annual Report and Accounts 2022
https://www.icnorthamptonshire.org.uk/documents?media_folder=2582&root_folder=Northamptonshire%20CCG%20Annual%20Reports

1. Purpose of Report

1.1 It is a statutory requirement for NHS organisations to produce an annual report each year. As part of the requirements for the report there is an expectation for Integrated Care Boards to engage with local Health and Wellbeing Boards.

2. Executive Summary

2.1 It is a statutory requirement for NHS organisations to produce an annual report each year. As part of this process, we are asked to engage with local Health and Wellbeing Boards while drafting the report. Earlier this year, we shared a copy of the draft report, which included text on the health of our local population and how we had engaged with our Health and Wellbeing Boards and invited comments from members.

2.2 Now the reports have been approved and published on our website, we are bringing the final versions back to the Board.

2.3 We would like to make members aware that after we shared the text for the ICB report, there was an additional request for us to engage with Boards regarding the CCG report. Due to time pressures, we have included the text agreed with the Boards for the ICB report in the CCG report as well.

3. Recommendations

3.1 The Board are asked to note the reports.

4. Report Background

4.1 Nothing to share in addition to the executive summary

5. Issues and Choices

5.1 Nothing to share in addition to the executive summary

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 Nothing to share in addition to the executive summary

6.2 **Legal**

6.2.1 Nothing to share in addition to the executive summary

6.3 **Risk**

6.3.1 Nothing to share in addition to the executive summary

6.4 **Consultation**

6.4.1 The report has been through the following approval process within the ICB

05.10.22	N/A	DRAFT CCG Annual Report and DRAFT ICB Annual Report to be submitted to NHS England for review and comments
15.06.23	Audit Committee and ICB Board	FINAL CCG Annual Report and Accounts and FINAL ICB Annual Report and Accounts to be approved
30.06.23	N/A	FINAL CCG Annual Report and Accounts and FINAL ICB Annual Report and Accounts to be submitted to NHS England

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Nothing to share

6.6 **Climate Impact**

6.6.1 Nothing to share

6.7 **Community Impact**

6.7.1 Nothing to share

7. Background Papers

7.1 Nothing to share

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NHS
Northamptonshire
Integrated Care Board

Northamptonshire ICB Annual Report 2022/23

Covering the period from 1st July 2022 to 31st March 2023

Contents

Performance report

The performance section provides information on the Integrated Care Board (ICB), our main objectives and strategies and how we have discharged our duties and functions.

Within this chapter you will find updates from our Chief Executive and Chair, information about who we are and what we do as well as the services we commission on behalf of our local population, and how we have performed against the NHS Standards.

Toby Sanders
Chief Executive (Accountable Officer)
20 April 2023

Chair’s introduction

Welcome to the first NHS Northamptonshire Integrated care Board’s (NICB) Annual Report, which covers the first 9 months of the NICB from 1 July 2022 to 31 March 2023, following the disestablishment of Northamptonshire CCG. The CCG statutory duties transferred to Northamptonshire ICB when it was established on 1 July 2022. This report details the progress we have made in delivering the four aims of ICBs: improving health for all, reducing health inequalities, wisely spending public resources, and contributing to the economic and social development of the area we serve.

The ICB received an allocation of money to be spent on health services for the people registered with a Northamptonshire GP practice. This included the cost of hospital outpatient appointments, inpatient stays and operations, prescribed medicines, investigations, GP practice appointments and care, GP out-of-hours services, Corby Urgent Care Centre, community and mental health facilities and many other services. We also cooperated with our partners across health and social care, and this includes Kettering General Hospital Foundation Trust (KGH), Northampton General Hospital (NGH), Northamptonshire Healthcare Foundation Trust (NHFT), West Northamptonshire Council (WNC) and North Northamptonshire Council (NNC) as well as the voluntary and charitable sector and other organisations. A key feature of ICBs is greater collaboration across local authority and NHS services, as well as greater collaboration within the NHS across primary, community and hospital services. All these organisations working together are often referred to as our ‘System’.

This has been an extremely challenging year for the System. Not only are we continuing to feel the effects of COVID-19, but system pressures on our health and social care services, financial pressures, workforce challenges and industrial action have all impacted on how we have been able to deliver NHS services. The cost-of-living crisis is also affecting our local communities as well as many of our staff. Our partners at North Northamptonshire Council and West Northamptonshire Council have been supporting those who are struggling with rising costs by offering financial and practical support to help them manage these costs, aiming to reach the families and individuals who are most in need. They have

also been running schemes such as the warm spaces network, which offers local people safe and welcoming places across the county where they can come together to stay warm, talk to someone if they need support and perhaps enjoy a hot meal or a cup of tea and a biscuit. Health has been supporting the warm spaces by providing another route for anyone who needs mental health support to understand how to access talking therapies and other types of help. You can read more about the mental health support being offered to local people on pages 17 to 19.

I believe we have one of the best health system in the world, and we are always working to make it better. This has been one of the most challenging years in its history and I would like to thank everyone who is working locally in our NHS for their very hard work each day. I welcome your views on this annual report.

Naomi Eisenstadt
Chair
4th April 2023

Foreword

Welcome to the first Annual Report for NHS Northamptonshire Integrated Care Board, which covers the period 1 July 2022 to 31 March 2023. Northamptonshire is one of 42 Integrated Care Systems (ICSs) to be rolled out in England. An ICS brings together hospital, community and mental health trusts, GPs and other primary care services with local authorities and other care providers to work together and apply their collective strength to addressing their residents' biggest health and care challenges.

This report aims to give you an overview of our organisation, our staff and how we work with partner organisations. It shows how we work through robust governance arrangements and how we assure ourselves and others that our services are delivered safely and to a high standard of quality - always working to ensure that the patient experience is positive. We will explain our mission, goals, and achievements, highlighting the partnerships that we rely on to ensure the best possible outcomes for patients.

The report is retrospective by nature and showcases the achievements and challenges of our organisation over the period gone by. Although there is a great deal to be proud of this year, I also need to acknowledge that this has been one of the most challenging years for the NHS that I can recall. We are still feeling the effects of the pandemic as our system works hard to recover and provide the best care we can for the local population we serve alongside financial pressures, industrial action and our local population experiencing a significant rise in the cost of living, which has had an adverse impact on some of the most vulnerable people's health and we are proud that health has been supporting the warm spaces coordinated by our colleagues at North Northamptonshire Council and West Northamptonshire Council, who have been providing somewhere safe and warm for people to gather if they need additional support.

The progress made in 2022/23 has been delivered in a climate of change and external pressure, which in some cases has resulted in us not achieving some of our key constitutional standards and targets. It is also important to note that some of the constitutional standards and targets

were suspended due to COVID-19. We have been working with our providers to ensure our local population is able to access the best possible health services available. You can read more about our performance on pages 37 – 49.

During the first 9 months of the ICB, we have been building on our relationships with partners. There are already several positive examples of this partnership and collaborative approach making an impact, including around our work for mental health and elective care.
I would like to take this opportunity to thank all the hard-working health and care staff who are the backbone of our local system and without whom we could not do what we do.

We hope that you find this Annual Report informative, providing you with an overview of the period covered but please do contact us if you would like to know more about the ICB.

Toby Sanders
Chief Executive
4th April 2023

Performance overview

NHS Northamptonshire Integrated Care Board (ICB) was officiated by NHS England and NHS Improvement on 1 July 2022, following the de-establishment of NHS Northamptonshire CCG.

The organisation had a budget of £1,103,276,000 for the period covering 1st July 2022 to 31st March 2023, and responsibility for planning and funding the majority of health services in Northamptonshire on behalf of 822,129 registered patients across Corby, Daventry, East Northamptonshire, Kettering, Northampton, South Northamptonshire and Wellingborough.

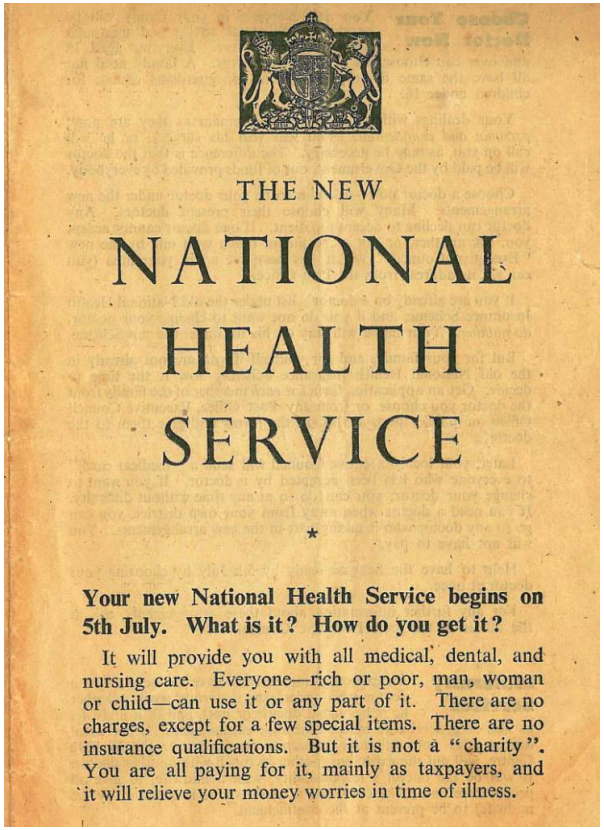
The Integrated Care Board (ICB) is a statutory body responsible for local NHS services, functions, performance, and budgets. It is directly accountable to the NHS and is made up of local NHS trusts, primary care providers, and local authorities.

The ICB is responsible for joining up care services to improve patient experience in the community. The Board includes a chair, the chief executive and representatives from NHS organisations, primary care (GPs) and local authorities (councils).

The Integrated Care Partnership (ICP) is a statutory committee that brings together all system partners to produce a health and care strategy. As a forum to support partnership working, the ICP brings together local authorities, health and social care, and housing providers.

How does it work?

The ICB helps bring together hospitals and family doctors, physical and mental health, the NHS, local councils and community and voluntary sector services. By bringing together partners, it allows for greater input from all those involved in delivering services, resulting in better care wrapped around individuals. You can view a copy of the Governance structure on page 93.



THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Why do we have an Integrated Care Board?

The ICB ensures that the best possible care is available to people in our communities. It constantly assesses what needs to change to meet the level and complexity of care in the county. The ICB ensures that integrated care improves population health and reduces inequalities between different groups.

Mission, vision, and values

Our mission

Our mission is working together, the reason we do what we do, is to empower positive futures. Whenever we work and whatever our role, we all want people in Northampton to be able to choose well, stay well, live well.

Our vision

Our vision for the future of Northamptonshire's health and care services is through joined effort and shared resources we create a positive lifetime for all of health, wellbeing, and care in communities.

Our values

Each day our shared values will help to guide our decisions and what is most important to us:

- Our patients and our local population come first
- We work together in an open and accountable way
- We trust, challenge, and support each other
- We say what we say we will do

ICB partner members

There are six ICB partner members who have been appointed to the Board through a nomination and selection process. The partner members bring knowledge and experience from their sector and contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

Two Partner Members from NHS Trusts and NHS Foundation Trusts will be nominated by the following NHS Trusts and NHS Foundation Trusts:

- Northamptonshire Healthcare NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Northampton General NHS Trust

Two partner members from Primary Medical Services will be nominated by providers of Primary Medical Services for the purposes of the health services within the ICB area.

Two partner members from local authorities will be jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area.

Those local authorities are:

- North Northamptonshire Council
- West Northamptonshire Council

Constitution

The ICB's Constitution sets out the ICB's governing principles, rules and procedures established to ensure probity and accountability in the day-to-day running of our organisation.

The Constitution applies to all our member practices, our organisation's employees, any individuals working on behalf of our organisation and to anyone who is a member of the governing body or committees established by the organisation.

THE NHS CONSTITUTION
the NHS belongs to us all

NHS Northamptonshire ICB's Constitution sets out

Legal position	Membership	Decision making	Committee structures	Financial policies

Performance summary

NHS Northamptonshire ICB measures its performance against national NHS standards. These are a series of measures which are used to assess the performance of each health service. We, and our providers, have struggled to meet many required standards in 2022/23 as COVID-19 has continued to have an impact on performance.

We and our providers successfully delivered many of the required standards in Quarters 2 -3 of 2022/223 including:

- Maximum one-month wait for subsequent anti-cancer drug treatment
- Maximum one-month wait for subsequent radiotherapy treatment
- Patients given cancer diagnosis outcome within 28 days
- IAPT treatment completion times
- No urgent operation to be cancelled for a second time

The challenging areas that require our continued focus in Quarter 2-4 of 2022/23 are:

- Four hour waits at NGH (KGH does measure this)
- Ambulance handover times
- Cancer two week waits and cancer 62 day waits
- Referral to treatment times
- Diagnostic test waiting times

A full performance analysis is included on pages 37 to 49.

Working as a system

The following pages describe how the healthy system has come together to deliver for the local people of Northamptonshire. ICBs have a legal duty to develop joint forward plans for integrated care board and its partners (14Z52).

Children and young people

This section sets out how we have supported patients from birth into childhood and beyond.

Maternity and neonatal services

The Local Maternity and Neonatal System (LMNS) continue to work on the Northamptonshire LMNS Equality and Equity assessment and 5-year plan. The Equity and Equality plan aims to address the findings of the MBBRACE-UK reports about mothers and babies from the groups most at risk of poor health outcomes. It enables us to understand the local population so that interventions can be targeted at groups of women and families within the community who are more likely to experience poorer outcomes. The action plan has been co-produced with user representatives and will help guide our work and refresh our approach to help achieve equity and equality for all mothers and babies in Northamptonshire.

Engagement

The Northamptonshire Maternity Voices Partnership (MVP) collate most of the user feedback and provide a valuable means for us to hear the voice of birthing people and families in Northamptonshire. The MVP are a voluntary group made up of mothers, fathers and families and they have been set up to listen to and speak for service users who have accessed local maternity services. We recently recruited a new MVP Chair and despite being busy with a new baby and a toddler, she has continued to administrate and oversee the MVP Facebook page, which has over 2,200 members, and she is very active on the MVP Instagram and Twitter accounts.

The LMNS Equality & Equity plan was co-produced with the MVP and one of the actions was to recruit an MVP Equality & Diversity Champion who could support the MVP Chair and lead on specific co-production around women and families from seldom heard communities.

The MVP have also been instrumental in the need to redesign the LMNS website as feedback from users was that they didn't find it useful or informative. Members of the MVP have helped to design the new website which is expected to 'go live' in early 2023 and aims to provide a one stop platform for information about pregnancy, birth, and early years parenting.

Children and young people

The legacy of the COVID-19 pandemic continues to impact the health and wellbeing needs of our county's children and young people, with increases in all areas both volume and complexity. To meet this need we have sought to enrich collaboration with system partners and maximise opportunities for co-production that will enhance the development of resilient, effective, and high-quality services that are accessible to all. Within this we have also continued with our ambition on reducing inequalities and inequities to ensure that those most in need are supported in achieving best outcomes.

Engagement

We believe passionately that engagement and coproduction should be at the heart of our work in enabling informed commissioning decisions. Some examples of work we have commissioned includes:

- A review of the accessibility of our mental health services by deploying a group of children and young people as 'mystery shoppers' as part of a project led by the REACH Collaborative
- Engagement events held in Northamptonshire Schools and the outputs from an online survey completed by our children and young people from diverse ethnic minority groups and who have accessed services to understand their experiences and hi-light areas of improvement
- Research workshops, observations, and a report to produce recommendations for a countywide CYP engagement strategy conducted by Free 2 Talk CIC, working in partnership with Home Start and the University of Northampton

- Research, development, and implementation of the ‘Key Worker’ role that will provide support to Children and Young People with learning disabilities who may be at higher risk of escalating need

Children and young people with special educational needs and disabilities (SEND)

The statutory duties undertaken by NHS Northamptonshire Clinical Commissioning Group in relation to children and young people with SEND transferred over to the NHS Northamptonshire Integrated Care Board (NICB) on 1st July 2022. The Children and Families Act (2014) requires local partners across Education, Health and Social Care to work effectively together to improve outcomes for children and young people up to the age of 25 with SEND.

In accordance with NHS England’s recommendation, we have a Senior Responsible Officer for SEND at executive level within NICB. The Designated Clinical Officer (DCO) supports NICB with our statutory responsibilities and works with SEND partners on quality assurance and improvement.

SEND is clearly referenced in our Children and Young People Transformation Programme (CYP TP) and together with Safeguarding and Transition underpins all 4 pillars of the Transformation Programme. SEND is primarily located in the Complex Needs Pillar, however, there are direct links between the CYP TP and the Mental Health Learning Disability/Autism Programme ensuring the health needs for disabled children and young people with SEND are being met. SEND is embedded within work streams for both programmes.

A multi-agency Northamptonshire SEND Data dashboard is under development for North and West Northamptonshire and health data is being provided to meet this locality focus. This will inform our future joint commissioning and strategy. Data sharing has been agreed as an essential element of effective partnership working in Northamptonshire.

Education Health Care Plan (EHCP) performance data is included in the North and West SEND Data Dashboards. A system for direct reporting

on the number of EHC needs assessments undertaken by health teams and compliance with the 6-week timescale for providing advice is being trialled. There are aspirations in the long term to further improve the effectiveness of the EHCP data we have.

A multi-agency quality assurance framework has been developed to identify best practice and secure improvement in consistency of quality of advice and EHCPs. This links with ongoing SEND Workforce development to increase our understanding of SEND identification and support.

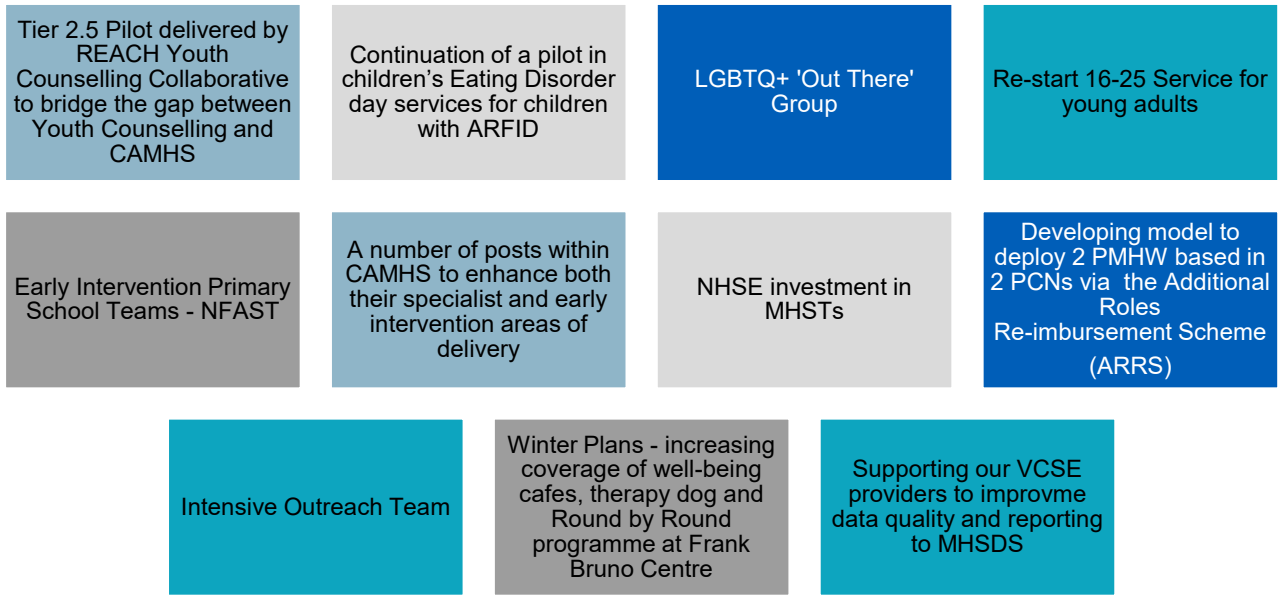
Health teams have participated in SEND Peer Reviews that have been undertaken in both North and West Northamptonshire this year to understand how well we are doing and to identify areas for further progress.

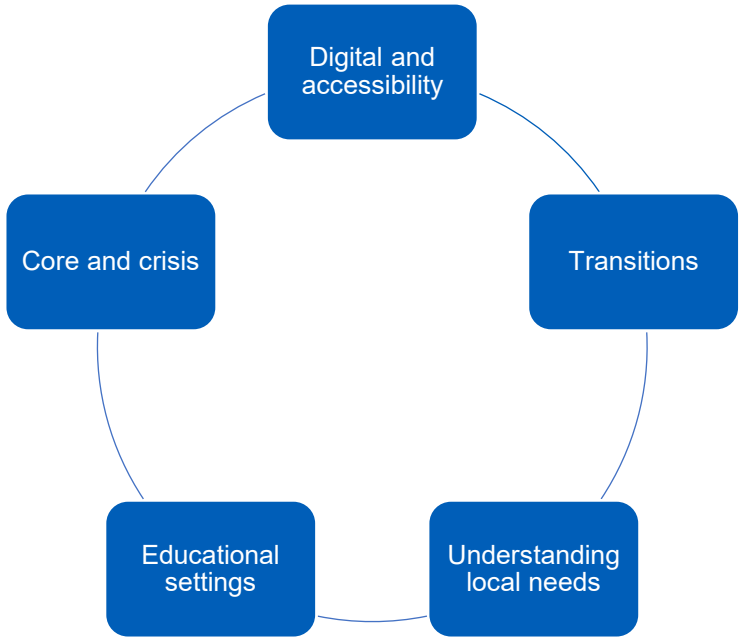
Partnership working and co-production with CYP and parents/carers is a key element of our SEND strategic and operational work. Both the CYP Transformation Programme and SEND Accountability Board have made a commitment to ensure that children and young people will have more say over what support and services are offered in their local area, and that more help will be available for them as they prepare for adulthood.

Children and young people's mental health

We know that more children and young people are asking for help with their emotional wellbeing and mental health.

We have worked across the system to innovate and develop services that not only improve the range of services for our CYP but also to ensure that we are able to meet the targets for increased access, set out in the NHS Long Term Plan. Areas in which we have been able to invest this year include:



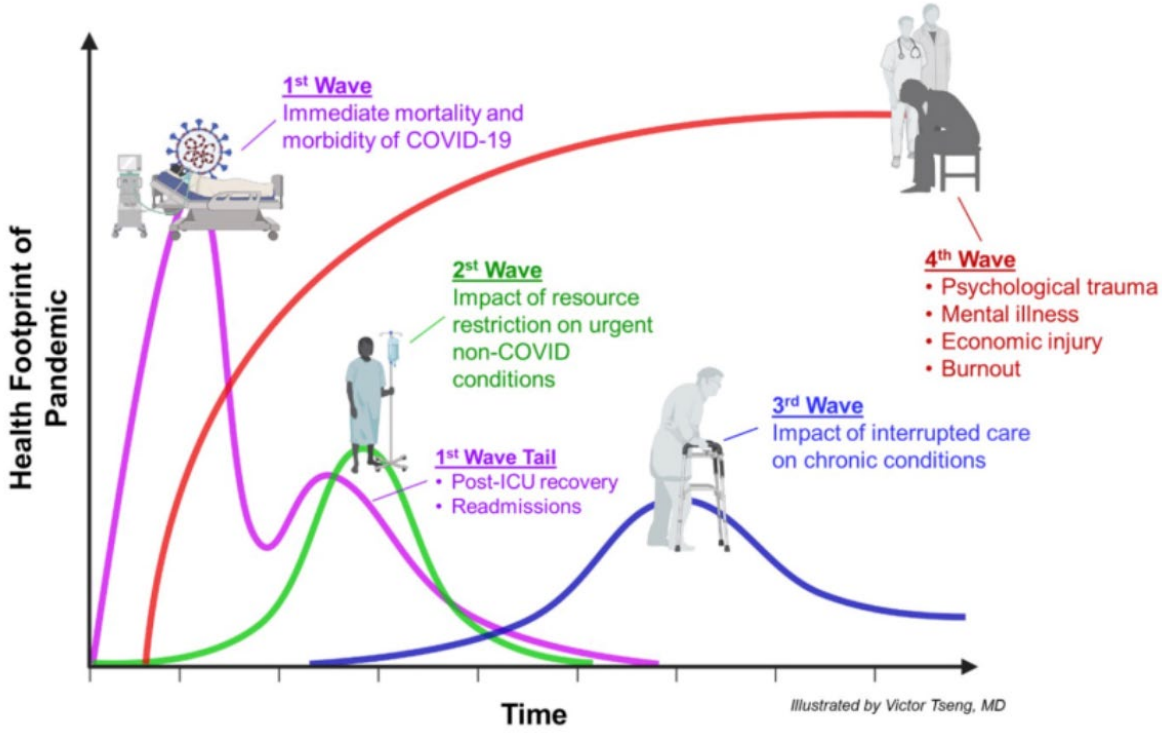


The refresh of the CYPMH Local Transformation plan in November 2022 has enabled us to consider feedback and case studies from our children and young people with our local health, care, and voluntary sector organisations. Early discussions identified priority areas for system investment and development in 2023/24 are set out in the diagram on the left.

Next steps will include development of opportunities for joint commissioning, by understanding respective organisational ambitions and priorities in readiness for development of options once available funding levels are understood.

Mental health

Whilst the acute phases of the COVID-19 pandemic created significant pressure on urgent physical health pathways, services to support mental health and wellbeing often experience their highest pressures in the years that immediately follow. The pandemic created an additional layer of mental health need (characterised by grief, financial worry, family hardship and loss of education). These are coming to the foreground as people start to process their experiences. Added to this, the cost-of-living crisis is creating new anxieties around job security, debt management, maintaining tenancies and food/fuel costs.



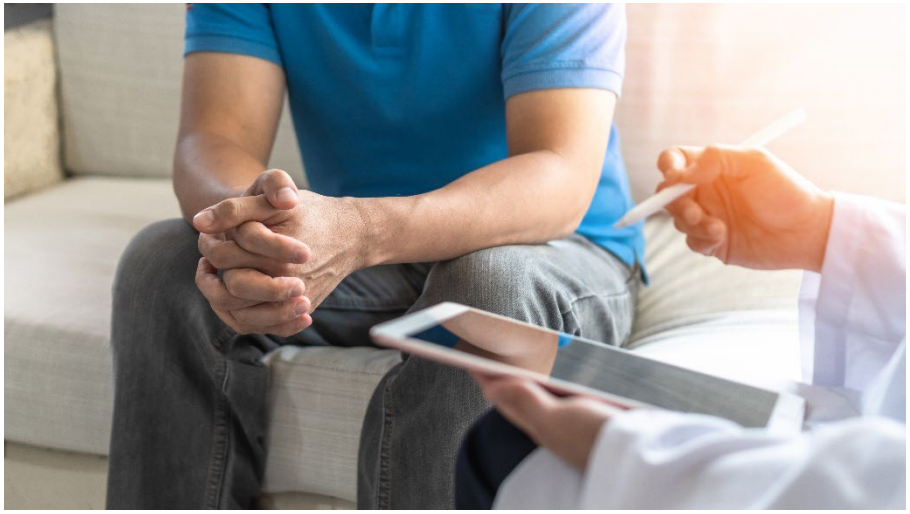
Urgent mental health care

To provide timely access to immediate crisis support, we expanded our work with Accommodation Concern – providing more help to maintain tenancies, reduce debt and ensure residents were claiming all entitled benefits. For those being discharged from mental health inpatient services, additional support was provided to cover rent deposits, purchase household necessities, and make house repairs or alterations to allow people to return home swiftly and safely. We expanded provision to our employment support service, to help people with mental health issues to obtain and maintain employment or engage in volunteering if they wished.

We also commissioned a new Crisis Response Unit, which will work closely with ambulance services to provide a more personalised response to people with urgent mental health concerns and prevent (where possible) the need to go to an Emergency Department. We have reviewed and

redesigned our Suicide Prevention Strategy to focus on increasing awareness, reducing stigma, and providing training on how health and care staff should respond to a patient with suicidal ideation (including across primary care, housing teams, debt advice teams and other services).

Northamptonshire maintains its highly developed crisis pathway for mental health. We have 158 hours of crisis cafés available each week, currently attended by c.250 each month. We continue to provide Hospital @ Home packages, and in the past 12 months our Crisis Houses have prevented over 100 people requiring mental health hospital treatment.



Additional mental healthcare

It has also been important that we continue to provide early intervention and preventative support to stop our people's becoming unwell, and to address mental health concerns at the earliest opportunity. To that end, we have further expanded our Psychological Talking Therapies service, which now has capacity to support >20,700 residents a year. The service is also in the process of alignment with various physical health teams, in order to help join-up people's mental and physical healthcare in a more holistic way.

We have also made a further expansion to our Perinatal Mental Health service. The service can now support c.900 women each year, and has been developed to include mental health assessment, advice, and signposting for partners of perinatal women. The service continues to offer a range of therapeutic options as well as a Maternal Mental Health service to support mothers and partners experiencing issues such as birth trauma, tokophobia and grief.

In order to support young people transitioning to adulthood, we have implemented 'Re:Start' – a flexible, responsive, needs-led service, working with people from the age of 16 to 25 years. The service will work alongside mental health services for children and adults, helping to ensure a smooth handover. Additionally, the service can support young people with a range of additional needs (including housing, employment, higher education, drug & alcohol support, and accessing crisis services).

Too often, people with mental health diagnoses experience poorer than average physical health. Therefore, we have launched a new scheme to support our GP and Primary Care colleagues to undertake a comprehensive annual physical health check for people with severe and enduring mental illnesses. The health check will explore 12 aspects of health, from cholesterol, glucose, and BMI, to medication, dental health, and cancer screens – as well as undertaking all required referrals for follow-up interventions.

Wider system developments

There are many different partner organisations delivering mental health care to our population, and we are all working closer than ever to join-up our care pathways so that people can get the help they need, when they need it.

We are supporting our partners in Public Health to complete a detailed Joint Strategic (Mental Health) Needs Assessment. This comprehensive project will allow us to understand the different types of mental health need across our population (both over the course of a lifetime, from infancy to older adults; and broken down to the various boroughs and neighbourhoods across our county).

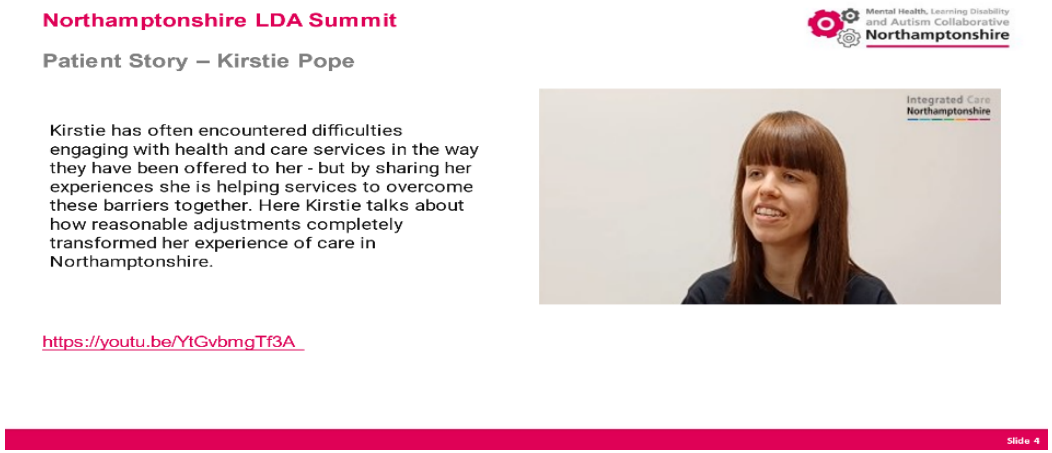
As an Integrated Care System, we been successful in applying to become one of the first ICS Mental Health Prevention Concordats – this acts as our commitment to preventing mental ill health through the development of schemes that support people with health determinants (such as housing, employment, financial stability, and access to equal opportunities).

We have delivered against our commitment to implement an Outcome-Based Collaborative Contract, which was signed on 30th June 2022. This will bring c.35 mental health services under a single contractual framework, which will mean services can be more integrated with each other, and more responsive to our residents needs as they grow or change.

Learning disabilities and neurodiversity

With the inception of the ICB, we have used this as an opportunity to strengthen our support of our learning disabled and Neuro Diverse Communities (e.g. Autism, ADHD etc.) for all ages by seizing the opportunity of the transformation of local authority reforms, introduction of the ICB and an opportunity to bring partners together under the wider banner of Mental Health, Learning Disabilities and Autism (MHLDA) that expands on the ethos of “no decision about us, without us”

Our Autism Advisory Panel (AAP), the newly formed Young Autism Advisory Panel in collaboration with En-Fold, a local Voluntary Sector Partner, our Autism Enabler Group and Autism Champions have continued to drive the continued evolution of services to improve access to services and improved health and wellbeing out comes. As a system we have partnered with Get On Board to improve our co-production with our Learning Disabilities community too. And we are working with Public Health and community groups to engage with a wider diversity of our communities.



We continue to improve access to annual health checks for people over the age of 14 with learning disabilities. Significantly more people accessed health services compared to the last two years, thanks to the work between our strategic health facilitators, our primary care networks, our Community Team for People with Learning Disabilities (CTPLD), social care, carers and service users understanding how important they are.

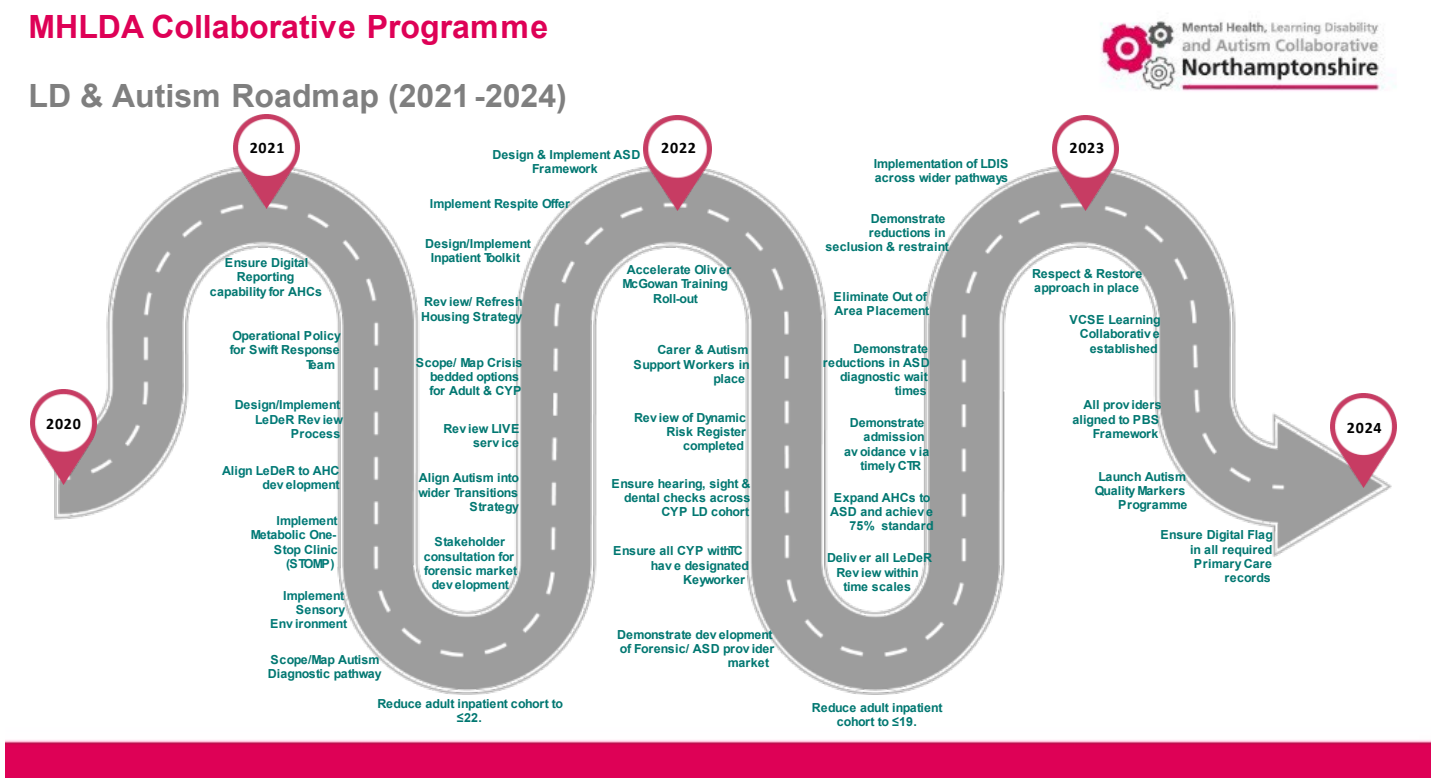
This is our first year of including autistic people within our learning disabilities mortality review programme (LeDeR) and this should continue to inform our learning on how we can support people with LDA well and to live longer. We are using the newly launched Oliver McGowan Mandatory Training, a national programme to educate all staff in health, social care, and our community providers to better understand the needs and more importantly, the reasonable adjustments we can take to better serve our citizens.

Our Transforming Care Programme continues to ensure we get the right support for the right people at the right time where they are at risk of going into hospital due to their mental health. There has been a slight increase in LDA people requiring hospital care currently, and this is in line with the general population also finding the pandemic has had an adverse impact on their mental health. We are therefore using the learning from this to review our strategy and plan further to try different approaches to supporting people to live their best lives.

We are pleased to announce our new key worker service has gone live in partnership with Barnardo's and En-Fold to work with our children and young people in the Transforming Care arena. This service will support children and young people between the ages of 0 to 25 to work across the system to try to improve their mental health and opportunities to stay at home. It they need to go to hospital due to their mental health; this team will also work to help repatriate them back to the community.

New exciting initiatives are developing to look at how we can improve our support of our LDA community who have epilepsy or seizures. We are developing how we can:

- Improve our autism and forensic pathways
- Improve inclusivity in our communities including more easy read materials including our newly published Children and Young People Long Term Plan that includes a young person version and an Easy Read Version
- Continue to enhance our LDA workstreams to enhance our all-age offer
- Develop our community hubs across the partnership



- Improve our crisis response and discharge pathways
- Continue to ensure partners are using tools to better support our LDA community e.g., communication plans, hospital passports, advance care plans etc.
- Continuing to develop our strategies and plans with partners in the county, region and nationally

Special educational needs and disabilities (SEND)

There is a need to improve how SEND communities can access the services they need, and therefore we have been undertaking work in the area across our partnership including:

- We have been using the ICS SEND maturity matrix to ensure our local systems are sighted on CYP with SEND and upholding our statutory duties. This self-evaluation has enabled us to assess how well we are doing (and where we need to improve. NHSE/I gave Northamptonshire positive feedback in relation to the work we are undertaking in this area.
- Our health and social care system continue to co-produce our model with CYP and families for short breaks and this will inform our work when we go to market with a new framework in late 2022

Learning disabilities and autism

There have been several key areas we have sought to improve, including:

- Recruiting staff for a new key worker and peer support service to assist CYP and families at risk of admission to hospital
- We have been piloting a new approach to fast-track individuals on the waiting list for autism assessments to help us design our new transformation project to improve waiting times
- We have been working with our partners including special schools to ensure more young people from the age of 14 receive their annual health checks

Physical health and complex needs

- Our new support service to improve health outcomes for young offenders are improving the future for this vulnerable group
- We continue to work as a partnership to improve the timeliness of initial and review health checks for children in care
- We are reviewing the improvements that can be made within health services for children and young people, especially regarding long term conditions such as asthma

- We are using the learning from a recent paediatric palliative care project to inform the design of future palliative and end of life services for children and young people, to support them and their families as they come to the end of their only years of life

None of these pieces of work would not have been possible without the teamwork across the system, and we have a vision for Northamptonshire's children transformation that is a true partnership

Elective care

From July 2023 the ICB has supported the system w ide approach to Elective recovery and transformation as a partner in the emerging Elective Collaborative. A significant element of this work has focussed on ensuring all patients waiting longer than two years are treated. Due to the relatively strong position of Northamptonshire we were able to to support patients who had been waiting in neighbouring systems be treated sooner. Waiting times, and the number of patients waiting, are amongst the lowest in the country.

Several priority pathways have been identified by the system that the ICB has supported development of a health and social care system that is increasingly integrated in approach to better support patients and carers

Cardiovascular

The system has made progress on implementing a refreshed approach to system working on cardiovascular it has been agreed to begin with three key priorities:

- Heart failure
- Cardiac Rehab/ Lipid Management

- Atrial fibrillation

The ICB is working closely with colleagues across the system as part of the Elective Care Collaborative. A working group has been stablished inclusive of clinical professionals across both hospital sites, population health management, and primary care to agree an approach to one of the biggest challenges we face locally will lead on delivery against the programmes. The deliverables against the programme will be implemented with support from the Cardiology Forums Network.

Cancer

Both local acute hospital trusts continue to prioritise cancer on behalf of its most vulnerable patients to ensure the best possible outcome and experience. Both trusts are routinely meeting and exceeding the Faster Diagnosis Standard (FDS) to ensure patients who are referred for suspected cancer receive a timely diagnosis. During Quarter 1 the system cancer programme has focussed on key plan priorities as follows:

- Development of a GP resource pack supporting implementation of the Network contract Direct Enhanced Service (DES) in Primary Care
- Continuation of Corby Targeted Lung Health checks, on track for completion of baseline low dose CT scans by end Quarter 2 2022/23
- Participation in the national NHS Galleri trial (GRAIL), aiming to detect cancers earlier by looking for abnormal DNA shed from cancer cells into the blood. Baseline tests April-May 2022, with trial completed by 2023
- Planning for acceleration of Rapid Diagnostic Services for FDS pathways and alignment with Community Diagnostic Hubs by end Quarter 2 2022/23

- Planning for the introduction of FIT (Faecal Immunochemical Testing) for all Lower GI FDS pathways, where clinically appropriate, by Quarter 3 2022/23
- Continued delivery of colon capsule endoscopy and cytopsonge innovations in the Lower and Upper GI pathways
- Implementation of breast pain pathway clinics in the community Quarter 2 2022/23
- Planning for the introduction of personalised stratified follow up pathways (PSFU) with remote monitoring for gynaecology, thyroid, endometrial and skin by Quarter 4 2022/23

Diabetes

The ICB, trusts and national team are united in pushing Diabetes restoration services as a fall out from Covid. We have prioritised current programmes of work and initiated projects to ensure the increase in the patients being diagnosed are addressed, ensuring not only value for money but increased patient care following NICE guidance.

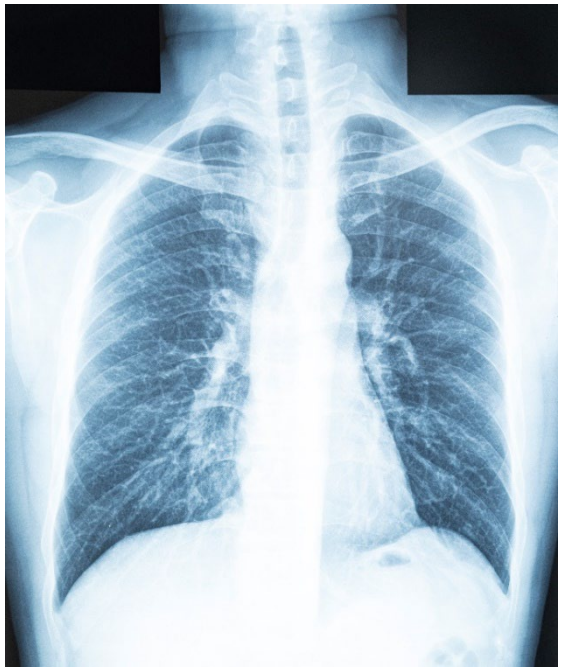
- Recruited a Band 6/7 Prescribing DSN to be a co-ordinator based with ICT working with KGH & NGH A&E / admission assessment units with a focus on;
  Admission avoidance – trouble shooting and redirecting to primary / community care with a management plan
  Accelerating Safe Discharges – improving the flow of the patient from admission to discharge, communicating with wards, SPOA / Community Nursing, Care Homes, to ensure the patient has the right equipment and the prescriptions are correct and appropriate for the service they are being discharged to.
  Work with the MDT on frequent flyers, vulnerable adults.
  DSN to support the inpatient service working with the MDT and cover the weekend / BH on shortened hours / on-call basis.

- Upskill and support primary care clinicians to deliver a higher quality service, with good data as this enables us to access and model care for the future. £6,000 has been planned for spend on upskilling provider staff in EDEN. This links into primary care and can push the messages needed to embed best practice. This funding would support enough staff to cover each hospital site (NGH and KGH) with 3 for the community (North, Central and South) and an additional place funded to act as cover. To further support this,
- £16,000 has been split equally (£1,000 each) across the 16 PCN's as an incentive to support the initial time to embed this learning.
- Rolled out a national programme across health and social care to improve patient safety by training care home staff to develop competency to deliver insulin to named residents.
- 3 x PDSA cycles trialled in September 2022
- PDSA 3 adopted & implemented October 2022
- NHS Low Calorie Diet Programme is in the planning stages of expansion to the remainder of England. Northamptonshire to prepare for procurement in February 23.
- NDPP initiated face to face groups. Highest conversion rate in England.

Respiratory

Since forming the new System Respiratory Programme, underpinned by a core System Leadership Team, a plan has been developed setting out key priorities for the next period. These include:

- The continuation of support for long Covid/post Covid syndrome through the further enhancement of workforce, and referral management in line with NHSE priorities
- Restarting of spirometry post COVID-19 within primary care for those with new symptoms
- Designing a Pulmonary Rehabilitation Programme offer for those living with COPD, whilst working with national partners to develop our local model of care against the NHS Long Term Plan, and new five-Year Vision for Pulmonary Rehabilitation plan published this year.



- Working with My Health to review implementation of a digital service application for patients to support self-management in the community which will launch in the next period
- Working with The Health Economics Unit to improve our understanding of local need, through the STAR Tool project. This work includes a review of local system projects against their value to support direction and focus of the Respiratory programme for the next period. This work has taken place in partnership working with other regional systems, national partners, and our local councils.
- Working with Public Health to support patients with Tuberculosis, an area identified by the national team as a priority within Northamptonshire. With support from national teams on plans and funding to support this implementation over the next 3 years.
- Continuing to support patients who receive Home Oxygen Services

Ophthalmology

A system wide Ophthalmology working group has been established that has reviewed pathways and processes between primary and acute care. This has focussed on delivery of the best practice “High Volume Low Complexity” pathway. We are working with colleagues from the Local Optometry Committee to improve patient information and sharing of best practice across the system.

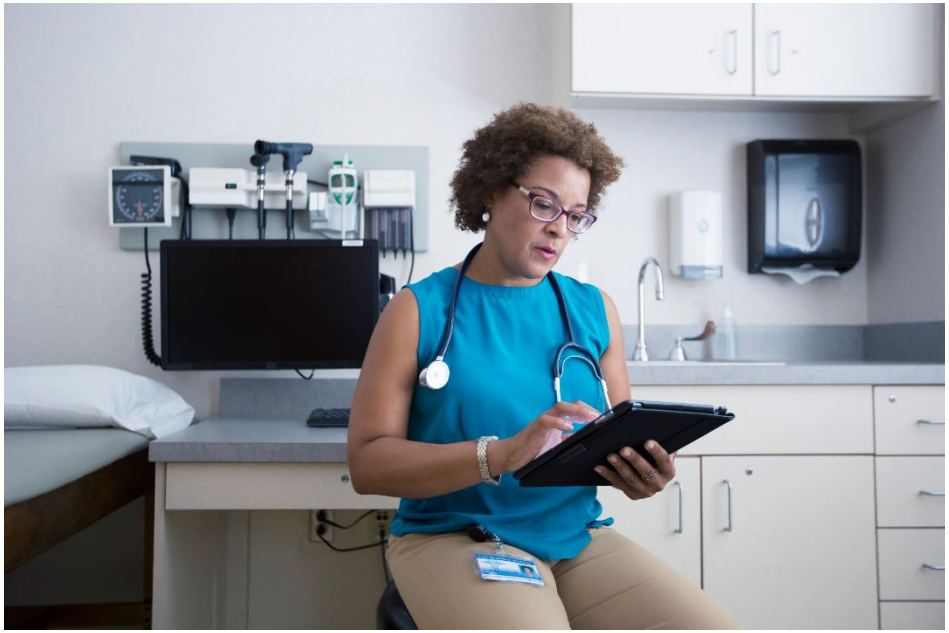
The ICB has commissioned community contract services to make best use of the capacity we have in our system. This will increase choice for our local population and increase the number of providers in the local population. At the time of writing this procurement is at the contract award stage.

Gynaecology

Through the Elective Care Collaborative, the system is piloting a Gynaecology Triage and Treat model in the North of the County. This service puts care closer to patients and utilises skills in Primary Care, whilst working closely with Acute colleagues. The pilot will run until the end of 2022/23 and will be evaluated to inform future.

- In addition to this the system has had a “Getting it Right First Time” Gateway Review for Gynaecology and will be developing a system wide action plan to improve services for our local population. This will involve all elements of the pathway, from pre-referral through to hospital and post discharge care.

Urgent care



After a very difficult start to 2022 when Northamptonshire declared a system wide major incident due to pressure in the urgent care system, work started to identify a number of transformation projects and rapidly progress other initiatives planned for launch in 2022. It was our ambition to have these developments in place for the following winter.

Heading into the spring, ambulance response times were causing concerns locally and this position was replicated nationally. Predominantly, the response times across the county were being hindered by busy Accident and Emergency (A&E) Departments, full wards and delays in patients being discharged that needed support into the community. An ambulance recovery plan was developed for Northamptonshire to improve the position. A number of immediate actions were put in place to ensure patient safety was maintained, including an agreement that ambulance crews could immediately hand over a patient to A&E if they needed to respond to an emergency in the community and EMAS our ambulance provider were given the ability to divert ambulances between the two hospitals based on waiting times without the prior approval of the hospitals.

In early summer, the newly formed ICB Board approved a business case for the launch of Rehabilitation Independence Beds (RIB) in Turn Furlong Specialist Care Centre. This was a joint initiative between health and social care and meant that a further 17 beds would be opened in the unit as well as developing the existing 34 beds to enable patients with a higher needs to be admitted. The service launched in November with a plan to be fully operational by the end of March 2023.

As planned, other transformational projects started to come on line in the autumn, including the expansion of virtual wards, the community rapid response team working with EMAS to respond to patients better served by a nurse and the launch of system dashboards which enabled better visibility and understanding of patients waiting for discharge. A temporary ward which was due to be returned following the renovation of a ward at Kettering General Hospital was kept on site to support winter pressures and community based respiratory hubs, operated by General Practice were launched for a four month period to support the expected increases in respiratory illnesses during the winter months.

All of the above was made possible due to winter investment and a social care discharge fund. In addition to the health developments, significant investment enabled further capacity to be purchased by social care to facilitate hospital discharges back in to the community.

Late autumn and early winter was extremely challenging due to high numbers of influenza, COVID, other respiratory infections and concerns with Strep A which was highly publicised by the media. In addition a number of strike dates for ambulance and nursing staff were announced. Nationally it was described as the most difficult winter in the history of the NHS with both COVID and flu peaking on the 29 December. Northamptonshire as a system responded to this pressure extremely well in very difficult circumstances, this was a reflection of the hard work and dedication of all health, social care and voluntary sector workers that worked tirelessly together to keep patients safe and well.

Primary care

In July, August, September, and October 22 **1.5 million** appointments were provided by GP practices in Northamptonshire including:

- 975,000 face-to-face appointments or home visits
- 450,000 telephone appointments
- Over 9,000 video or online appointments

This has meant over **550,000 appointments** offered on the same day (1 in 3) and over **75,000 appointments** offered next day.

Patient experience also showed:

69% of patients stated that the practice website is easy to use. Further work is underway to improve this and make the practice website the first-place patients go to for information

61% of patients had an in-person appointment, in line with the national average and higher than in 2021

82% of patients rated the practice receptionist as helpful which was the same as in 2021

95% of patients had confidence and trust in the healthcare professional treating them in 2021

97% of patients were asked for information about why they were making an appointment to ensure they received an appointment with the right healthcare professional.

88% of patients stated that they were involved as much as they wanted to be in their care.

Shared decision making is on the increase, so this is expected to increase

Care navigation training

Care navigation training has continued throughout the pandemic virtually to support all Care Navigators in implementing the soft skills which support the project. The training agendas include an introductory course for those who may have never navigated before or those needing a refresher, soft skills such as communication, conflict resolution and assertiveness and lastly Reception Plus. Reception Plus was devised to support staff in a holistic approach by bringing all aspects of the original four agendas into one training course. Training to support the staff builds confidence and skills to enable the staff to effectively care navigate.

BSL training

We have been holding British Sign Language (BSL) Training for non-clinical staff across the county. The training demonstrates the basics of BSL such as the alphabet, numbers, and small talk conversations. The training also included basic medical signs to help support non-clinical staff in their roles within Primary Care.

By providing this training this has empowered practice staff to feel more confident in their role. The feedback we have received from our practices has been great and below are some quotes from practices.

"The session was fantastic and really interesting- thank you for organising!"

"Thank you so much for organising the BSL training. My reception staff have been buzzing, although I'm not sure all the hand signals they do to the patients are in the BSL handbook!!! They have loved the course and thought it was well run and engaging."

Restoration of services

Funding was provided at the end of March for practices to conduct a '**Waiting List Risk Stratification & Management'** exercise.

The intention was for practices to review patients who were waiting for procedures usually offered by the practice and deferred due to COVID-19.

Due to COVID-19 and delivery of the COVID-19 mass vaccination programme, many GP services were stepped down, and as a result GP practices held waiting lists for patients waiting for operational procedures. There are two parts to the scheme:

- Risk stratification and validation
- Ongoing management of patients waiting for procedures

GP practices have the autonomy to design how they created any extended capacity and flexibility of how they safely manage patients that are identified as a priority.

GP-CPCS

Community Pharmacy Consultation Service (GP-CPCS) is a formal pathway that enables GP Practices to refer patient with minor illnesses for a same day consultation with an NHS Community Pharmacist. To support our practices and care navigators we have created training videos for practice staff on what the service is and how to use the referral process. These videos are short cartoon videos which we have one for Systm1 and one for EMIS which are our two clinical systems our GP practices use in Northamptonshire.

Remote Monitoring in Care Homes

Several care homes and PCNs across Northamptonshire are trying digital tools to improve out of hospital care.

It's too soon to analyse the benefits for this report, but it is hoped data will be available for the next report

Covid vaccination and flu immunisation

For the Autumn – Winter 2022 Covid Vaccination Programme 230,887 total Covid vaccine doses have been administered. 80.93% of Care Home residents are completed as of 5th December 2022.

Flu Immunisation uptake in Northants:

Northamptonshire ICB Flu Immunisation uptake up to 21/11/2022			
Cohort	2021 -2022 % uptake	2022 - 2023 % uptake	Difference
Aged 65+	74%	75%	1%
6 months to under 65 at risk	36%	41%	5%
Pregnant Women	27%	27%	No change
Aged 2 years old	37%	26%	-11%
Aged 3 years old	38%	28%	-10%
Aged 4 years old to 10	14%	39%	25%
Aged 50-64 not at risk	31%	34%	3%
Aged 50-64 at risk	55%	55%	No change

In comparison to a similar time period last year, there is an improvement in uptake in people aged 65+, people within the at risk group and the primary school age children.

Uptake remains the same for pregnant woman. However, vaccinations in children aged two and three shows a decline of around 10% from last year.

Digital journey planner

The primary care team have been working closely with Redmoor Health to support practices with their digital presence. Redmoor has developed their Digital Journey Planner (DJP) system alongside the NHS to optimise the practice knowledge, understanding and process to improve patient experience, thus helping to deliver a more consistent digital journey.

The DJP uses a step-by-step approach, focused on three criteria: baseline / learn / improve, which can be fully supported by the team in the Redmoor support centre. The DJP has been developed with NHSE/I Digital first primary care team to help general practice with digital transformation.

Several pilot sites have already worked through the first available modules, with the support offer open to all practices within Northamptonshire.

Supporting the Afghan refugee's project

Since September 2021, our health providers have been supporting Afghan refugees in two Northamptonshire hotels as part of the Home Office scheme.

Wrap-around care including Primary Medical, Maternity and Mental Health Services have been put in place to support refugees while they are placed in hotels until more permanent accommodation can be found for them.

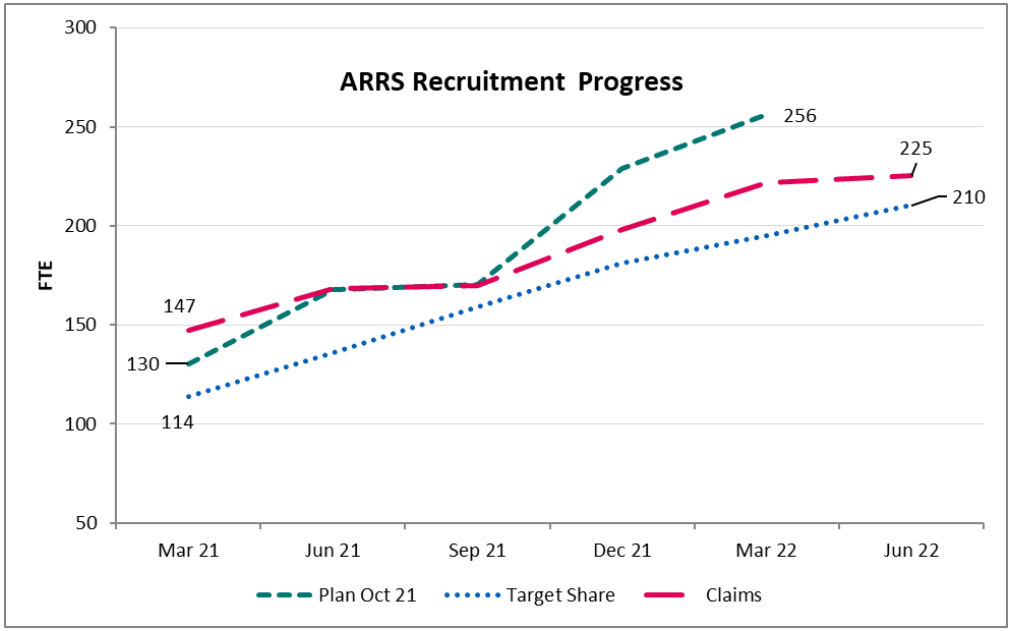
The Home Office completed an audit of these hotels and the health care provision provided was considered a platinum service.

All the Health staff involved in this project has stated that overall the experience has been incredibly positive and all report a huge sense of satisfaction on carrying out their roles.

Workforce

Our most recent data shows continuation of a positive trajectory for the trend in Northamptonshire's workforce numbers. This trajectory indicates a 4.6% increase in permanent GPs between 2019 and 2022. It also includes a 10% increase in GP Registrars indicating a positive outlook for future GPs.

Direct patient care staff in primary care have increased by 19% since 2019. However, when combined with the direct patient staff employed by Primary Care Networks via the Additional Roles Reimbursement Scheme (ARRS) the increase rises to 158.25%. ARRS recruitment in Northamptonshire is tracking above the local share of the government's 26,000 full-time equivalents (FTE) by 2024.



The plan was to recruit a greater number, but several factors have had an impact on this, the number 1 being available space in primary care settings.

Since July 2021, Albany House Medical Centre has been acting as a caretaker to provide Primary Medical Services at Earls Barton Medical Centre and Penvale (branch) Surgery. Meanwhile, commissioners at Northamptonshire ICB conducted a procurement exercise to appoint a more long-term provider. Following this exercise, Weavers Medical have been appointed and will be taking over the contract from 1st February 2023 for a period of 10 years with an option to extend for a further 5 years. Patients registered at Earls Barton and Penvale will still be able to access the full range of services they always have, which will continue to be delivered from the same locations.

September 2022 workforce figures show a 12% increase in GPs since March 2019

GPs in a training grade have increased by 5% since 2019

Since March 2019 Nurses in Primary Care have increased by just 3%

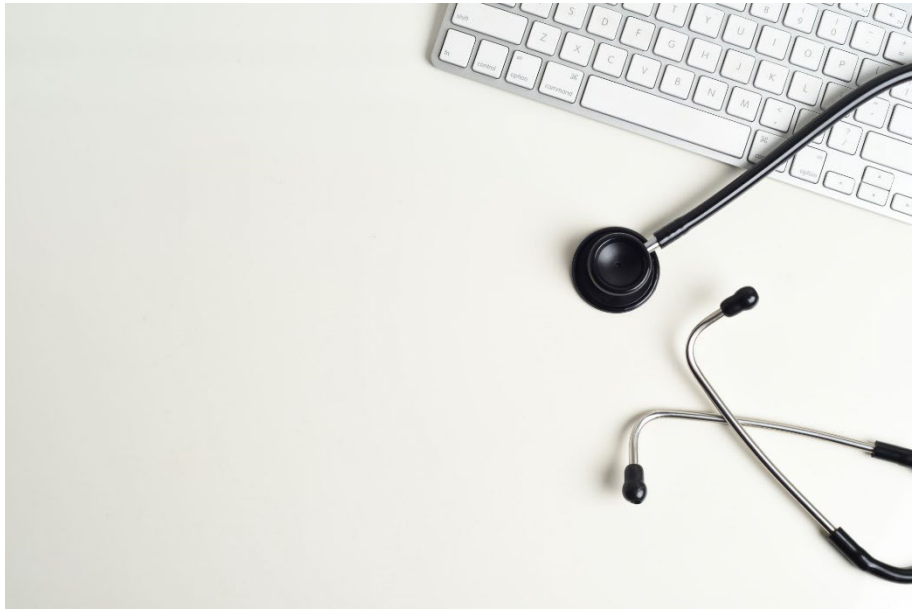
38% of the Primary Care Nursing Workforce is over 55 years of age and 50% are over 50

With the inclusion of additional roles, Direct Patient Care staff has increased by 199%

The Additional Roles Reimbursement Scheme is on track to exceed its target share of 26,000 new roles by 2024

Enhancing opportunities programme

The Enhancing Opportunities Programme (EOP) is being developed by the Primary Care Team and consists of 4 workstreams. The EOP aims to help PCNs and Practices to develop clinical strategies based on population health needs, strengthen governance arrangements across Practices and other organisations, support innovative ideas and understand where investment in enablers such as digitisation and estates is required. Building a picture of the local challenges and potential solutions will lead to plans starting to form for Practices and PCNs. An understanding of these plans will allow the ICB to swiftly respond to investment opportunities as they arise and channel any funding in the most beneficial way.



Update on PCN service and estates planning toolkit

NHS England issued guidance in mid-2019 asking Primary Care Networks (PCN) to prepare plans for the management and development of their combined estate. Whilst PCNs have been focused on the vaccination program since the guidance was issued, NHSE has continued to work in the background with Community Health Partnerships (CHP) and the National Association of Primary Care (NAPC) to create a strategy development toolkit for use by PCNs to create a consistent and simplified approach to strategy development.

As part of this piece of work CHP will employ the services of a clinical planner to work with Clinical Directors to set out a clinical vision for the PCN. This plan will identify the key issues the PCN faces clinically and set out some principles needed to inform a detailed clinical strategy in the future. The plan will then go on to identify staffing, digital and estate's needs. Following this, an Estates planner will be employed to assess the current estate and proposed clinical models, undertake an estates gap analysis to identify where space may impact upon delivery of the proposed clinical model, and where needed identify opportunities which may bridge that gap.

The exercise will be a light touch process, providing an initial baseline from which to build more robust plans in the future. It is intended to help PCN leaders and GP practices create an evidence base to substantiate any claims for additional space and facilities moving forward.

Going concern assessment

At the time of preparing the financial statements Northamptonshire ICB is still to complete its first year of existence. The ICB is part of Northamptonshire ICS which integrates care between Health partners and the Local Authorities. As the ICB is still within the public sector, the going concern basis of preparation of the financial statements will remain appropriate.

When considering whether Northamptonshire ICB is a going concern for at least 12 months after the accounting period and that its accounts should be prepared on that basis Northamptonshire ICB needs to document its consideration of any material uncertainties that may cast doubt on the body's ability to continue as a business. As part of this assessment process the ICB undertakes a review of its status in advance of producing the Annual Report and Statement of Accounts and has procedures in place to make that assessment including the following:

- The Financial Strategy and Financial plan both consider the financial position of the organisation over the short and medium term and are designed to ensure that the ICB is financially sustainable and continues as a going concern.
- Internal Audit's work plan provides an on-going review of key elements of the financial controls and delivery of ICB priorities to ensure its delivery or to highlight at an early stage any unforeseen risks.
- Sound financial management & reporting including budget monitoring carried out by the Finance Department and assured through the Integrated Planning and Resources Committee so that financial control is carried out to ensure the continuation of the ICB’s business.
- The ICB has remained in a financially stable position throughout 2022/23 and is going to deliver an underspend at year end.
- The ICB is expecting to submit a surplus financial plan to NHSE for 2023/24 when it submits the final plan at the end of April.

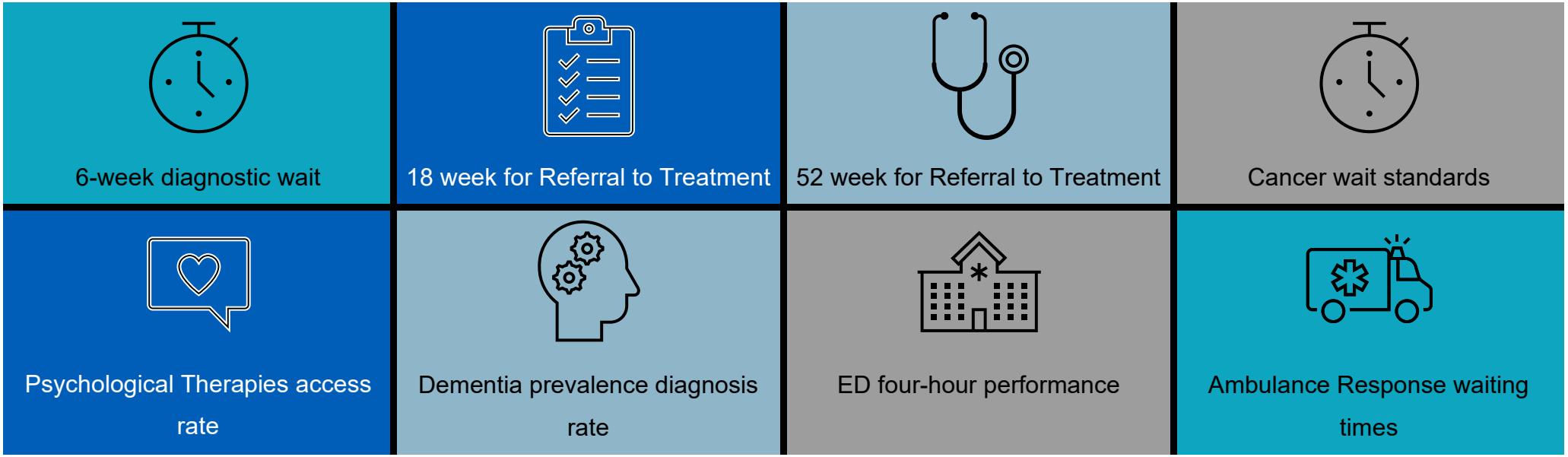
The ICB is not aware of the existence of any other events or conditions that may cast doubt on the ICB's ability to continue as a going concern.

The Statement of Financial Position has therefore been drawn up at 31 March 2023 on a going concern basis.

Performance analysis

NHS Northamptonshire ICB measures its performance against national NHS standards. These are a series of measures which are used to assess the performance of each health service. We, and our providers, have struggled to meet many required standards in the current period as COVID-19 has had a significant impact on both physical capacity for and volume of appointments.

This is due to COVID-19 protection measures, social distancing and sanitising equipment between patients leading to challenges, even where standards were being consistently or periodically achieved prior to the pandemic. Examples of the NHS standards are below.



All performance issues are escalated to the ICB Quality Committee and the Governing Body, which considers performance at every meeting. More detail about performance is included in the section on the following pages. Only data is available for 2022-23 due to being a new organisation.

Urgent care - patients waiting four hours or less in ED

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED waits	Patients to be admitted, transferred, or discharged within four hours of arrival at ED	**95%**	**NGH**	NA	**66.66%**	**65.37%**	**67.29%**	**66.38%**
			KGH *	Not monitored formally during urgent and emergency care (UEC) Clinical Review of Standards field-testing exercise				N/A

Urgent care - patients waiting on a trolley over 12 hours

Delivering the Emergency Department (ED) four-hour standard is a national challenge. The ongoing impact of the COVID-19 pandemic is only one of the many reasons the standard has not been achieved. A continuing high demand for emergency care services for patients with complex care needs has challenged the hospitals' capacity, and continuing bed closures both in and outside of the Acute Trusts has affected flow.

These combined pressures have led to ambulances having to wait far longer than the target time to unload patients into ED, and to patients waiting more than 12 hours in ED for a bed to be available: this has not happened in significant volumes, since before this measure was regularly recorded.

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED Waits	Waits from decision to admit (DTA) to admission (trolley waits) over 12 hours	**0**	**NGH**	NA	**2,272**	**1,945**	**1,502**	**5,719**
			KGH	NA	N/A	N/A	N/A	N/A

Ambulance handover

All handovers between ambulance and ED must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Please note data for this measure is from East Midlands Ambulance Service (EMAS) and can differ from the Acute Trusts' ED data. Please not also that the delays of over 30 minutes INCLUDE the delays over one hour.

2022/23 – Quarters 2 – 4							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over 30 minutes)	**0**	**NGH**	NA	**2,942**	**3,092**	**2,167**	**8,201**
		KGH	NA	**1,806**	**2,518**	**1,774**	**6,098**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over one hour)	**0**	**NGH**	NA	**1,055**	**1,405**	**573**	**3,033**
		KGH	NA	**245**	**576**	**270**	**1,091**

The key driver of delays in ambulance handover is usually that emergency departments are beyond capacity. The actions we are currently taking, detailed in the Urgent Care section of this report, are helping to resolve ambulance handover issues, and the ICB continues to work closely with EMAS to improve processes. There was a peak in volumes of both A&E patients and ambulances in December, leading to the Q3 spike.

Cancer waiting times

Before the COVID-19 pandemic and its knock-on effect on both demand and capacity, KGH was meeting and maintaining the required performance against all cancer standards. This continued in most months throughout the first half of 2021/22, except for the 62-day standards. Subsequently, achievement of the standards has become much more variable, with wide swings from month to month. The length of waiting lists is a cause for concern, and is being tackled within the Cancer Working Group, in discussion with providers, some of whom are out of county. In most cases, in the shorter standards (2WW and 31 days) even where the target is not met, it is close, with performance in the high 80s and 90s

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits Two-week wait	Maximum two-week wait for first outpatient appointment for suspected cancer	**93%**	**Northamptonshire ICB**	NA	**86.62%**	**90.21%**	**90.32%**	**89.01%**
			NGH	NA	**84.83%**	**90.76%**	**90.10%**	**88.52%**
			KGH	NA	**92.28%**	**92.15%**	**92.17%**	**92.20%**
	Maximum two-week wait for first outpatient appointment referred urgently with breast symptoms	**93%**	**Northamptonshire ICB**	NA	**92.03%**	**75.85%**	**94.98%**	**87.55%**
			NGH	NA	**97.65%**	**66.79%**	**95.40%**	**86.28%**
			KGH	NA	**96.89%**	**90.98%**	**93.39%**	**93.98%**

In contrast, NGH was already struggling with maintaining its performance consistently against these standards: although 2021/22 showed an improvement over 2020/21 in almost all categories which is continuing into 2022/23. However, the only standard achieved every month was 31-day wait for radiotherapy treatment. Recovery has been seen in many areas, but volumes of referrals are high, and the Trust does not always have sufficient capacity to treat them within the required time frame.

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits **31 days**	Maximum one-month wait from diagnosis to first definitive treatment for all cancers	**96%**	**Northamptonshire ICB**	NA	**90.68%**	**90.72%**	**88.73%**	**90.10%**
			NGH	NA	**91.36%**	**92.20%**	**88.61%**	**90.71%**
			KGH	NA	**94.30%**	**94.07%**	**96.65%**	**94.99%**
	Maximum one-month wait for subsequent surgical treatment	**94%**	**Northamptonshire ICB**	NA	**77.12%**	**80.92%**	**75.00%**	**77.39%**
			NGH	NA	**75.76%**	**72.50%**	**74.58%**	**74.24%**
			KGH	NA	**94.59%**	**93.75%**	**88.16%**	**91.30%**
	Maximum one-month wait for subsequent anti-cancer drug treatment	**98%**	**Northamptonshire ICB**	NA	**98.65%**	**99.72%**	**98.36%**	**98.90%**
			NGH	NA	**98.54%**	**100%**	**98.43%**	**98.98%**
			KGH	NA	**100%**	**98.44%**	**100%**	**99.52%**
	Maximum one-month wait for subsequent radiotherapy treatment	**94%**	**Northamptonshire ICB**	NA	**97.69%**	**96.82%**	**96.14%**	**96.86%**
			NGH	NA	**98.98%**	**97.21%**	**95.44%**	**97.14%**
			KGH	NA	No patients	No patients	No patients	No patients

The 2WW and 31 day categories are in the process of being replaced by 28 Day Faster Diagnosis Standard (FDS) – and in this category both NGH and KGH are exceeding the target and are achieving among the highest rates in the region. This measure has now been added to this report.

2022/23								
NHS Constitution measures – quarterly		**Std**	**Organisation**		**Q2**	**Q3**	**Q4**	**Year**
28 Day Faster Diagnosis Standard	Patients given cancer diagnosis outcome within 28 days	**75%**	**Northamptonshire ICB**		**82.11%**	**83.86%**	**83.48%**	**83.13%**
			NGH		**79.79%**	**82.41%**	**81.81%**	**81.33%**
			KGH		**88.12%**	**87.97%**	**87.73%**	**87.94%**

Both NGH and KGH are consistently exceeding this measure and achieving among the highest providers in the region.

There has still been no consistency in achievement of these 62 day standards, on either site or across the ICB. In sporadic months they have been achieved at one Trust or the other, but these have not been maintained. Referral levels are significantly above the same period in 2019/20, and show no sign of abating.

2022/23 – Quarters 2 -4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits 62 days	Maximum two-month wait from urgent GP referral to first definitive treatment	**85%**	**Northamptonshire ICB**	NA	**63.36%**	**61.54%**	**57.29%**	**60.85%**
			NGH	NA	**65.34%**	**59.69%**	**56.13%**	**60.39%**
			KGH	NA	**64.97%**	**67.56%**	**62.26%**	**64.98%**
	Maximum two-month wait from referral from an NHS screening service to first definitive treatment	**90%**	**Northamptonshire ICB**	NA	**67.11%**	**72.73%**	**72.58%**	**70.80%**
			NGH	NA	**74.24%**	**82.95%**	**77.59%**	**78.77%**
			KGH	NA	**60.44%**	**61.11%**	**66.22%**	**62.00%**
	Maximum two-month wait for first definitive treatment following a consultant's decision to upgrade	**No std**	**Northamptonshire ICB**	NA	**75.00%**	**70.67%**	**68.81%**	**71.34%**
			NGH	NA	**75.23%**	**69.88%**	**70.37%**	**71.61%**
			KGH	NA	**74.56%**	**80.80%**	**76.56%**	**77.38%**

Planned care: referral to treatment (RTT)

This standard requires that at least 92% of patients waiting for consultant-led treatment have been waiting less than 18 weeks. The recovery from the COVID-19 related low point in May 2020 was gradual but consistent for around 18 months, and levels have remained stable for the

subsequent 6 months, although still some way off pre-Covid performance for both Trusts.

While the formal standard of 18 week waits % has remained relatively constant, the long waits (52ww and above) have been steadily decreasing. The small recent rises have been related to both NGH and KGH offering mutual aid to UHL for their 104ww patients. The plan for 2022/23 shows these long wait patients decreasing significantly.

2022/23 – Quarters 2 - 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment 18-week wait	Patients on incomplete non-emergency pathways for less than 18 weeks (yet to start treatment)	**92%**	**Northamptonshire ICB**	NA	**66.07%**	**62.81%**	**61.41%**	**61.41%**
			NGH	NA	**70.58%**	**66.37%**	**62.18%**	**62.18%**
			KGH	NA	**65.48%**	**61.78%**	**62.11%**	**62.11%**

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment 52-week wait	No patient should wait over 52 weeks from Referral to Treatment (incomplete pathways)	**0**	**Northamptonshire ICB**	NA	**1,151**	**1,310**	**2,150**	**2,150**
			NGH	NA	**174**	**250**	**972**	**972**
			KGH	NA	**103**	**125**	**220**	**220**

Diagnostics

This standard requires that no more than 1% of patients wait over six weeks for a diagnostic test. While NGH has not met this standard since March 2019, the issue in 2019/20 was internal, and despite this the percentage achievement did not fall below 93.5%. In 2020/21, COVID-19

related capacity shortfall led to performance dropping below 50% for several months, and then showing gradual improvement, but recovery has still not reached pre-Covid levels, and is now consistently falling, on account of capacity shortfalls, particularly in MRI and Ultrasound.

At KGH, the standard was being fully achieved before the COVID-19 pandemic and recovery was faster, but in 2022/23 capacity issues had a significant impact, particularly within CT and Echocardiography.

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Diagnostic test waiting times	Patients waiting less than six weeks for a diagnostic test	**99%**	**Northamptonshire ICB**	NA	**64.78%**	**49.82%**	**60.85%**	**60.85%**
			NGH	NA	**77.18%**	**62.94%**	**68.04%**	**68.04%**
			KGH	NA	**52.50%**	**35.84%**	**48.71%**	**48.71%**

The Northamptonshire healthcare system now has funding for community diagnostic centres (CDC) to come online during Q1 of 2023/24, which will allow one stop diagnostic facilities for patients closer to home within the community.

This will also facilitate shorter wait times for patients and a reduced footfall onto acute hospital sites, allowing for focused provision of diagnostics for urgent care and elective inpatients within hospital.

Still more capacity is needed, however, and a business case for a second wave of CDC provision is currently under discussion.

Dementia diagnosis

Achievement has been close to, although failing to achieve, the 66.7% target throughout the last three years. Northamptonshire is, however, above the regional average. Timely access to brain scans is a concern, and the aftercare pathway is currently under review.

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**		**Q2**	**Q3**	**Q4**	**Year**
Dementia	Diagnosis prevalence rate, ages 65+	**66.7%**	**Northamptonshire ICB**		**61.89%**	**62.39%**	**61.72%**	**62.00%**

Mental health: care programme approach

No figures are available for the current year as data collection has not been resumed following the COVID-19 pandemic.

Improved access to psychological therapies (IAPT)

There are two performance standards for IAPT; one relates to ensuring appropriate access and the other to recovery rates following IAPT. Completed treatment rates are being achieved, and recovery is consistently within 0.5%. However the access standards have not been met since the increase in the standard in 2019/20. Performance has, however, recovered to above pre-Covid levels. The main issue is generating sufficient referrals.

2022/23 – Quarters 2 – 4								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Improved Access to Psychological Therapies (IAPT)	IAPT access (monthly)	**2.08% mth**	**Northamptonshire ICB**	NA	**5.12%**	**5.51%**	**5.59%**	**16.22%**
	IAPT access proportion (rolling)	**25% FY**		NA	**20.01%**	**20.96%**	**21.33%**	**21.33%**
	IAPT recovery rate	**50%**		NA	**48.83%**	**49.87%**	**50.12%**	**49.59%**
	% completed treatment six weeks	**75% by year end**		NA	**95.54%**	**96.68%**	**97.67%**	**96.61%**
	% completed treatment 18 weeks	**95% by year end**		NA	**99.33%**	**99.23%**	**99.54%**	**99.37%**

Performance against other NHS measures

NHS services are also required to meet the following standards from the NHS Constitution:

The mixed sex accommodation standard is being impacted by the overall capacity issues since beds are at a premium.

2022/23 – Quarters 2 - 4							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
No mixed-sex accommodation breaches	**0**	**Northamptonshire ICB**	NA	**94**	**194**	**104**	**392**
		NGH	NA	**75**	**165**	**78**	**318**
		KGH	NA	**0**	**0**	**0**	**0**
		NHFT	NA	**0**	**0**	**0**	**0**

2022/23 – Quarters 2 - 4							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4 2 months**	**Year**
Operations cancelled on or after the day of admission to be offered another binding date within 28 days	**0**	**NGH**	NA	**0**	**0**	**0**	**0**
		KGH	NA	**17**	**1**	**4**	**22**

2022/23 – Quarters 2 – 4							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
No urgent operation to be cancelled for a second time	**0**	**NGH**	NA	**0**	0	**0**	**0**
		KGH	NA	**0**	**0**	**0**	**0**

How has the organisation managed risks?

The Annual Governance Statement section outlines how the organisation mitigates for and manages the impact of key risks. Please go to page 111 onwards to read more about this.

Mental health

Northamptonshire ICB spent £122,480 on mental health during the period 1st April 2022 to 31st March 2023. We have outlined the expenditure in the table below. You can read more about the schemes supporting mental health on pages 17 to 19.

Financial years	2021/22	2022/23
Mental health spend	112,260	122,480
ICB programme allocation	1,351,944	1,427,408
Mental health spend as a proportion of ICB programme allocation	8.30%	8.58%

Children and young people (CYP) safeguarding

In July 2022, the *Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework - SAAF (NHS England)* was updated, reflecting the context for safeguarding as it continues to change and expand in response to the findings of large-scale enquiries, incidents in a rapidly evolving and increasing digitalised world, the lived experience of the child, young person and family and new legislation aimed to strengthen protection of those at risk. Programmes include Prevent, human trafficking, child exploitation, working together, domestic abuse.

The SAAF sets out the safeguarding roles across the National Health Service and provides guidance and minimum standards of the programmes which are explicitly contained within the framework. In terms of the ICB (which includes primary care), the organisation will ensure that:

- The organisations from which they commission services provide a safe system that safeguards children, young people, and adults at risk of abuse or neglect
- They are fully engaged with local safeguarding children's partnerships and safeguarding adult boards with engagement at statutory reviews, sub -group activity, audit work, revision of policies, procedures and processes and training
- Robust processes are in place to learn lessons from cases where children, young people and adults die or are seriously harmed, and abuse or neglect is suspected and;
- They work in partnership with NHSE to ensure that the health commissioning system as a whole is working effectively to safeguard and improve the outcomes for children, young people, and adults at risk.

The ICB works in collaboration with NHSE and has responded to safeguarding assurance requests on behalf of the local health system. The safeguarding compliance assurance tool (SCAT) was completed in 2021 and updates are provided on a quarterly basis. Other national priorities such as the mental capacity act, self-neglect, Liberty Protection Safeguards (LPS), multi-agency safeguarding hubs (MASH), neglect and child exploitation are reported on a regular basis as an additional assurance mechanism and in response to national reviews such as Arthur and Star.

The ICB has agreed a quality assurance framework for identifying, monitoring, and challenging quality, including safeguarding in organisations that are commissioned. Assurance about the safeguarding provision of local providers is monitored through the Quality Committee and also annual safeguarding meetings following completion of the SCAT. Furthermore, the strategic planning, discussion, and delivery is managed through the Northamptonshire Strategic Health Safeguarding Forum. The forum membership comprises of executive level leads from commissioned services that are accountable for safeguarding within their own organisations. This approach ensures that both commissioners and providers have ownership and commitment to driving forward the safeguarding priorities at a strategic level.

At an operational level, the Designated Professionals hold a monthly meeting with the Named Safeguarding Professionals across the county to discuss how national/local priorities are to be implemented and implemented such as the phase two of the Child Protection Information Sharing (CP-IS) programme. All providers have in place their own governance structure within which safeguarding activity is reported and which are then highlighted within an annual report. The Designated Professionals are members of these provider safeguarding assurance meetings. This is in line with the statutory assurance processes set out in the SAAF and which Northamptonshire ICB follow.

Additional strategic and governance processes are the ICB safeguarding annual report (due for publication in July 2023), ICB safeguarding children in care annual report (due for publication in September 2023), ICB safeguarding policy and ICB safeguarding strategy. For further details of the ICB safeguarding activity access https://www.icnorthamptonshire.org.uk/quality

The ICB safeguarding team and the health system generally have adopted a ‘Think Family’ approach to safeguarding and as such acknowledge that many priorities have a wider focus than just adults and children. However, to ensure that the ICB statutory duties are captured safeguarding adults and safeguarding children have been separated.

Safeguarding children

The ICB has statutory responsibilities to ensure safe systems of care that safeguard children and young people at risk of abuse and neglect and to ensure that robust structures, systems, and standards are in place commensurate to Working Together to Safeguard Children (2018); the Children’s Act (Section 11: 2004) and the National Assurance Framework (NHSE/I 2019).

Working Together to Safeguard Children (2018) sets out a statutory framework for the three local safeguarding partners (the local authority; a clinical commissioning group, now the ICB and the chief officer of police of their local area) to make arrangements to work together to safeguard

and promote the welfare of local children including identifying and responding to their needs. This includes the responsibility of both the local authority and the ICB to make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for those not normally resident in the area.

In accordance with the statutory guidance Working Together to Safeguard Children (2018) child death review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that re relevant to the welfare of children in the area or to public health and safety, and to consider whether actions should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.

Child deaths in Northamptonshire have shown a slow increase over the past three years after falling significantly in 2019/20. However, with the exception of 20/21 when an increase was seen, unexpected deaths have remained steady over the past five years. For 2021/22 there were forty deaths (30 expected and 10 unexpected deaths). Seventy per cent of all child deaths occurred in the first year of life with unexpected death occurring more commonly in this age group than any other. This is in line with national figures reported by the National Child Mortality Database. Further resource has been identified by the statutory partners to ensure that there is a central point of contact for families and more robust administration in place. This work will progress during 2023/24.

The outcomes for children in care are poorer than children in the general population. The responsibilities of ICB's to Looked after Children are outlined in *Promoting the Health and Well-Being of Looked after Children (2015).* ICB's in collaboration with health providers and the Local Authorities have a responsibility to ensure the timely and effective delivery of health services to looked-after children. In fulfilling those responsibilities, ICB's contribute to meeting the health needs of looked after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child. This includes initial and review health assessments. The expected trajectory for completed initial health assessments has been hard to achieve due to the availability of consultant paediatricians. This concern will continue to be escalated by the ICB locally and nationally due to other ICB's experiencing the same issue.

In Northamptonshire statistics (Northamptonshire Safeguarding Children's Partnership Annual Report 2021/22) up to 31st March 2022, highlighted that:

- There were 43,393 initial contacts received in children's social care, which was 2,020 more than 2020/21
- 12, 959 of the contacts were progressed to referrals, which was 1,602 more than 2020/21
- 9,110 section 17 assessments were completed with ninety-eight per cent completed within 45 days
- There were 2,670 child protection enquiries (section 47) compared to 2,436 compared to the previous reporting period
- Eighty-two per cent of child protection conferences were completed within 15 days
- Twenty-eight per cent of children were on a second or subsequent plan compared to twenty-three per cent in 2020/21
- Forty-seven per cent of children in care had initial health assessments within twenty-eight days of entering care
- Twelve point seven per cent had three or more placements over the year compared to eight point eight per cent in 2020/21
- Sixty-three per cent of care leavers were in education, employment or training compared to fifty-nine per cent last year.

In addition to the statistics, as a direct result of Covid-19, the impact of poverty, anxiety, non-school attendance, poor child and adult mental health, loss and bereavement have contributed to an increase in the number of families requiring support due to complexity of needs. The impact of the rising cost of living is also exacerbating the needs of families.

Northamptonshire Safeguarding Children's Partnership (NSCP) is the overall local safeguarding governance arrangements for safeguarding children and the ICB is one of three statutory partners (the other partners are the local authority and the police). The purpose of the safeguarding partnership is to support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted
- Partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children
- Organisations and agencies challenge appropriately and hold one another to account effectively
- There is early identification and analysis of new safeguarding issues and emerging threats

- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- Information is shared effectively to facilitate more accurate and timely decision making for children and families.

The NSCP's three priorities are:

- Child exploitation
- Neglect
- Domestic abuse

In terms of child safeguarding practice reviews (CSPR's), the ICB works in collaboration with other statutory partners to ensure that CSPR's are published as per national and statutory guidance. Themes from local CSPR's undertaken or currently in progress include suicide, fatal wounding, safe sleeping, child exploitation and neglect. These are all themes that are being reported both at a regional and national level.

Further details of the NSCP including the annual report and business plan, can be accessed via http://www.northamptonshirescb.org.uk/

Further safeguarding updates

Safeguarding adults is a statutory duty for Local Authorities with adult social services responsibilities in England under the Care Act 2014 in order to safeguard adults at risk from abuse or neglect.

The ICB is required to take account of the principles within the Mental Capacity Act (2005) (MCA) and to ensure all services from whom it commissions services have a comprehensive policy relating to the MCA (2005) and if appropriate the Deprivation of Liberty Safeguards DoLS) (2009).

The Law Commission's Report published in March 2017 proposed urgent reforms to the Mental Capacity Act and the replacement of the Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS). The Mental Capacity Amendment Bill received Royal Assent

in May 2019 and was expected to be implemented in 2020, however this has been delayed due to COVID-19 and a national consultation process. No implementation date has been finalised

Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to stop people supporting terrorism or becoming terrorists through early intervention at a shared partnership level. Under the Prevent duty, the health sector is required to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation. Additionally, any provider commissioned using the NHS Standard Contract has a wider contractual safeguarding responsibility which includes Prevent. The ICB works with the Local Authority and the Police to ensure that there is a robust multi-agency process in place when concerns are raised about an individual.

In Northamptonshire statistics (Northamptonshire Safeguarding Adults Board Annual Report 2021/22) up to 31st March 2022 highlighted that:

- Within the reporting period 5,118 concerns were raised with 3,750 remaining safeguarding alerts and 1,368 became section 42 enquiries
- The age band of the section 42 enquiry forty-two per cent for 18-64; thirteen per cent for 75-84; twenty-one per cent for 86-94 and five per cent for 95 and above
- The most common type of risk in section 42 enquires was neglect which accounted for fifty-four of risks; thirteen per cent physical; eleven per cent psychological and nine per cent financial
- Following investigation, ninety-three per cent identified with risk had their risk removed or reduced

Northamptonshire Safeguarding Adult's Board (NSAB) is the overall local safeguarding governance arrangements for safeguarding adults and the ICB is one of three statutory partners (the other partners are the local authority and the police). The purpose of the safeguarding adults board is to assure itself that local safeguarding arrangements and partners act to help and protect the welfare of local adults who may be at risk of abuse and harm. This is in accordance with the Care Act 2014 and supporting statutory guidance.

Safeguarding adults' boards have three core duties under the Care Act 2014 which are to:

- Publish a strategic plan for each financial year and its strategy for achieving its objectives
- Publish an annual report including what has been achieved during the year, what it has done to implement the strategy, what members have achieved and findings of reviews

- Conduct adult reviews in accordance with section 44 of the Care Act 2014.

The NSAB's three key priorities in line with other adult safeguarding boards in the East Midlands region are prevention, quality and making safeguarding personal which include the themes of:

- Domestic abuse
- Street homelessness
- Serious organised crime
- Adults that do not meet the need for statutory services (adult risk management process).

In terms of safeguarding adult reviews (SAR's), the ICB works in collaboration with other statutory partners to ensure that SARs are published as per national and statutory guidance. This will ensure that agencies and individuals learn lessons that improve the way they work to safeguarding and promote the welfare of adults and reduce the risk of recurrence of similar incidents in both the county and nationally. Themes from local SAR's undertaken or currently in progress include self-neglect, suicide, homelessness and serious neglect within a care home setting.

Further details of the NSAB including the annual report and business plan can be accessed via https://www.northamptonshiresab.org.uk/

Domestic abuse and serious violence duty

The Domestic Abuse Bill became law in April 2021 therefore widening the legal definition beyond physical violence to include emotional, coercive, and controlling behaviour and economic abuse. The ICB recognises domestic abuse as high risk and a safeguarding priority, alongside the detrimental impact on health and wellbeing for all ages. As such, there is senior representation on the two Local Authority Domestic Abuse Partnership Board, supporting work at both strategic and operation levels.

Generally, across the system, health safeguarding teams recognise domestic abuse and sexual violence as a high priority and therefore representation and engagement are in place at Multi Agency Risk Assessment Conferences (MARAC) and Multi Agency Public Protection Arrangements (MAPPA). The ICB have secured funding for several years that Hospital Independent Domestic Violence Advisors (HIDVA's) are in place within the acute hospital setting to offer advice and support to both patients and staff.

The Home Office recently published statutory guidance for the 'Serious Violence Duty' and ICB's from 31st January 2023 have a duty to undertake a strategic needs assessment and produce a plan to tackle 'serious violence' with partners such as Local Authorities and the Police. The definition of 'serious violence' now includes domestic abuse and sexual offences.

In Northamptonshire a Serious Violence Board has been formed hosted by the Police, Fire and Crime Commissioner in the absence of a violence reduction unit (VRU). The main priorities for the ICB to contribute during 2023/24 will be to focus on training, data collection and analysis and consideration of preventative action that can be undertaken in health settings for both victims and perpetrators.

In addition, the ICB will continue to be an active participant in Domestic Homicide Reviews (DHR's) across the county to ensure that recommendations and learning is formally shared and monitored across the health system.

Environmental matters

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental, and economic assets we can improve health both in the immediate and long-term, even in the context of a rising cost of natural resources.

We are committed to providing high quality sustainable healthcare in Northamptonshire and embedding sustainability into operations as well as encouraging key partners and stakeholders to do the same.

As a part of the NHS, public health, and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health, and social care system. The net zero target for the NHS carbon footprint in England is by 2040, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028-2032.

Sustainability and procurement

NHS Northamptonshire ICB (ICB) has been actively involved in considering Sustainability issues: Social Value and more recently the Carbon Reduction Plan requirements as part of the planning (pre-procurement) and procurement process. Please see below:

Northamptonshire Green Plan 2022

Acknowledging the links between climate change, sustainable development and health inequalities is an important consideration in the development of priority actions within the ICS Green Plan, with a commitment to deliver joint action to reduce health inequalities.

With our Northamptonshire population expecting to continue growing and ageing faster than the national average, the demands on our public and health services will grow exponentially, and with no concerted and coordinated actions to improve the sustainability of these, so will the impact we have on our local environment and the health impact of the communities that live in it.

Whilst it is a requirement of the NHS Standard Contract that each NHS Trust and System has a Green Plan in place for the start of 22/23, the approach we are committed to taking in Northamptonshire is not just about the NHS organisations in our county.

Our ambition is to have a true system partner approach to all aspects of our response; our actions to respond to the climate change extreme events locally, and our actions to lower our carbon footprint and encourage and support healthier lifestyles in our communities.

Read the Green Plan in full on the ICB website (link)

Social value

Social Value commitments are evaluated as required by Planning Policy Note (PPN) 06/20 (Social Value in effect from 1st January 2021). PPN 06/20 sets out how to take account of social value in the award of contracts by using the Social Value Model. Policy themes are:

- Covid-19 recovery
- Tackling economic inequality
- Fighting climate change
- Equal opportunity and
- Wellbeing

Social value is considered as early as possible in a procurement, ideally when the requirement is still in the pre-procurement stage. As a first step, we suggest consulting with key stakeholders, supply market, and customer base, to reach a common understanding of what social value might look like within the service being contracted. This is done through a Market Engagement Questionnaire (MEQ) where the ICB can set out the questions (in relation to the policy themes listed above) it believes would be applicable for the procurement and seek market feedback. Based on the feedback, Social value requirements are included in the standard suite of procurement documents. In line with PPN 06/20, 10% weighting is assigned to Social value within the evaluation process.

Carbon reduction plan

In addition, from 1st April 2023 as per the requirements of Planning Policy Note (PPN) 06/21 (Carbon Reduction Plan), NHS organisations are required to ensure that all suppliers of new contracts for goods, services, and/or works with an anticipated contract value above £5 million per year (excluding VAT) publish a carbon reduction plan (CRP) for their emissions. As this is a new requirement, where applicable (i.e. qualifying contract value), CRP related questions and guidance for bidders will be incorporated into the standard suite of procurement documents. In line with PPN 06/21 guidance, questions included within the selection questionnaire are assessed on a Pass/Fail basis.

Evaluation

Subject Matter Experts (evaluators) are provided training on how to evaluate bidder responses.

Reducing the overall environment impact in our buildings

We continue to work with NHS Property Services and ICB staff to reduce power and water consumption, and we are working with our landlords to ensure sustainable practices are adopted such as recycling and good use of energy in our ICB headquarters. During 2022 we were able to increase the range of recycling available in our buildings. The impact of COVID-19 has been significant, with most staff working from home for part of their working week during 2022 under the Agile Working Policy. This has reduced our impact from commuting, and power and water consumption.

Due to us leasing our ICB headquarters building and its shared occupancy, we are unable to provide figures for energy and water usage or waste and recycling.

Reducing the overall environment impact through our schemes

The ICB is committed to embedding sustainability into staff behaviour and other partners in shared premises, concentrating on the reduction of paper, increased recycling, car sharing and use of local public transport where possible.

We currently run a salary sacrifice scheme for staff which enables them to lease vehicles directly from the lease company. Currently 18 members of staff are leasing cars in this way, and some are currently leasing electric vehicles, which they may not otherwise have had access to due to the cost of these types of vehicles. As these are private arrangements between staff and the lease company, we do not capture information about the emissions of these vehicles.

No air travel took place during the period of 1st July 2022 to 31st March 2023 by any member of staff working on ICB business.

Business continuity

On 01 July 2022, Northamptonshire Clinical Commissioning Group (CCG) transitioned to be Northamptonshire Integrated Care Board. As part of the associated changes, the ICB is now a Category 1 responder under the Civil Contingencies Act 2004.

The CCG was previously a Category 2 responder, although we had delegated responsibility from NHSE to act as a Category 1 on their behalf. As a Category 1 responder the ICB must:

- Assess the risk of emergencies
- Undertake Business Continuity Management
- Plan for emergencies
- Warn, inform, and advise the public
- Cooperate with other local, regional, and national responders
- Share information

Business continuity

All business continuity plans and policies were reviewed during July 2022 to ensure they were fit for purpose when the CCG transitioned to an Integrated Care Board (ICB) as of 1 July 2022.

The ICB had no business continuity incidents to report during 2022/23.

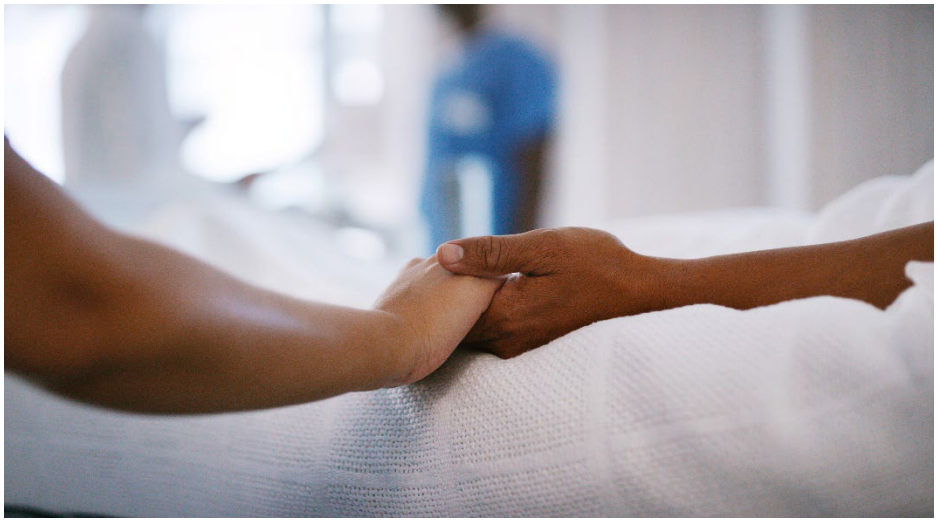
NHS Northamptonshire ICB (previously CCG) has been assessed as non-compliant against the revised full set of standards for 2022-2023. This is comparable to regional peers, with no ICBs achieving above partial compliance regionally, and NHS England (NHSE) have recognised the organisational changes and newly amended Core Standards for 2022 have presented challenges. The NHSE Core Standards are reviewed and revised every 3 years, with 2022 presenting a renewed focus on system-wide business continuity and we are working across partner organisations to develop collaborative ICS-wide plans. The ICB was assessed as Fully Complaint against the previous iteration of Core Standards and recognises that whilst the ICB has work to do to regain Fully Compliant status, this is comparable to regional peers, and we are confident in our ability to respond to and manage incidents.

As part of the transition to ICB it is recognised that there is an opportunity to develop new strategies and improve our resilience. We have updated the ICB plans that form the basis of the ICB response to major incidents, business continuity incidents and critical incidents. These plans and policies have supported the ICB in our self-assessment of the NHSE Core Standards for Emergency Preparedness, Resilience and Response.

In addition, the ICB has strengthened its preparedness and resilience for incident response with a new team of Resilience Operations Officers (ROOs) who work across seven days supporting our On-Call strategic and tactical leads, also acting as a single point of contact for the ICB in relation to NHS England system requests, supporting the Covid-19 vaccination programme and Surge activity. As we headed into the Winter period, this team represents a stronger response and support mechanism across Northamptonshire's health and care system

Improve quality

This section sets out how Northamptonshire ICB has discharged its general duties per sections 14Z34 (Duty to improvement in quality of services) of the National health Service Act 2006 (as amended).



In the last year the Integrated Care Board quality team developed quality governance processes to ensure successful transition from a Clinical Commissioning Group to an Integrated Care Board (ICB). This has included the development of a System Quality Group, and Quality Committee in line with National Guidance.

Quality assurance process

We have a system of quality assurance in place which provides information about the safety, effectiveness, and patient experience of services we commission for our community. This enables us to identifying early signs of concerns and act where standards fall short of expectation. It also helps to inform our commissioning decisions at all stages of the commissioning cycle. Following our first year as an ICB we will be reviewing and strengthening our quality assurance processes to enable us to be more proactive in the future.

Risk

A system quality risk register has been developed and is in place as part of the quality assurance process. The risk register captures agreed system risks and identifies partners across the system working to eliminate and reduce risk.

Moving forward all partners will take responsibility for improving the quality of care and the continued development of a system quality risk register to ensure oversight and agreement by the system of any risks to quality and the actions taken to mitigate these.

Serious incidents (SI)

Serious incidents in health care are defined as “adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.”

Serious incidents continue to be reported, under the NHSE Serious Incident Framework, 2015. During the COVID-19 pandemic, NHSE suspended the 60-day deadline for the completion of Serious Incidents. Locally it was agreed to implement a 90-day timescale which was monitored by the CCG quality team, (now ICB).

As the 60-day timescale will not be reinstated the quality team are working collaboratively with system partners to ensure that there is an agreement on timescales going forward whilst awaiting the publication of the Patient Safety Incident Response Framework (PSIRF).

Providers reported 218 serious incidents in 2022/23. This is a decrease from the 225 incidents reported for 2021/22. COVID-19 outbreaks continued to be reported as serious incidents through 2022/23, accounting for 22 of the reported incidents. This is a marked decrease on the 53 reported for 2021/23.

Following investigation, 14 incidents were deemed as no longer meeting the SI criteria and were downgraded.

218
serious incidents

14
serious incidents downgraded as did not meet criteria

3
serious incidents were recorded as never events

Patient Safety Incident Response Framework

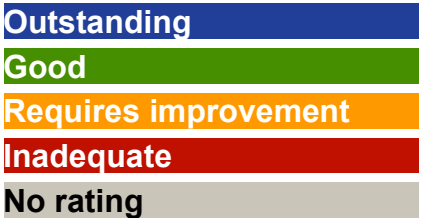
The NHS Patient Safety Strategy (PSIRF) was published in July 2019 and originally full implementation of the PSIRF was due by July 2021. However, in February 2021 this was updated to state that national rollout of PSIRF would start by Q1 2022/23.

The quality team has meet throughout the year with Patient Safety Specialists from provider organisations and through Serious Incident

Assurance Meetings and Quality Review Meetings ensured that providers were taking any actions as required in anticipation of the publication of PSIRF.

Central to the development of this will be the role of Patient Safety Partners (PSPs) who are patients, carers and other lay people who can support and contribute to organisations governance and management processes for patient safety. This is will on-going work through the coming year as the System develops its safety framework.

Quality improvement - Northamptonshire Care Quality Commission ratings



As of February 2023	IA	RI	GO	OU	NR	Total
Provider trusts	0	2	0	1	0	3
GP	0	1	60	2	3	66
Nursing homes	2	17	37	4	4	64
Residential homes	2	44	97	17	11	172
Other hospitals	0	2	3	0	0	5
Other providers	0	0	2	0	3	5

Name	Report published	Domain ratings	Overall rating	Key points
Kettering General Hospital NHS Foundation Trust	May 2022	Safe **RI** Effective **RI** Caring **Good** Responsive **RI** Well-led **Good**	**Requires improvement**	• Most staff had completed mandatory falls training • Processes to enable the supervision of patients at risk of falling were not always consistently implemented • Concerns re staffing levels • Concerns re implementation of actions from incidents
Northampton General Hospital NHS Trust	October 2019	Safe **RI** Effective **Good** Caring **Good** Responsive **Good** Well-led **RI**	**Requires improvement**	• Staff did not always feel respected, supported and valued Culture of poor behavior • The audit committee was not consistently operating effectively • Visibility of leaders varied • Concerns re risk management
Northamptonshire Healthcare NHS Foundation Trust	December 2019	Safe **Good** Effective **Good** Caring **Outstanding** Responsive **Good** Well-led **Outstanding**	**Outstanding**	• Strong focus on patient safety • Strong culture of openness, honest and learning • Thorough and detailed risk assessments

Northampton General Hospital (NGH) have not had a CQC inspection published since October 2019. The trust was at this time reported as 'requires improvement' key findings from the visit were: Staff did not always feel respected, supported and valued, a culture of poor behaviour, the audit committee was not consistently operating effectively, visibility of leaders varied and there were concerns re risk management.

Northamptonshire Healthcare Foundation NHS Trust (NHFT) have not had a CQC inspection published since December 2019. The trust was at this time reported as 'outstanding' key findings from the visit were: there was a strong focus on patient safety, a strong culture of openness, honest and learning and the trust had thorough and detailed risk assessments.

The CQC undertook an unannounced inspection to Kettering General Hospital Foundation Trust (KGH) between 4-5 May 2021. The trust was rated as ‘inadequate’ and had enforcement action taken as a result to promote patient safety in relation to falls prevention and management.

In March 2022 CQC carried out an unannounced focused inspection to check the quality of services in response to the warning notice issued in May 2021 ratings of the service went up based on the improvements identified during the inspection, in relation to falls prevention and management only. The trust is now rated as ‘requires improvement.’

In December 2022 KGH had an unannounced CQC visit to the Children’s and Young Peoples Services and Paediatric Emergency Department. A final report is still awaited, and the ICB are working closely with the trust to support the extensive improvement plan that is in progress.

Urgent and emergency care

The quality team recognises that both acute providers have experienced significant pressures at their accident and emergency departments over the last year linked with COVID 19, Industrial Action and the pressures of ‘winter’. This has been added to the system risk register and is on the System Quality Group agenda as we continue to work in a whole system approach to address this issue.

Infection prevention and control

All healthcare providers must adhere to national and local infection prevention standards set by NHS England and NHS Improvement (NHSE/I), the Care Quality Commission (CQC), National Institute for Health and Clinical Excellence (NICE) and the ICB. It is the ICBs’ role to monitor performance and compliance with these standards and to promote continuous improvement. The quality team works with providers to ensure that infection prevention and control arrangements are prioritised across the health economy.

Preventing and controlling the spread of COVID-19 has continued to be the ICBs

Infection Prevention and Control priority throughout 2022/23. The support to Primary and Secondary care providers came in the form of regular phone calls, meetings, visits and constantly reviewing the situation on the ground and advising on required actions to minimise or prevent the spread of infections.

In the coming year the ICB is planning a whole system improvement plan and whole system IPC Strategy led by the IPC Lead at the ICB. We will identify collaboratives to support improvement work including auditing community acquired cases to ascertain themes for quality improvement initiatives such as IPC Best Practice in Care Homes Guidance.

Collaborative quality visits

The quality team have developed a process for collaborative visits this was tested out by undertaking a falls assurance visit to KGH, led by the ICB quality team and supported by falls experts from NGH. This methodology has also been implemented as part of the current Improvement Plan with Children & Young Peoples Services at KGH.

Host commissioner

The ICB quality team acted as host commissioner when a 99 bedded mental health hospital in Northamptonshire was issued with a Notice of Proposal to remove registration by the regulator. This was an extensive piece of work which included the co-ordination and management of 11 out of county providers and the review of each person within the hospital.

No individual was relocated from the hospital due to poor care outcomes or safeguarding concerns. The hospital did not lose its registration and continues to operate.

Primary care quality

A Primary Care Quality Information and Risk Sharing Group (RSG) continues to meet; reporting to Primary Care Commissioning Committee (PCCC). The ICB quality team actively supports the practices that require improvement, offering support to practices both for the registration process and preparation for inspection.

Quality Outcome Framework - (QOF) was reinstated and is based on the indicator set agreed for 2020/21. The updates for 2021/22 include:

- A new vaccination and immunisation domain consisting of four indicators to replace the current Childhood Immunisation Directed Enhanced Service (DES). Three of these indicators focus on routine childhood vaccinations and one on incentivising the delivery of shingles vaccinations
- The reintroduction of three indicators focused on patients with a serious mental illness to promote improved uptake in all six elements of the SMI physical health check.
- A new indicator focused on cancer care has been introduced and amendments made to the timeframe and requirements for the cancer care review indicator.

Care homes

The ICB currently commission with over 112 care homes throughout Northamptonshire. Care homes are an integral element to providing out of hospital / care within the community. To deliver this, the sector must be able to meet complex health and care needs to the required quality standard.

At least one annual visit to every care home where there are people funded by health is undertaken by the quality team. Each visit consists of a review of a percentage of funded clients, conversations with staff, residents, and other stakeholders inclusive of family. A monitoring tool is used, and each provider receives a copy complete with recommendations where these are required to ensure continued development and improvement. Where there are identified recommendations, the provider is requested to produce and action plan on how these areas will be addressed within 28 days of receipt of their report. The tool was update in June 2022 to reflect new national guidance.

Supplementary visits are then undertaken to ensure the implementation of actions.

The tool covers twenty-two areas including the CQC fundamental standards, each domain is risk rated and scored. In the last year, August 2021 to August 2022 there have been:

Topic	Number
Full monitoring visits	71
Supplementary visits	60
Telephone reviews	4
Safeguarding referrals (care homes)	425
Liaisons with place following Sova review	200
Multidisciplinary meetings	12
Regulator meetings	9
Strategy meetings	38

The quality team were key to the distribution of pulse oximeters throughout the care home sector enabling conditions to be monitored within the community. 116 pulse oximeters distributed to 52 care homes with health funded residents.

Domiciliary care providers

All domiciliary care providers with health funded clients undergo the same monitoring review process as the care homes. Since January 2021 providers have been asked to submit a quality self-assessment form bi-monthly. This allows the providers to report on their current staffing levels, Covid status, and any patient safety issues such as missed calls and medication errors. They also provide a training matrix which identifies any areas where staff require training. This enables the quality team to target support to ensure the safety of service users.

Following the lifting of Covid restrictions in January 2022 the quality team have begun visiting providers again in person. Since January 2022 the quality team undertook:

- 20 review visits to domiciliary care providers
- 32 telephone interviews with NHS funded service users
-

These visits allow the team to monitor governance and management oversight of domiciliary services, to gain assurance but also provide focused recommendations and support to the provider.

Patient experience - GP Survey 2022

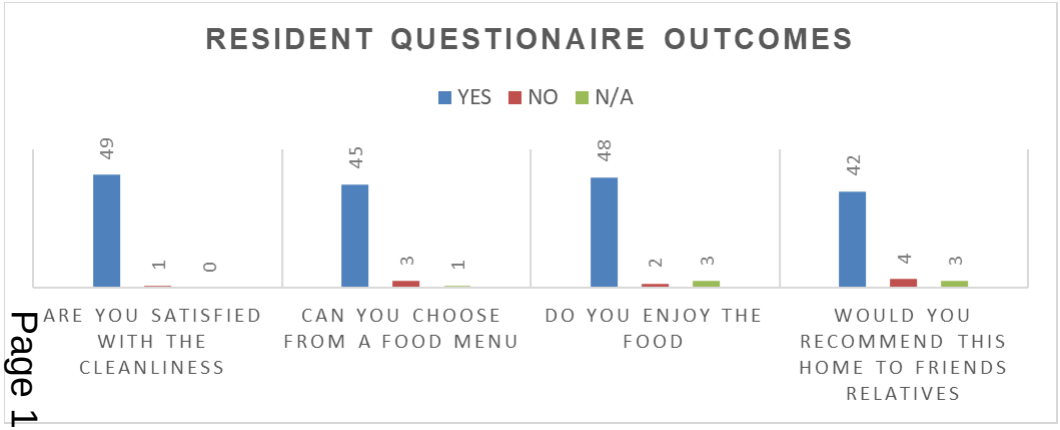
The GP Patient Survey assesses patients' experience of healthcare services provided by GP practices, including experience of access, making appointments, the quality of care received from healthcare professionals, patient health and experience of NHS services when their GP practice is closed.

22,750 surveys were sent out with 7,794 returned giving a response rate of 34%. This is in line with the national average.

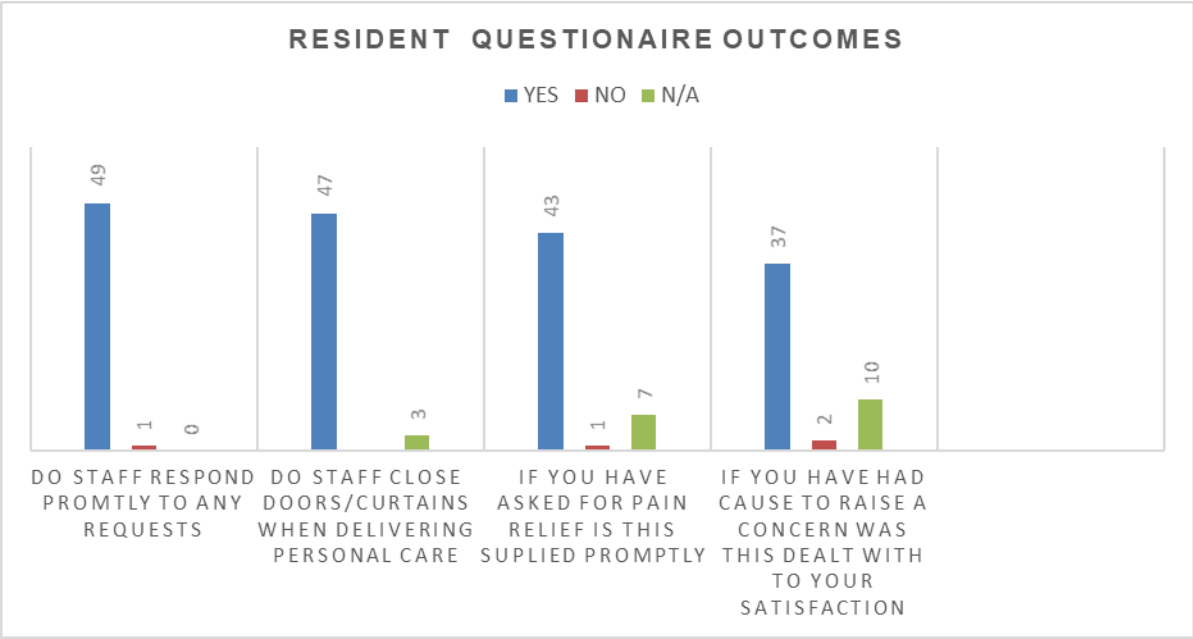
- Overall experience of being good was rated by 69% of patients (England 72%), this is a decrease from last year (82%)
- Ease of getting through on the phone % reporting positive experience is 48%
- Receptionists being helpful % reporting positive is 82%
- 82% of patients reported that they were given the time they needed, felt they were listened to and were treated with care and compassion

You can read more about patient experience on page 30.

Patient experience – care homes



A snapshot from 50 resident responses. As part of the monitoring and review process residents within the care home are individually spoken to by the QIN to ensure the care, they are receiving meets the identified needs within care plans but also to ensure their 'voice' is heard with regards to the care they receive.



Training

Quality Service Improvement and Redesign Training (QSIR)

To promote quality development and initiatives throughout the system the quality team have been delivering QSIR training.

QSIR programmes are highly successful service improvement programmes. These are delivered in a variety of formats to suit different levels of improvement experience, the QSIR programmes are supported by publications that guide participants in the use of tried and tested improvement tools and featured approaches and encourage reflective learning. The QSIR programmes suit clinical and non-clinical staff involved in service improvement within their organisation and/or system. Each cohort typically consists of people from a range of backgrounds and professions. This mix helps to make the programmes so vibrant. There's always huge wisdom in the room and many perspectives, providing a rich learning environment.

The ICB has two QSIR Associates that are qualified to deliver QSIR training both throughout the ICB QSIR faculty and jointly with NHFT QSIR faculty.

QSIR P delegates	Total
QSIR practitioner	24
QSIR associate	10

The table left indicates the numbers of associates across the two faculties and the total number of people that the quality team has been involved in training.

Care homes

Training and development sessions have been delivered during 2022-2023 to care homes:

- Falls prevention
- Infection protection control/donning and doffing
- Identification of the deteriorating patient
- End of Life
- Baseline Observations and how to escalate concern

Work has also been undertaken to ensure the use of a tool to monitor deterioration:

Restore 2 tool	NEWS 2 tool	Observation charts used	None
8	26	24	12

Engaging people and communities

The ICB has a legal duty under The Health and Social Care Act 2012 to ensure that individuals to whom our services are provided, or may be provided, are involved in the planning, development, and operation of commissioning arrangements (14Z45).

In preparation for the launch of our ICB in July 2022 and in line with proposed legislative changes to the Health & Social Care Act, through March to June 2022 we worked together to co-produce our Community Engagement Framework: a strategic approach for working together with people and communities. This framework and our approach were developed by and for members of Integrated Care Northamptonshire (ICN), in partnership with Traverse – an independent social purpose consultancy – and with a wide range of local partners and people through a co-production process. Progress against its delivery will be monitored and owned by Northamptonshire's Integrated Care Board (ICB).

Working in partnership with people and communities forms the foundations of our strategic approach to developing integrated care for all Northamptonshire's citizens. The objective of our Community Engagement Framework is to enable ICN partners to work more effectively together, as it provides a clear expectation for working with people and communities in the design, delivery and improvement of health and care systems. This framework also supports ICN (monitored via the ICB) to meet its obligations as set out in the NHS 'Working in Partnership with People and Communities Statutory Guidance'.

You can read more about the Community Engagement Framework and a copy of our Community Engagement Annual Report via the ICS website https://www.icnorthamptonshire.org.uk/involvement as well as in the working as a system section on pages 12 – 36.

Reducing health inequality

Promoting equality is at the heart of the ICB's values, ensuring that we commission services fairly and that no community or group is left behind when we make commissioning decisions on behalf of our population, especially in relation to meeting the challenges the NHS faces, as outlined in the NHS Long Term Plan.

We are committed to taking Equality, Diversity and Inclusion, and human rights into account in everything we do through commissioning services, employing people, developing policies, communicating, and engaging with local people in our work. As a public body, we work to ensure we meet our Public Sector Equality Duty (PSED), as set out in the Equality Act 2010 and our obligations under the Human Rights Act 1998.

We will continue to promote and protect people's dignity and rights by upholding the values set out in the NHS Constitution.

In addition, the ICB implements the NHS Equality Delivery System 2 (EDS) to support its work to tackle discrimination and health inequalities within local communities and for staff. We have a positive culture toward employing disabled people and developing a more diverse, inclusive, and engaged workforce. You can read more about this in the Staff Report on pages 135-137.

The Public Sector Equality Duty

The ICB has worked to show how it is meeting the aims of the Public Sector Equality Duty as set out in the Equality Act to:

- Eliminate discrimination
- Advance equality of opportunity

- Foster good relations between different people when carrying out their activities

This means the ICB must work to prevent discrimination as well as harassment and victimisation from happening. We also take steps to meet the health needs of people with certain protected characteristics.

As set out in the Equality Act 2010, the Protected Characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race and ethnicity
- Religion or belief
- Gender
- Sexual orientation

The ICB's staff members participate in mandatory Equality, Diversity, and Inclusion training. The Equality Act requires public bodies to publish information about how it has met the Equality Duty each year and to set specific measurable equality objectives. This information is published on our website annually on ICB's website.

Equality objectives and leadership

Our equality objectives (listed right) are refreshed annually so they remain relevant to the ICB's business and changing priorities. We also prepare a progress report, which outlines how the equality objectives are met and embedded across ICB activities (where appropriate).

Equality analysis and due regard

The ICB has embedded equality and human rights by developing an integrated Quality and Equality Integrated Impact Assessment (QEIIA) tool. This continues to ensure the ICB considers quality, equality and human rights when undertaking decisions on what healthcare to buy and what services it might change in order to meet local needs. We have developed and delivered training in Equality Impact Assessment/Equality Analysis to senior managers and staff who are directly involved in commissioning work and service reviews to ensure the ICB gives appropriate due regard at every level of decision-making.

Equality objective 1: Continue to integrate inclusion & equality conditions into our decisions

Equality objective 2: Continue to develop as an inclusive employer

Equality objective 3: Continue to focus on understanding gaps in health outcomes for the diverse local communities and working to reduce inequality

Implementing the NHS Equality Delivery System (EDS)

This third version of the EDS was commissioned by NHS England and NHS improvement in conjunction with the NHS Equality and Diversity Council (EDC) with, and on behalf of, the NHS. It is a simplified, updated, and easier-to-use. Due to the impact of COVID-19 on Black, Asian, and minority ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) by encouraging organisations understand the connection between those outcomes and the health and wellbeing of staff members. The EDS now supports organisations to look at the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three domains, which are:

1) Commissioned or provided services

2) Workforce health and wellbeing

3) Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is the ratings that provide assurance or identify the need for improvement. We are in process of developing an action plan for 2023 to implement all three domains to generate regional and local conversations about what is working well and what is not working so well, to make necessary improvements.

Equity of service delivery

We want to:

- Create a community where local people and clinicians continue to work together to improve healthcare quality and outcomes
- Ensure that the objectives of Northamptonshire Integrated Care Board continue to focus on equality in everything we do.

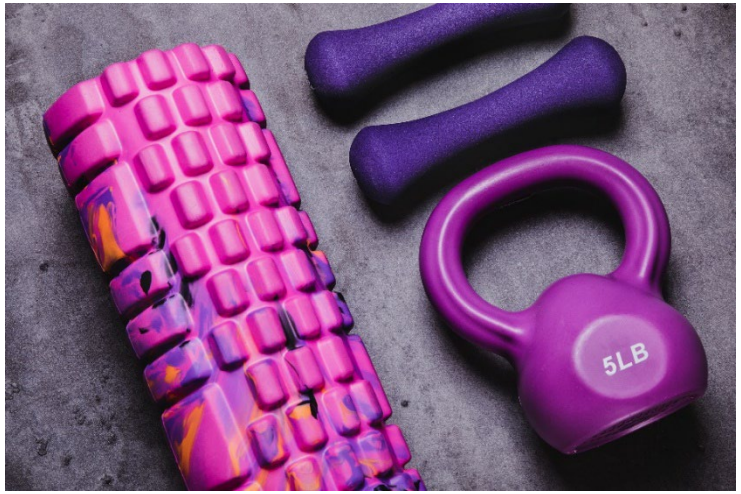
Our aim is to:

- Integrate inclusion and equality considerations into everything we do by becoming an inclusive organisation. We are committed to listening and responding to our community and colleagues by meeting their diverse needs and addressing local health inequalities
- Deliver on statutory and legal obligations, aligning this with our work to address health inequalities by focusing on improving organisational performance.
- We are also working hard to reduce health inequalities between people of different protected characteristics.

You can read more about how we have delivered equality of service delivery to different groups in our working as a system section from pages 12 to page 36.

Health and wellbeing strategy

Section 116B of The Health and Social Care Act 2012 sets out the responsibilities of local authorities and integrated care boards for preparing joint health and wellbeing strategies.



The ICB is an active member of West Northamptonshire's Health and Wellbeing Board and North Northamptonshire's Health and Wellbeing Board, which both consist of senior leaders and stakeholders from across Northamptonshire who provide a strategic lead for the health, care and wellbeing system.

The overall purpose of each Board is to secure:

- Better health and wellbeing outcomes for the local population
- Better quality of care for all patients and care users
- Better value for the taxpayer
- A reduction in the health and wellbeing outcomes gap (inequalities) between different groups

The Boards should work with local people to identify health and wellbeing needs of the population, agree priorities, and ensure that the NHS, local government and partners work together in a more joined-up way.

The Boards drives a more joined-up approach to the commissioning and delivering of health and social care services alongside services that provide the building blocks for health (such as housing, leisure, planning).

It also provides a key forum to increase democratic legitimacy in the shaping of health and care services through its elected members.

Each Board must ensure the preparation and delivery of a Joint Local Health and Wellbeing Strategy.

A Joint Local Health and Wellbeing strategy will provide a jointly agreed and locally determined set of priorities for West Northamptonshire and North Northamptonshire .

Outcomes from the Local Joint Health and Wellbeing Strategy will be contained within the Northamptonshire Integrated Care Strategy.

Integrated Care Northamptonshire has launched a 10 year strategy, **Live Your Best Life**. The strategy sets out how we can achieve better outcomes throughout all stages of life: From pregnancy, birth and early years, followed by improved education and better employment opportunities, plus an ambition of better access to health and care services, right through to the end of life.

It has been developed by NHS providers, local councils, voluntary and community organisations and others, aiming to work together to address challenges and improve the health and wellbeing of those who live and work in the area.

Our local population

West Northamptonshire council serves the areas of Daventry District, Northampton and South Northamptonshire, and North Northamptonshire council serves Wellingborough, Kettering, Corby and East Northamptonshire.

The diagrams below dated February 2021 provides a snapshot of health and wellbeing outcomes across a person's lifetime in North Northamptonshire and West Northamptonshire.

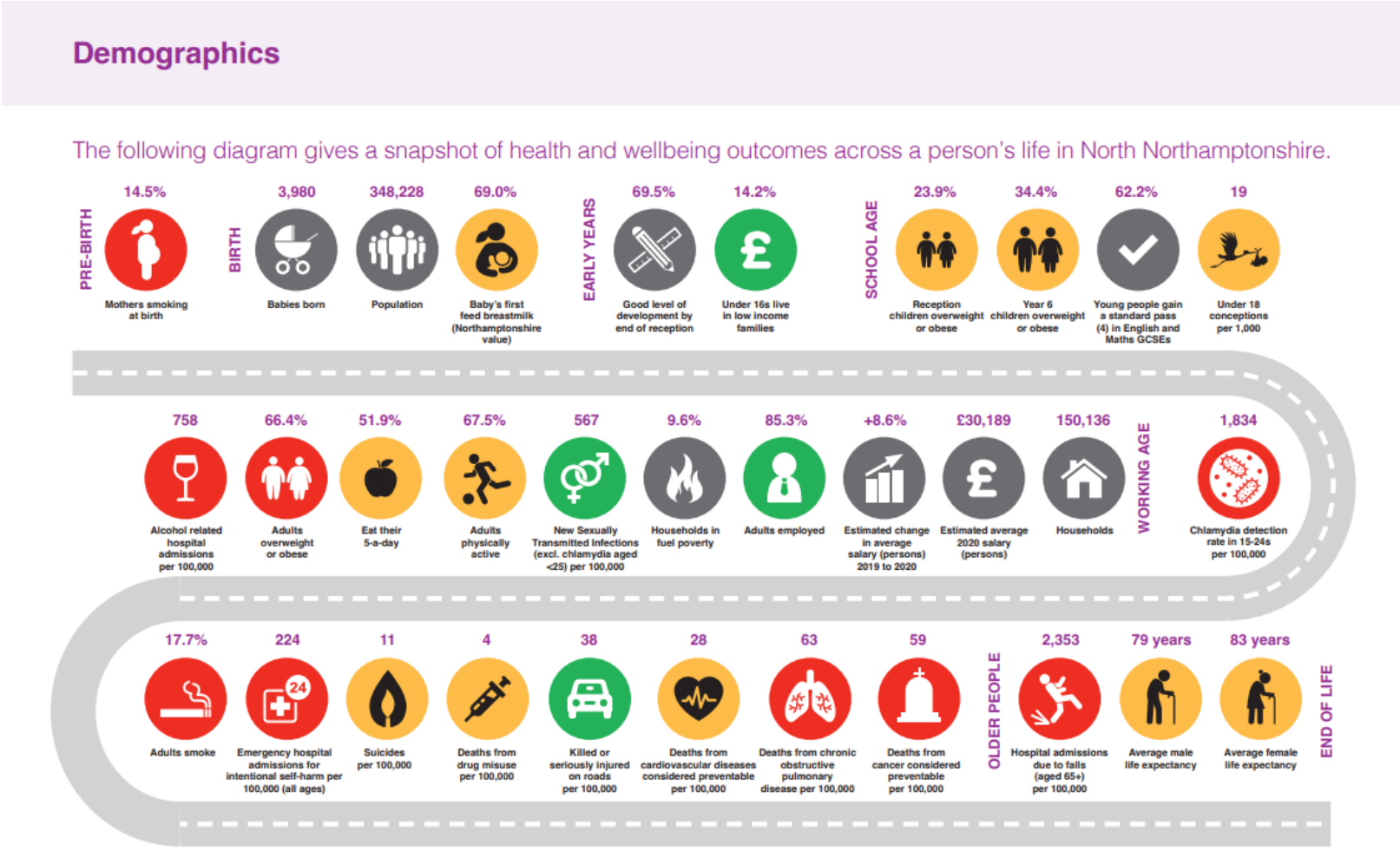


Figure 1. Health and Wellbeing in North Northamptonshire, February 2021
Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Demographics

The following diagram gives a snapshot of health and wellbeing outcomes across a person's life in West Northamptonshire.

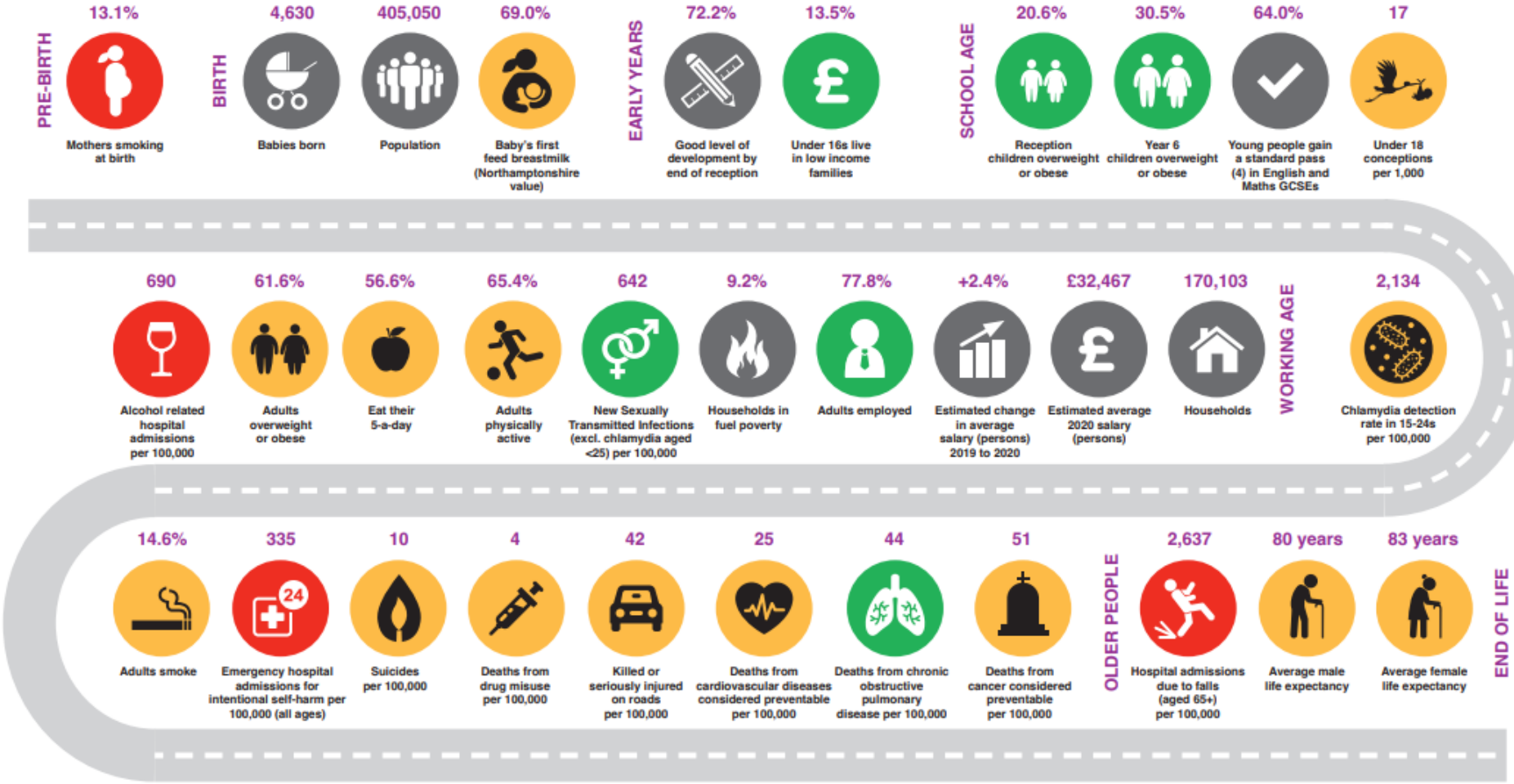


Figure 2. Health and Wellbeing in West Northamptonshire, February 2021
Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Compared to England average:

BETTER	SIMILAR	WORSE	NOT COMPARED

What actions are being taken to tackle health inequalities?

There are several activities the public health team and partners are working on to reduce health inequalities. For example, the stop smoking service is undertaking targeted work in both acute trusts to offer support and with specific GP practices where smoking prevalence is high.

The NHS health check programme targets people who are at high risk of having a heart attack or stroke in the next 10 years. It is currently offered across the county in GP practices. It can help to tackle health inequalities, as the burden of early death from cardiovascular disease is higher in the most deprived communities compared with the least deprived. A new delivery model is currently being developed to improve uptake.

To tackle inequalities by helping people to be more physically active, Northamptonshire Sport continues to provide a universal, countywide activity programme. A range of activities are offered to encourage people to be more active.

These include the provision of behavioural change training and approaches, making better use of green open space for physical activity and making PE and school sport inclusive to all which helps to build a resilient physical activity habit for life. These actions have a focus across the county, but with an increased emphasis on those living in the most deprived areas where healthy life expectancy is known to be much worse.

Eight geographical hotspots have been identified where there will be an increased focus of energy and effort across the system, led by Public Health Northamptonshire.

How have we consulted with the Health and Wellbeing Boards?

We requested the North Northamptonshire Health and Wellbeing Board and the West Northamptonshire Health and Wellbeing Board delegate review of the annual report content to the respective Chair of the Health and Wellbeing Boards in consultation with the Executive members for Adults, Health and Wellbeing, the Directors of Public Health and Wellbeing and the Executive Directors for Adults, Health Partnerships and Housing, in order to ensure that required timescales are met.

This was agreed by both Boards and our intention is to bring the final version of the annual report, once auditing has been completed, back to future Health and Wellbeing Board meetings in the North and West.

Capital Expenditure

Under the National Health Service Act 2006, Integrated Care Boards have a responsibility for a joint capital resource plan with its partners (section 14Z56).

The Northamptonshire system created a capital plan for 2022/23 that reflected the joint ambition of NHS Northamptonshire ICB and its partner NHS Trust and Foundation Trusts. The plan was centred around three key areas over the course of the year:

- Routine and backlog maintenance of both estates and equipment
- Medical equipment maintenance and refresh
- Digital improvements including clinical systems and work on Electronic Patient Record.

The plan utilised a number of funding sources including internally generated funds from within the provider trusts and foundation trusts along with Public Dividend Capital as part of national NHS programme funding.

The total capital expenditure in 2022/23 was £50.224m

Accountability report

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

It comprises three sections:

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

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

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

Toby Sanders
Chief Executive (Accountable Officer)
20 April 2023

Corporate governance report

Member's report

Profiles and composition of Governing Body (Board)

The following section contains information about how we are structured and governed. The Governing Body (Board) composition is below.

Naomi Eisenstadt, Chair

Naomi started her career at the front line, working in nurseries, before joining the civil service to be the first director of Sure Start. After Sure Start, Naomi served three years as Director of the Social Exclusion Task Force. In addition, Naomi was on the Milton Keynes PCT Board for 11 years, and since leaving the civil service, served as Poverty Advisor to the First Minister of Scotland.

Toby Sanders, Chief Executive

Before the transition to Northamptonshire ICB, Toby was the Chief Executive of Northamptonshire CCG. With 15 years' experience in the NHS, Toby was previously the Managing Director of West Leicestershire CCG. Toby is passionate about working with health and care professionals across public services to achieve the best value and outcomes.

Dr Shade, Agboola, Non-executive member & Chair of Primary Care Committee

Dr Agboola holds a particular responsibility for primary care. As a Non-Executive Member to Northamptonshire ICB, Dr Agboola is also the Director of Public Health for Warwickshire County Council. A fellow of the Faculty of Public Health she has over 11 years' experience of working in public health and brings a broad experience across health and local government.

Andrew Hammond, Non-executive member, Chair of Integrated Planning & Resources Committee & Chair of Remuneration Committee

Andrew is an experienced Executive and Non-executive Director working in Charity, Commercial and Public sectors. He spent his early career establishing a National Awareness Charity, and is now Chief Executive of Instructus, an education charity working in skills development, personal development, and apprenticeships.

Janet Gray, Non-executive member and Chair of Delivery and Performance Committee and Chair of Quality Committee

Janet is currently Chief Executive and Registrar at the Academy for Healthcare Science. Her previous roles have included a Non-Executive Director at University Hospitals Northamptonshire and Director of the Department of Health's Modernising Scientific Careers Programme

Afzal Ismail, Non-executive member, and Chair of Audit Committee

Afzal is currently a Non-Executive Director at University Hospitals Coventry & Warwickshire and recently served as a trustee of a large multi schools academy trust board.

He is also a Group Executive Director at Orbit Housing Group.

Eileen Doyle, Chief Operating Officer

Eileen previously worked as the county's Integrated Care System (ICS) Transition Director and has almost 30 years of NHS experience. She has held several executive positions including as Hospital CEO at Northampton General Hospital and Hospital Chief Executive at Kettering General Hospital.

Yvonne Higgins, Chief Nurse

Prior to Yvonne's appointment to Chief Nursing Officer, Yvonne worked as a Deputy Director of Nursing at The Royal Wolverhampton NHS Trust and Walsall Healthcare Trust. An experienced nurse, Yvonne has previously held senior management roles in provider, CCG and NHS England regulatory functions.

Dr Matt Metcalfe, Chief Medical Officer

Dr Matt Metcalfe was appointed as the Chief Medical Officer of Northamptonshire Integrated Care Board in June 2022. Prior to this Dr Metcalfe joined NGH as a Medical Director in Autumn 2017, having been Deputy Medical Director at University Hospitals of Leicester NHS trust and their medical lead for the cancer centre there.

Sarah Stansfield, Chief Finance Officer

Before the transition to Northamptonshire Integrated Care Board, Sarah held the position of Deputy Chief Executive for Northamptonshire CCG, overseeing all aspects of contracting, performance, and organisational development. she will take up in July 2022. Before joining the Northamptonshire CCG, Sarah was the Executive Director of Finance for Gloucestershire Hospitals NHS Foundation Trust.

Rob Bridge, Partner member – local authorities

Rob began his role in November 2020 and is honoured to be the first Chief Executive of the new North Northamptonshire Council. He was previously Chief Executive of Welwyn Hatfield Borough Council (WHBC) and brings a wealth of public sector leadership and finance experience. As a successful strategic leader, Rob has driven positive cultural change and believes in creating cultures that allow people to be their very best.

Dr Jonathan Cox – Partner member – primary medical services

Jonathan is the Chairman of Northamptonshire's Local Medical Committee, a Clinical Director of a Primary Care Network, and Immediate Past Past Chairman of the group of 16 CDs in the county, working closely with Northamptonshire's Clinical Commissioning Group. Jonathan is an elected member of the local LMC, a director (and a past chairman) of the local Federation and a GP Partner in Wellingborough.

Anna Earnshaw, Partner member – local authorities

Anna is Chief Executive of West Northamptonshire Council, one of the county's two new unitary authorities created in April 2021 as part of major local government reform. With a successful leadership career spanning the public and private sectors, Anna has extensive experience of the social care and health agenda coupled with a strong track record in business change and transformation.

Angela Hillery, Partner member – NHS and Foundation Trusts

Angela has worked in the NHS for over 30 years and has a clinical background as a speech and language therapist. She is NHFT's longstanding Chief Executive who consistently ranks in the Health Service Journal's Top 50 rated NHS Chief Executives. In 2019, Angela was appointed Chief Executive of Leicestershire Partnership Trust and is now the joint Chief Executive of both organisations.

Dr Andrew Rathborne - Partner Member - primary medical services

Dr Andrew Rathborne has been a GP partner in Brackley for 25 years. As well as his work as a GP he has been a GP trainer, helping teach the next generation of doctors over the past 20 years. More recently he has become involved in the healthcare organisation, being a representative for the LMC (local medical committee). He is also clinical director for Brackley and Towcester Primary care network.

Simon Weldon – Partner member – NHS and Foundation Trusts [1]

Having served as Chief Executive of Kettering General Hospital from April 2018, Simon Weldon was appointed s Group Chief Executive for both Northampton and Kettering General Hospitals from July 2020. Building on the significant improvements made at Kettering Hospital, which were recognised by the CQC in May 2019. His focus is on strengthening collaboration between the hospitals to improve the quality of services for local people.

[1] Deborah Needham, Interim Group CEO, University Hospitals of Northamptonshire, has been acting as deputy partner member since 16 January 2023 and holds this post until further notice

Committees

Committees(s), including Audit committee

- ICB Board
- Audit committee
- Remuneration committee
- Non-executive remuneration committee
- Integrated planning and resources committee
- Quality committee
- Delivery and performance committee
- Primary care committee

Membership of the Audit committee can be found on pages 99-101

Register of interests

The ICB is aware of the importance of its obligation to identify and address any potential or actual conflict of interest when transacting its business. The ICB has an embedded and robust system for:

- Registering interests of the governing body (Board), its sub-committees, and staff
- Publication of its register of interests
- Updating the register on a quarterly basis
- Taking any actual or potential conflicts into account when transacting the business of NHS Northamptonshire ICB

The ICB's register of interests is available on its website via the link.

Personal data related incidents

There have been 0 personal data breaches during the period 1 July 2022 – 31 March 2023, none requiring reporting to the Information Commissions Office (ICO).

We have an established Data Security and Protection Management Framework and have developed processes and procedures in line with the Data Security and Protection Toolkit (DSPT). We place high importance on ensuring there are robust data security and protection systems and processes in place to help protect patient and corporate information alike and as such these processes are under continuous review.

We recognise that having technical and operational security mechanisms in place to protect the data we process goes a long way. However, it is essential that we ensure the same level of rigour is placed on our staff. All staff are therefore required to undertake annual Data Security and Protection training to ensure awareness of data security and protection roles and their responsibilities.

Modern Slavery Act

Northamptonshire ICB 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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board 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 Northamptonshire ICB 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.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of Northamptonshire ICB. The responsibilities of an Accountable Officer, including responsibility 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 Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the Northamptonshire ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable

Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

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 Northamptonshire ICB'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.

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 Northamptonshire ICB'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.

Toby Sanders
Chief Executive (Accountable Officer)
NHS Northamptonshire ICB

Governance statement

NHS Northamptonshire Integrated Care Board (ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Northamptonshire ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB 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 population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Governance arrangements and effectiveness: governance structure

The main function of the Board 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. Further detail on the membership of the Board can be found in the Annual Report on pages 85 – 87.

The Executive Leadership Team (ELT) provides the executive leadership for the organisation. The ELT structure enables health population strategy/planning developments,

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Northamptonshire ICB'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 the NHS Northamptonshire ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the NHS Northamptonshire ICB 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 ICB as set out in this governance statement.

transformational delivery of the plans, increasing performance, efficiency and quality through contracting for outcomes, focusing on integration of primary and community services to support delivery of care in the community/closer to home and enables us to monitor and drive quality, safety and equity of services throughout the organisation.

The governance structure as set out below, details the Board and committees for the organisation. Further detail on the remit of the Board and committees can be found later in the Governance Statement.

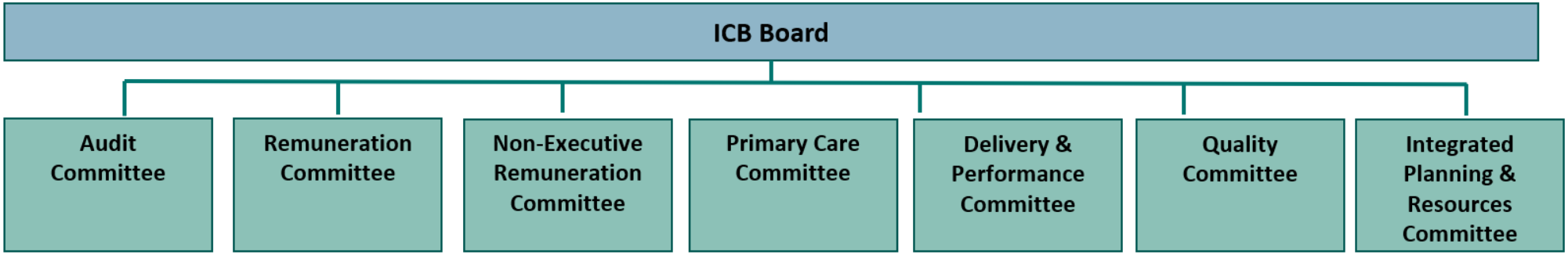


Diagram 1: NHS Northamptonshire ICB governance structure

ICB governance arrangements

The ICB has established robust governance arrangements and a system of internal control. Corporate governance is the system by which the Board directs and controls the organisation at the most senior level in order to achieve its objectives and meet the necessary standards of accountability and probity.

The ICB's Constitution sets out the organisation's commitment to good governance and the arrangements the ICB has in place to help to deliver the vision, mission, objectives and aims. The Constitution also sets out how the ICB will discharge the organisation's legal obligations and to engage with our members, our patients and our community, and other key stakeholders and partners to achieve this. It states that the ICB of the group will throughout each year have

THE NHS CONSTITUTION
the NHS belongs to us all

an ongoing role in reviewing the group's governance arrangements to ensure principles of good governance are reflected. This includes reviewing the effectiveness and the operation of Board meetings and the committees of this meeting.

Responsibilities and decision-making are defined in the ICB's prime financial policies and scheme of delegation, which are reviewed annually to maintain accuracy and relevance.

The key features of the ICB Constitution in relation to governance are:

- Discharge of functions - the arrangements made to discharge the functions of the ICB and the Board. The Constitution describes how we operate, the role of the Board, the appointment of committees and the specific duties of the Chair, Chief Executive Officer (Accountable Officer) and Chief Finance Officer.
- Primary decision-making processes - the primary decision-making processes and procedures to be followed by the ICB and the Board including the arrangements for securing transparency in decision-making such as the provision for Board meetings to be held in public.
- Conflict of interest management – how the ICB deals with conflicts of interest, including the arrangements we have made to maintain and grant public access to registers of interest and ensure that declarations of conflicts or potential conflicts of interests are made. This is to ensure that conflicts or potential conflicts do not and do not appear to affect the integrity of the decision-making process. A copy of the ICB's register of interests is available on the ICB website.
- Board membership - details of how appointments are made to the Board and how the membership of the organisation is involved in these appointments.
- Scheme of Reservation and Delegation - sets out the decisions that are the responsibility of the Board and its committees, alongside the decisions delegated to individual members and employees.

The Constitution sets out the arrangements the ICB has made for the discharge of the Board's functions, including the following:

- Established committees of the Board:
    - Audit committee
    - Remuneration committee

- Non-executive member remuneration committee
- Integrated planning and resources committee
- Quality committee
- Delivery and performance committee
- Primary care committee

- Delegated Board functions to the committees, as committees of the Board.
- The Standing Orders and Scheme of Reservation and Delegation (SORD).

ICB assessment of committee effectiveness and improvement

The Board throughout each year have an ongoing role in reviewing the ICB's governance arrangements, and effectiveness of these, to ensure principles of good governance are reflected. The Board reporting structures have embedded and communicated codes of conduct and defined standards of behaviour for ICB Board members and staff by:

- Having a code of conduct for the Board members showing mutual trust, respect and honesty
- Members of the Board adhere to the Nolan Principles for public life
- Each committee is authorised by and accountable to the Board
- Each committee is responsible for approving and keeping under review the terms of reference and membership, and the Board seek regular assurance that this duty is discharged accordingly

The ICB has a duty to keep under review the skills, knowledge and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions (Duty 14Z49). The Board members are subject to statutory and mandatory training. Training and development is provided on a group basis through Board workshops and through individual need as identified through the annual appraisal process.

The Board is provided with a range of information and using risk management mechanisms, the Board brings together the various aspects of governance; corporate, clinical, financial and information to provide assurance on its direction and control across the whole organisation.

The Board is committed to assessing and improving its own performance. All members of the Board are able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and have established credibility with all stakeholders and partners. The ICB understands that the Board must be in tune with system partners and must secure and maintain their confidence and engagement.

The Board sets the strategic direction for the ICB and focuses on gaining assurance of the delivery of the ICB's priorities, corporate objectives and statutory duties. The Board has focused on key performance issues throughout the year, ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the ICB's principles of good governance. The Board brings together the various aspects of governance to provide assurance on the ICB's direction of travel and control across the whole organisation.

Since establishment on 1 July 2022 and up to 31 March 2023, has continued to be a challenging time for the NHS as a whole with the continued response to the COVID-19 global pandemic, and as such has been a challenging time for the ICB with the establishment of the organisation.

For the first 9 months of the ICB operation, the organisational focus for the ICB has been the establishment of the ICB as part of the wider Northamptonshire Integrated Care System (ICS) and Northamptonshire Integrated Care Partnership (ICP), the Northamptonshire system continued response to the COVID-19 pandemic, whilst maintaining the statutory duties of the ICB. Alongside these areas of focus the ICB has also reviewed the following areas:

- COVID-19 system and organisational response
- Assurance of the COVID-19 vaccination programme
- Development of the ICS and assurance of the establishment of the ICB
- System collaboration with system partners
- Development of strategy
- Ensuring commissioning arrangements in place across Northamptonshire

- Monitoring performance including the financial position, activity and progress against key standards including NHS Constitutional Standards, contract performance
- Obtaining assurance the risk management process is effective to manage and mitigate risk
- Ensuring effective clinical leadership
- Ensuring meaningful patient and public involvement in commissioning decisions
- Seeking assurance on safeguarding
- Monitoring of quality and performance of services
- Monitoring and seeking assurance on patient safety
- Ensuring transparent remuneration arrangements are in place for employees and others
- Assurance of the ICB's governance arrangements, including the ICB Constitution and Governance Handbook.

The ICB values the opportunities provided by the holding of Board meetings in public, ensuring that we hear and respond to our public voice and provide assurance on the work we are undertaking on behalf of the population of Northamptonshire.

Challenges brought by the national response to the COVID-19 pandemic required the ICB to adapt the way we conduct our meetings in public. To ensure that the national guidance in relation to COVID-19 was followed, the CCG conducted our meetings virtually utilising remote teleconferencing platforms to enable members to be present. From December 2022 the ICB has moved to holding meetings in public with the public able to attend in person.

The Board has met in public on a bi-monthly basis during 2022/23. Board development sessions in private are held on the alternate months to the formal meetings in public, which provide protected time to develop understanding of key strategic issues. Five Board meetings were held in public from 1 July 2022 to 31 March 2023.

Board membership attendance is detailed in the table below and demonstrates that each meeting was quorate with good attendance from members from 1 July 2022 – 31 March 2023. Where members were unable to attend a suitable nominated deputy attended on their behalf where possible, please see comments below.

Name	Job title	01/07/22	18/08/22	20/10/22	15/12/22	16/02/23	Total	%
Naomi Eisendstat	ICB Chair	1	1	1	1	1	5	100%
Toby Sanders	ICB Chief Executive Officer (CEO)	1	1	1	1	1	5	100%
Sarah Stansfield	ICB Chief Finance Officer	1	1	1	1	1	5	100%
Matt Metcalfe	ICB Chief Medical Officer	0	1	1	1	1	4	80%
Yvonne Higgins	ICB Chief Nursing Officer	1	1	1	1	1	5	100%
Eileen Doyle	ICB Chief Operating Officer	1	1	1	1	1	5	100%
Andrew Hammond	ICB Non-Executive Member	1	1	1	1	1	5	100%
Janet Gray	ICB Non-Executive Member	1	1	1	1	1	5	100%
Afzal Ismail	ICB Non-Executive Member	1	1	1	1	0	4	80%
Dr Shade Agboola	ICB Non-Executive Member	0	0	1	1	1	3	60%
Dr Jonathan Cox	ICB Partner Member for Primary Medical Services (Chair, Local Medical Committee)	1	1	1	1	1	5	100%
Dr Andy Rathborne	ICB Partner Member for Primary Medical Services (GP)			1	0	1	2	66%
Simon Weldon**	ICB Partner Member NHS & Foundation Trusts (Group CEO University Hospitals of Northamptonshire)	1	1	0	0	0	5	**100%
Angela Hillery	ICB Partner Member NHS & Foundation Trusts (CEO Northamptonshire Healthcare Foundation Trust	1	1	1	1	1	5	100%
Anna Earnshaw*	ICB Partner Member Local Authority (CEO West Northants Council)	1		1	1	1	4	*100%
Rob Bridge	ICB Partner Member Local Authority (CEO North Northants Council)	0	1	1	1	1	4	80%
* Stuart Lackenby	Deputy Partner Member for Local Authorities (deputising for Anna Earnshaw)		1					20%
**Andy Callow	Deputy ICB Partner Member for Trusts (deputising for Simon Weldon)			1	1	0	2	40%
**Debbie Needham	Deputy ICB Partner Member for Trusts (deputising for Simon Weldon)					1	1	20%
Board meeting quoracy		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**		

In addition the Board has regular attendance from the following participants, who are invited to the Board, receive advance copies of the notice, agenda and papers for board meetings. Participants may ask questions and address the meeting but may not vote:

- Chair of the University Hospitals Northamptonshire (UHN)
- Chair of Northamptonshire Healthcare NHS Foundation Trust (NHFT)

Committees of the Board

The established committees of the Board up until 31 March 2023 were:

- Audit committee
- Remuneration committee
- Non-executive member remuneration committee
- Integrated planning and resources committee
- Quality committee
- Delivery and performance committee
- Primary care committee (the Primary care committee was disestablished on 31 March 2023, further detail can be further on in the Annual Governance Statement within the Primary care committee section)

Audit committee

The Audit committee's work focuses on ensuring the organisation has appropriate governance and internal control in place, and oversees the management of risk. The committee provides the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the ICB. The committee seeks to provide assurance to the Board that an appropriate system of internal control is in place.

From 1 July 2022 – 31 March 2023 the ICB Audit committee has regularly monitored the following:

- Oversight and assurance of the risk management processes within the ICB

- Reviewed and approved the Risk Management and Board Assurance Framework Policy
- Seeking assurance of decision making and COVID-19 expenditure in line with the interim governance arrangements
- Head of Internal Audit presented the Head of Internal Audit Opinion to the Audit committee
- Internal and external audit reports with focus on the implementation of agreed management actions
- Updates on the work of the Local Counter Fraud Specialist
- Management of conflicts of interest and Register of Interests and Register of Gifts and Hospitality
- Sources of assurance in support of the Annual Governance Statement and the Annual Report and Accounts
- Financial controls and monitoring correct application of the Standing Financial Instruction and Scheme of Delegation
- Single tender waivers correct use monitoring
- Progress against and compliance with the General Data Protection Regulations 2018 and the Data and Security Protection Toolkit submission

The membership of the Audit committee as at 31 March 2023:

- Non-executive member for audit (Chairs)
- Three non-executive members

From 1 July 2022 – 31 March 2023, the Audit committee met four times. Membership attendance is detailed in the table below, and demonstrates that each meeting of the committee was quorate with good attendance from members. The Chief Finance Officer, external and internal auditors, as well as the Local Counter Fraud Specialist are regular attendees at the committee but do not form part of the membership.

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

Audit committee membership attendance is detailed below from 1 July 2022 – 31 March 2023.

Name	Job title	18/08/2022	20/10/2022	15/12/2022	16/02/2023	Total	Percentage
Afzal Ismail	ICB Non-Executive Member (Chair)	1	0	1	1	3	75%
Shade Agboola	ICB Non-Executive Member	0	1	0	1	2	50%
Andrew Hammond	ICB Non-Executive Member	1	1	1	1	4	100%
Janet Gray	ICB Non-Executive Member	1	1	1	1	4	100%
Committee meeting quoracy		**Y**	**Y**	**Y**	**Y**		

Remuneration committee

The Remuneration committee approves the remuneration, fees and other allowances for senior employees and for people who provide services to the ICB.

The Remuneration committee membership is made up of the following:

- Non-executive member integrated planning and resources
- Non-executive member delivery, performance and quality
- Non-executive member primary care
- ICB Chair

In addition the following are also invited as regular attendees:

- Senior HR advisor
- Chief Finance Officer
- Chief Executive Officer

From 1 July 2022 – 31 March 2023 the committee met two times. The Remuneration committee membership attendance is detailed below.

Name	Title	01/07/2022	01/11/2022	Total	Percentage
Andrew Hammond	Non-Executive Director - Chair	1	1	2	100%
Shade Agboola	Non-Executive Director - Chair	0	0	0	0%
Janet Gray	Non-Executive Director - Chair	1	1	2	100%
Naomi Eisenstadt	ICB Chair	1	1	2	100%
Committee meeting quoracy		**Yes**	**Yes**		

Non-executive member remuneration committee

The Non-executive member remuneration committee approves the remuneration, fees and other allowances for the non-executive members of the ICB Board.

The non-executive member remuneration committee membership is made up of the following:

- Chief Executive
- Partner Member for NHS Trusts and NHS Foundation Trusts
- Partner Member for Local Authorities
- Partner Member Primary Medical Services
- ICB Chair

In addition the following are also invited as regular attendees:

- Senior HR advisor
- Chief Finance Officer

From 1 July 2022 – 31 March 2023 the committee met two times. The Non-executive member remuneration committee membership attendance is detailed below.

Name	Title	01/07/2022	16/03/2023	Total	Percentage
Toby Sanders	ICB CEO (Chair)	1	1	2	100%
Naomi Eisenstadt	ICB Chair	1	1	2	100%
Anna Earnshaw	ICB Partner Member Local Authority (CEO West Northamptonshire Council)	1	0	1	50%
Rob Bridge	ICB Partner Member Local Authority (CEO North Northamptonshire Council)	0	0	0	0%
Angela Hillery	ICB Partner Member for NHS and Foundation Trusts (CEO NHFT)	1	1	2	100%
Simon Weldon	ICB Partner Member for NHS and Foundation Trusts (CEO UHN)	1	0	1	50%
Jonathan Cox	ICB Partner Member Local Authority (Chair of Local Medical Committee)	1	1	2	100%
Andy Rathborne	ICB Partner Member Local Authority (GP)		1	1	100%
Debbie Needham *	Interim ICB Partner Member for NHS and Foundation Trusts (Interim CEO UHN) (deputising for Simon Weldon)		0	0	0%
Committee meeting quoracy		**Yes**	**Yes**		

Integrated planning and resources committee

The Integrated planning and resources committee provides assurance to the Board on the following:

- Development of the strategic and operational plans
- Development and approval of short, medium and long term ICB plans/strategies
- Support the development of system short, medium and long term strategies
- Monitors contract activity
- Performance and budgets and makes recommendations to the Board regarding achievement of financial and performance objectives

- Makes recommendations on business cases for the delivery of new investments.

From 1 July 2022 – 31 March 2023 matters considered by the committee included but were not limited to the following:

- COVID-19 pandemic response
- Operational Plan
- ICS development
- Patient and public engagement
- Financial reporting
- Contracting and performance reporting
- Procurement activity and assurance reporting
- Planning update
- Financial allocations and financial plan
- Consideration of financial and procurement risks

The committee membership is made up of:

- Non-executive member integrated planning and resources
- Non-executive member delivery, performance and quality
- Chief Finance Officer
- Chief Operating Officer
- Chief Nursing Officer
- System Director of Finance
- Nominated System Digital lead
- Nominated System People lead

From 1 July 2022 – 31 March 2023, the committee met eight times. Membership attendance is detailed in the table below and demonstrates that each meeting of the committee was quorate with good attendance from members.

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

The Integrated Planning and Resources Committee membership attendance is detailed below from 1 July 2022 – 31 March 2023.

Name	Job title	05/07/22	02/08/22	06/09/22	04/10/22	01/11/22	06/12/22	03/01/22	07/02/22	07/03/22	Total	%
Andrew Hammond	Non-Executive Director of Integrated Planning & Resources (Chair)	1	1	1	1	1	1	cancelled	1	1	8	100 %
Janet Gray	Non-Executive Director of Delivery, Perfomance & Quality (Vice Chair)	1	0	1	0	1	1	cancelled	1	0	5	63%
Sarah Stansfield*	ICB Chief Finance Officer	1	1	1	0	1	1	cancelled	1	1	7	*100 %
Eileen Doyle**	ICB Chief Operating Officer	0	1	0	1	0	1	cancelled	1	0	4	**75 %
Yvonne Higgins	ICB Chief Nursing Officer	0	1	1	1	1	0	cancelled	1	1	6	75%
TBC	System Director of Finance							cancelled			0	0%
TBC	Nominated System Digital Lead							cancelled			0	0%
TBC	Nominated System People Lead							cancelled			0	0%
Andrew Burwell*	Deputy Chief Finance Officer (deputising for Sarah Stansfield)				1						1	100 %
Mark Darlow*	Deputy Director Contracting (deputising for Sarah Stansfield)				1						1	100 %
Julie Lemmy**	Deputy Director Primary Care (deputising for Eileen Doyle)	1									1	100 %
Chris Pallot**	Interim Deputy Chief Operating Officer (deputising for Eileen Doyle)					1					1	100 %
Committee meeting quoracy		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**N/A**	**Yes**	**Yes**		

Quality committee

The Quality committee provides assurance to the Board on the quality of services commissioned and promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience to the Board.

Key issues debated and reviewed by the committee from 1 July 2022 – 31 March 2023 included but were not limited to:

- Quality assurance report
- Quality risk register
- Equality and inclusion updates
- Quality strategy
- Workforce Race Equality Standard (WRES) report

The committee membership is made up of:

- Non-executive member delivery, performance and quality
- Non-executive member primary care
- Chief Nursing Officer
- Chief Medical Officer
- Director of Public Health

From 1 July 2022 – 31 March 2023, the committee met eight times. Membership attendance is detailed in the table below and demonstrates that each meeting of the committee was quorate with good attendance from members. The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

The Quality committee membership attendance is detailed below from 1 July 2022 – 31 March 2023.

Name	Job title	05/07/22	02/08/22	06/09/22	04/10/22	01/11/22	06/12/22	03/01/23	07/02/23	07/03/23	Total	%
Janet Gray	ICB Non-Executive Member (Chair)	1	0	1	1	1	1	cancelled	1	0	6	75%
Shade Agboola	ICB Non-Executive Member (Deputy Chair)	1	1	1	0	1	1	cancelled	0	1	6	75%
Matt Metcalfe	ICB Chief Medical Officer	1	1	1	1	0	0	cancelled	1	1	*7	*88%
Yvonne Higgins	ICB Chief Nursing Officer	0	1	1	1	1	1	cancelled	1	1	7	88%
Susan Hamilton	Public Health Representative - North Northants					1	0	cancelled	1	1	3	75%
TBC	Director of Public Health - West Northants										0	0%
Emma Donnelly*	Deputy Chief Medical Officer - Deputising for Matthew Metcalfe									1	1	100%
Committee meeting quoracy		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**cancelled**	**Yes**	**Yes**		

Delivery and performance committee

The Delivery and performance committee provides assurance to the Board on the delivery and performance for the ICB.

- Delivery of operational planning commitments (excl finance)
- Performance management against the Outcomes Framework
- Ensure the delivery of planning commitments
- Supporting collaboratives to continue to develop and unblock barriers where appropriate
- Drive delivery against improvements around health inequalities providing oversight and assurance
- Ensure providers/ collaboratives/ place are working in harmony to deliver the system's plan for improvement
- Oversight of any remedial plans for delivery in the future.

The committee membership is made up of:

- Non-executive member delivery, performance and quality
- Non-executive member audit
- Chief Operating Officer
- Chief Medical Officer
- Chief Nursing Officer
- Nominated system lead for estates

From 1 July 2022 – 31 March 2023, the committee met eight times. Membership attendance is detailed in the table below and demonstrates that each meeting of the committee was quorate with good attendance from members. The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

The Delivery and performance committee membership attendance is detailed below from 1 July 2022 – 31 March 2023.

Name	Job title	19/07/22	16/08/22	20/09/22	18/10/22	15/11/22	20/12/22	17/01/23	21/02/23	21/03/23	Total	%
Janet Gray (Chair)	ICB Non-Executive Member	1	1	1	1	1	cancelled	1	1	1	8	100%
Afzal Ismail (Vice Chair)	ICB Non-Executive Member	0	1	1	1	0	cancelled	1	0	1	5	63%
Eileen Doyle*	ICB Chief Operating Officer	1	1	1	0	1	cancelled	1	1	1	8	*100%
Polly Grimmett	System Estates Lead (Group Director of Strategy UHN)	1	1	1	1	1	cancelled	0	1	0	6	75%
Yvonne Higgins	ICB Chief Nursing Officer	1	1	0	1	1	cancelled	1	0	0	5	63%
Matt Metcalfe	ICB Chief Medical Officer	1	1	1	0	1	cancelled	0	1	1	6	75%
Sarah Stansfield*	Chief Finance Officer (Deputising for Eileen Doyle)				1						1	100%
Committee meeting quoracy		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**cancelled**	**Yes**	**Yes**	**Yes**		

Primary care committee

The Primary care committee provides oversight and assurance to the Board on the adequacy of the following within the ICB:

- Oversight and assurance of the processes in place to review, plan and procure Primary Medical Services.
- Take decision on the provision of services.
- Allocation and management of the financial resources, ensuring the demonstration of Value for Money (VfM).
- Oversight and assurance of the transition of Community Pharmacy, Dental and optometry services during 2022/23.

The committee membership includes:

- Non-executive member primary care
- Non-executive member integrated planning and resources
- Chief Operating Officer
- Chief Finance Officer
- Chief Medical Officer
- ICB operational lead for primary care

The Primary care committee considered the following items during 2021/22:

- General Practice Forward View
- Reimbursement of COVID-19 related funding for general practice
- Finance update
- Delegated contracts
- COVID-19 vaccination programme

From 1 July 2022– 31 March 2023, the committee met three times, with development sessions held on the alternate months.

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

The Primary care committee membership attendance is detailed below from 1 July 2022 – 31 March 2023.

The Primary care committee was disestablished on 31 March 2023.

Name	Job title	20/09/2022	17/01/2023	07/02/2023	21/03/2023	Total	Percentage
Shade Agboola	Non-Executive Member (Chair)	1	1	0	1	3	75%
Andrew Hammond	Non-Executive Member (Deputy Chair)	0	1	1	1	3	75%
Eileen Doyle	Chief Operating Officer	1	1	1	1	4	100%
Sarah Stansfield	Chief Finance Officer	1	1	1	1	4	100%
Matt Metcalfe	Chief Medical Officer	1	0	1	1	3	75%
Julie Lemmy	ICB Operational Lead for Primary Care	1	1	1	1	4	100%
Committee meeting quoracy		**Yes**	**Yes**	**Yes**	**Yes**		

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance; however, the ICB draws upon best practice available, including those aspects of the UK Code of Corporate Governance that we consider relevant to the ICB and best practice. We comply with the key principles of the code, which set out good practice in the areas of leadership, effectiveness, accountability, remuneration and relationships with key stakeholders.

Discharge of Statutory Functions

NHS Northamptonshire ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB 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 ICB's statutory duties.

Risk management arrangements and effectiveness

The ICB is committed to having a risk management culture that underpins and supports the business of the ICB. The ICB's Risk Management and Assurance Framework Policy sets out managing risk, identifies accountability arrangements, resources available and provides guidance on what may be regarded as acceptable risk within the ICB. The policy recognises that for the ICB to successfully manage risk, the ICB must:

- Identify and assess risks
- Take action to anticipate or manage risk
- Monitor and regularly review risk to assess for the potential for further action
- Ensure effective controls and contingencies are in place

Risk management is part of the strategic planning process and managed operationally through a robust process of governance around decision-making, set out in the organisation's scheme of delegation. Staff have received training and support through group training and focussed one to one sessions, especially with those responsible for maintaining risk registers. All employees are encouraged to highlight risks and report incidents and are provided with risk management training as required within their roles.

The Board and employees receive training in Equality and Diversity, and Equality and Human Rights considerations are included in the development of all strategies, policies and business cases to ensure impacts on protected groups are understood and taken into account when making decisions.

The Local Counter Fraud Specialist ensures awareness and provides training for the organisation as a deterrent to fraud risks arising. Further detail on counter fraud arrangements can be found later in this report. From 1 July 2022 – 31 March 2023 the Counter Fraud Risk Register was further maintained in line with national guidelines and incorporates all business areas.

The Board are accountable and responsible for ensuring that the ICB has an effective programme of managing all types of risks, which is achieved via review of the Board Assurance Framework (BAF) that reflects strategic risks and the Corporate Risk Register (CRR) that identifies high scoring operational risks.

For the 9 month period from 1 July 2022 – 31 March 2023, the ICB has continued to ensure an effective risk management process is in place, and the Board continues to recognise risk management as an important development area to improve internal controls and its own effectiveness, particularly in light of the internal audit findings during the financial year and the Head of Internal Audit Opinion received.

Each Directorate is responsible for reviewing and maintaining their risk register on a regular basis, ensuring that the risk register accurately and appropriately reflects the level of risk, the actions taken to manage the risks and records the effectiveness of controls and the level of assurance that can be given. The Directorate Risk Registers are usually reviewed by the Audit Committee on a rolling annual basis, with the relevant executive risk lead in attendance at the committee to provide assurance and undertake scrutiny and challenge from the committee. From 1 July 2022 – 31 March 2022 extensive work has been undertaken to ensure risk management reporting arrangements have been aligned to the newly established ICB. The Directorate Risk Registers are reviewed in light of the CRR to ensure that risks are escalated appropriately. The Directorate Risk Registers are all linked to relevant committees.

Risk Management reporting was undertaken to the Audit Committee and Board through formal reporting, led by the Chief Operating Officer with support from Executive colleagues, setting out the key prevailing risks facing the ICB. The reporting of risk focussed on the delivery of the agreed ICB's four aims. In addition and to support the identification, management and assurance of risks each agenda item presented to the Board ensured that the executive summary highlighted the prevailing risks for that item and where no risk was identified the report provided assurance of this to the relevant meeting.

The strategic risks detailed within the BAF as at 31 March 2023 are set out in the table below. Further detail on the mitigations and actions in place to manage the impact of and management of key risks can be found in the Risk Management Reports presented to each Board meeting in Public which are published in the Board papers here: add link to Board papers.

BAF Risk	BAF Risk Title	Responsible Chief Officer
1	Failure to identify those areas of highest risk to the health and wellbeing of the population where there is intelligence and scope to improve in Health and Care.	Chief Nursing Officer Chief Medical Officer
2	Failure of digital enablement to support improvement in outcomes, experience, access and inequalities remain.	Chief Medical Officer
3	Health & Care's current workforce model does not reflect the growing need and the ICS fail to build a workforce suitable to meet the current and future needs of our population.	Chief People Officer
4	The ICB fail to achieve system financial balance and there is no improvement in the productivity or value for money which leads to sub-optimal decision making and non-delivery of the financial plan.	Chief Finance Officer
5	ICB fails to identify productivity improvements to reduce inefficiency and maximise resource allocation	Chief Operating Officer Chief Finance Officer
6	The NHS fails to maximise the benefits of being an anchor institution in terms of the wider economic, social and environmental contribution across Northamptonshire, leading to missed opportunities in terms of employment, economic growth, community asset base and carbon footprint.	Chief Executive Officer
7	Health & Social Care fails to meet environmental/green plan which impacts the delivery of the estate's strategy and perspective green plan in response to climate change and Net Zero.	Chief Finance Officer
8	System capacity is at risk if all sectors are not provided adequate support to maintain local capacity, resilience and sustainability.	Chief Operating Officer

The ICB's four core aims are set out below, each of the priority deliverables is supported by a number of workstreams against which the ICB has sought to allocate resources.

ICB four core aims:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

Capacity to handle risk

From 1 July 2022 – 31 March 2023 the ICB has continued to maintain the management of risk as detailed above. The Board continues to recognise risk management as an important development area to improve internal controls and its own effectiveness.

Risk assessment

The ICB's Risk Management and Board Assurance Framework Policy clearly sets out how to assess risk. The policy and documentation ensures that each risk has a clearly identified executive risk lead, who is supported by the relevant clinical executive linked to that area. Each strategic risk is mapped to the core aim to which is relates.

As previously noted, the BAF comprises the ICB's strategic risks, which would impact the whole organisation and the achievement of the ICB's core aims. The most significant operational risks, which are identified from key business activity at an operational level, which would have an impact upon the whole organisation from an operational point of view, are managed via the CRR.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB 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 Audit Committee has oversight of the internal control mechanisms on behalf of the Board. Chief Officers oversee the management and delivery of internal control mechanisms. The Audit Committee bases its assessments, and therefore assurances, on the effectiveness of the ICB's controls on assurances provided by the Board and committees' work programmes;

- Review of the BAF which provides an oversight of the effectiveness of controls in place to manage the ICB's principle risks
- Reviews of ICB policies and procedures
- Provision of assurance from internal and external audit and other identified sources of assurance the committees of the Board oversee the management and delivery of the internal control mechanisms.

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 ICB and its members recognise the importance of managing conflicts of interest. Accordingly, a register of interests is maintained and updated regularly. A copy of the register of interests is available on the ICB's website

All meeting agendas of the Board and committees include guidance and definitions of interests and time is allocated at the start of each meeting for such declarations to be made.

Control measures are in place to ensure that all of the ICB's obligations under equality, diversity and human rights legislation are complied with.

Data Quality

Information used by the Board and its Committees enables the ICB to carry out our responsibilities and discharge our statutory functions. This information relates to operational, financial, performance, quality and patient experience.

The Board and its Committees are committed to improving the quality of the information received. There has been an improvement in the quality of data received and the Board has taken action to continue to improve this position.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The ICB published a Standards Exceeded position for financial year 2021/22. In accordance with NHS Digital timings for financial year 2022/23 the ICB has submitted a Baseline at 28th February and is on course to meet Standards when published as required by 30th June 2023.

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 data security awareness training and have implemented ~~a~~ staff information governance documents 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 established risk assessment and management procedures which includes information governance. There is an embedded information risk culture throughout the organisation against identified risks.

Business Critical Models

In the Macpherson report 'Review of Quality Assurance of Government Analytical Models' published in March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance Framework is in place and is used for all business-critical models. Business critical models were deemed to be analytical models that informed government policy. The ICB can confirm that in the 9 months from 1 July 2022 – 31 March 2023 it has not developed any analytical models, which have informed government policy.

The ICB receives Service Auditor Reports on the business-critical systems operated by organisations that provide services to the ICB, which includes Shared Business Services, the Arden and GEM Commissioning Support Unit (AGEM CSU). This enables the ICB to place reliance on

the quality controls established relating to the business-critical systems and models delivered through the Service Level Agreement in place. Further detail is described below.

Third party assurances

The ICB relies on the AGEMCSU as a third-party provider of commissioning support services. CSUs are part of NHSE and therefore the ICB relies on NHSE-led internal and external audit of CSUs. The ICB holds quarterly contract performance meetings with AGEMCSU.

Control issues

The Head of Internal Audit Opinion has identified that the organisation *has an adequate and effective framework for risk management, governance and internal control.*

However, the work of the Head of Internal Audit has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. This is further detailed in the Head of Internal Audit Opinion Section of the Governance Statement further on.

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

The ICB has managed its financial allocation throughout 9 months of operation from 1 July 2022-31 March 2023. The Financial Strategy and Budgets for 2022/23 were considered and approved by the Board upon establishment, alongside the strategic and operational plans for the ICB.

The ICB has an established system of financial control, which is led by the Chief Finance Officer with oversight from the Integrated Planning and Resources committee, the Audit committee and the Board. The Integrated Planning and Resources committee considers financial risks, including risk opportunities, which are reported to the Board via the Monthly Finance Report and risks are detailed within the Board Assurance Framework (BAF). This process is supported by the ICB's prime and detailed financial policies. Matters of concern are reviewed by the Board and assurance sought. Full copies of the Board papers can be found on the ICB website

The Chief Finance Officer and the Finance Team have worked closely with managers throughout the year to ensure that a robust annual budget has been prepared. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. The processes to achieve this are examined by internal and external audit as part of their annual activities, with a focus on the strategic risks and

key financial control processes. The ICB also ensures that an annual fraud risk assessment is undertaken by an independent party, providing key actions. Further detail on the counter fraud arrangements can be found later in this report.

NHSE/I has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every ICB. The ICB does not yet have an ICB Improvement and Assessment Framework (IAF) assessment. The last assessment undertaken was in 2019/20 for which the two former CCGs NHS Corby CCG and NHS Nene CCG were both rated as good for the CCG (IAF) 2019/20. More detail on the individual indicators is available via the NHSE website. Further detail with regards to the ICB's performance can be found in the Performance Report of this annual report.

The ICB works closely with health and social care providers and partners to achieve financial balance and sustainability across the Northamptonshire health and social care economy as part of the Integrated Care System (ICS). The ICB works with our Regulators and Trusts to gain assurance on processes to address areas of poor performance, the standard NHS contracts used with providers include detailed financial, activity and quality schedules and require providers to innovate to improve quality and efficiency. More detail of delivery of key performance indicators and constitutional standards are detailed within the Performance Report of this annual report.

Delegation of functions

The ICB undertakes a regular process of review of its internal control mechanisms, including an annual internal audit plan. All internal audit reports are agreed by senior officers of the ICB and reviewed by the Audit Committee.

A review of the effectiveness of the ICB governance structure and processes has been undertaken during the year, including a review of each committee's terms of reference. This has formed part of the work undertaken to further strengthen the good governance arrangements in place within the ICB, to streamline the ICB's governance arrangements as much as possible to make best use of resources and senior leadership's time.

The ICB ensures that where functions are delegated either internally or externally, that this is done in line with the ICB 's Scheme of Reservation and Delegation (SORD), which sets out the decisions that are the responsibility of the Board and its committees, alongside the decisions that are delegated to individual members and employees.

Where functions are formally delegated by the Board to one of its sub-committees, this is formally recorded by the Board through the minutes, which are presented as a true and accurate record of the meeting.

Counter fraud arrangements

RSM UK provide the Local Counter Fraud Service (LCFS) in a proactive and reactive investigative capacity for the ICB.

The LCFS work plan is designed to enable RSM UK to work efficiently alongside the ICB management and staff, targeting resources in those areas which are considered at the highest risk from fraud and bribery. The work plan is designed to meet the NHS requirements within the Government Functional Standards, as applied to all NHS healthcare commissioners.

The Counter Fraud team is made up of different levels of staff, all accredited LCFS and also junior support staff. The level of staff used to complete tasks is relevant and proportionate to the risks identified in any given piece of work.

The LCFS supports the ICB in it's annual submission of the Counter Fraud Functional Standard Return (CFFSR) to the NHS Counter Fraud Authority (NHS CFA) with the support and sign off of the Chief Finance Officer and Audit Committee Chair.

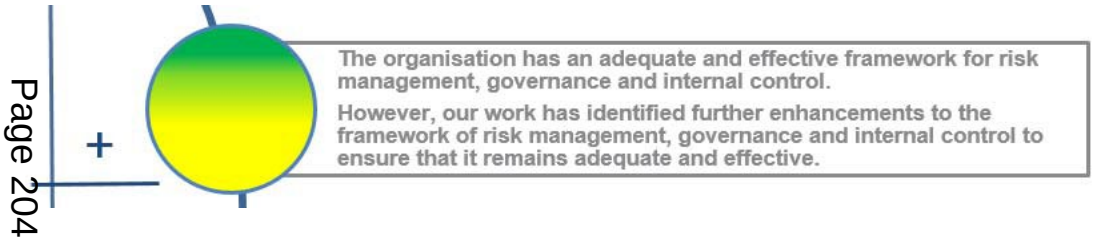
The oversight of the counter fraud provision remains with an executive director level, which is the Chief Finance Officer.

All work undertaken is in line with NHS CFA requirements and current UK legislation.

Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

The Head of Internal Audit Opinion for NHS Northamptonshire ICB, based on the work undertaken is set out as follows:



Scope and Limitations of the Work

The formation of the opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee. Our opinion is subject to inherent limitations, as detailed below:

- The opinion does not imply that internal audit has reviewed all risks and assurances related to the organisation;
- The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- The opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management/lead individual;
- The opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;
- Where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance; and
- It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be seen as a substitute for management's responsibilities around the design and effective operation of these systems.

Factors and Findings which have informed the opinion

RSM UK issued the following substantial assurance opinions in 2022/23:

- Financial Feeder Systems including Payroll;
- Primary Care Commissioning;
- Risk Management and Assurance Framework;

- Commissioning and Contract Management; and
- Governance.

RSM UK issued the following reasonable assurance opinion in 2022/23:

- Conflicts of Interests

In the audit shown above as providing Reasonable Assurance, controls were found to be adequately designed and generally well applied to mitigate associated risks to the ICB. However, RSM UK identified some areas where controls or their application could be strengthened and, in these areas, we have agreed suitable management actions.

RSM UK also issued the following advisory opinion in 2022/23:

- Financial Sustainability HFMA Review

A summary the Internal Audit opinions issued in 2022/23 is provided below:

Area of Audit	Level of Assurance Given
Financial Feeder Systems including Payroll	Substantial assurance
Primary Care Commissioning	Substantial assurance
Risk Management and Assurance Framework	Substantial assurance
Commissioning and Contract Management	Substantial assurance

Governance	Substantial assurance
Conflicts of Interests	Reasonable assurance
Financial Sustainability HFMA Review	Advisory

Where the internal audits have identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective, management actions have been agreed and are monitored via the Audit committee.

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 ICB 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 ICB 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 Quality committee
- Internal audit
- Assurance mechanisms including the Board Assurance Framework (BAF) and quality assurance processes.

The first year of operation as an Integrated Care Board (ICB) for Northamptonshire, the ICB has continued to develop governance maturity. I am satisfied that the ICB has developed appropriate plans to address weaknesses through the continued development programme.

Conclusion

As the Accountable Officer, and based on the review processes outlined above, I can confirm that the Governance Statement is a balanced reflection of the actual control position within the ICB, apart from those issues raised under the Head of Internal Audit Opinion.

Toby Sanders

Chief Executive (Accountable Officer)

NHS Northamptonshire ICB

Remuneration and staff report

As a commissioner of health services, the ICB believes health and wellbeing applies as much to our employees as it does to our local population.

During 2022/23 and under the shadow of continued system pressures, we have continued to remain fully committed to the health and positive wellbeing of our employees and understand that the health and wellbeing of the workforce is crucial to the delivery of the improvements in-patient care of local people.

Remuneration report

Remuneration committee

More information about the committee, including attendance, is available on pages 101 - 102.

Percentage change in remuneration of highest paid director (subject to audit)

Reporting bodies are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director. As the ICB came into existence on 1 July 2022, there is no prior year data available to enable a percentage change in remuneration to be calculated. The table below is therefore blank.

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

Pay ratio information (subject to audit)

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

The banded remuneration of the highest paid director in NHS Northamptonshire ICB for the period 1 July 2022 to 31 March 2023 was £185,000 to £190,000. The relationship of the organisation's workforce is disclosed in the table below. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23 M4 to M12	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£40,588	£48,526	£66,346
Salary component of total remuneration (£)	£40,588	£48,526	£66,346
Pay ratio information	4.62:1	3.86:1	2.83:1

During the reporting period 2022/23, no employee received remuneration in excess of the highest-paid director/member. Remuneration ranged from £23,177 to £187,673.

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.

Policy on the remuneration of senior managers

NHS Northamptonshire ICB's remuneration policy sets out the organisation's policy for directors, senior managers, and other staff. Where necessary we follow the recommendations of the Senior Salaries Review Body on senior managers' pay. This includes information about:

- Exit packages, severance packages and off payroll engagements
- Compensation on early retirement or for loss of office
- Payments to past directors
- Pay multiples
- Other staff information (numbers, composition, sickness absence data, consultancy, etc.).
- Staff policies for giving full and fair consideration for the application, employment, and ongoing training/career development of disabled persons

Remuneration of very senior managers

The ICB has established a Remuneration and Terms of Service Committee to approve the remuneration and terms of service for the executive directors, other staff on very senior manager (VSM) pay terms and conditions and other appointments to the ICB Board. The Committee also approves the pay rates offered to clinicians that work for the ICB on a contract for services basis. It was established under the Constitution and operates within terms of reference approved by our Board.

Senior manager remuneration (including salary and pension entitlements)

The NHS Northamptonshire ICB includes members (directors) of the Executive Leadership Team (ELT) in the Remuneration Report as well as the Board members. The ICB believes in complete openness and as important decisions are taken at ELT it is considered appropriate to include ELT members in the Remuneration Report

Salary and allowances 2022-23 (subject to audit)

Name and title	1 July 2022 to 31 March 2023 (Northamptonshire ICB)					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits To the nearest £1000	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Shade Agboola - Non Executive Member	10 - 15	400	0	0	0	10 - 15
Eileen Doyle - Interim Chief Operating Officer (Note 2)	135 - 140	0	0	0	n/a	135 - 140
Naomi Eisenstadt - Chair	40 - 45	0	0	0	0	40 - 45
Janet Gray - Non Executive Member	15 - 20	0	0	0	0	15 - 20
Andrew Hammond - Non Executive Member	10 - 15	300	0	0	0	10 - 15
Yvonne Higgins - Chief Nursing Officer	95 - 100	0	0	0	80 - 82.5	175 - 180
Afzal Ismail - Non Executive Member	10 - 15	0	0	0	0	10 - 15
Matt Metcalfe - Interim Chief Medical Officer (Note 2)	110 - 115	0	0	0	n/a	110 - 115
Toby Sanders - Chief Executive	135 - 140	0	0	0	67.5 - 70	205 - 210
Sarah Stansfield - Chief Finance Officer	120 - 125	0	0	0	62.5 - 65	185 - 190

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

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.

Note 1: The table above excludes ICB Board Partner Members as no remuneration is paid to them by the ICB for their role on the ICB Board.

Note 2: Eileen Doyle and Matt Metcalfe were employed by Northampton General Hospital NHS Trust and as such the ICB was recharged 100% of the salary costs for Eileen Doyle and 80% of the salary costs for Matt Metcalfe. The salary figure in the table above reflects the costs attributable to NHS Northampton ICB with total costs for Matt Metcalfe for the period shown on next page.

Total costs	Salary (bands of £5,000) £000	Expense Payments (Taxable) to nearest £100 £	Performance Pay and Bonuses (bands of £5,000) £000	Long Term Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Matt Metcalfe - Interim Chief Medical Officer	140 - 145	0	0	0	n/a	140 - 145

Pension benefits 2022-2023 (subject to audit)

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 July 2022 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2023 £000	(h) Employers Contribution to partnership pension £000
Shade Agboola - Non Executive Member	Non pensionable							
Eileen Doyle - Interim Chief Operating Officer (Note 1)	n/a							
Naomi Eisenstadt - Chair	Non pensionable							
Janet Gray - Non Executive Member	Non pensionable							
Andrew Hammond - Non Executive Member	Non pensionable							
Yvonne Higgins - Chief Nursing Officer	2.5 - 5	7.5 - 10	45 - 50	115 - 120	861	80	973	0
Afzal Ismail - Non Executive Member	Non pensionable							
Matt Metcalfe - Interim Chief Medical Officer (Note 1)	n/a							
Ruby Sanders - Chief Executive	2.5 - 5	2.5 - 5	45 - 50	75 - 80	657	53	743	0
Sarah Stansfield - Chief Finance Officer	2.5 - 5	0	30 - 35	0	282	28	333	0

Note 1: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

Note 2: Where Senior Managers are not directly employed by the ICB, the ICB does not have access to pension information (if applicable) and as such no disclosure is made.

Cash equivalent transfer values (subject to audit)

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 (subject to audit)

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).

Compensation on early retirement of for loss of office (subject to audit)

Payments to past directors (subject to audit)

Nil

Staff report

Number of senior managers

The ICB employs a total of 190 staff. On 31 March 2023, Northamptonshire ICB had seven senior managers at VSM grade. This figure includes one member of staff who is on an external secondment. It does not include any members of staff who have been seconded into the organisation.

Staff numbers and costs

Gender	Count	%
Female	5	71.5
Male	2	28.5

Board members

Gender	Count	%
Female	9	56.25
Male	7	43.75

Please note three men and five women are directly employed by the ICB, one man and one woman have been seconded into the organisation and three men and three women are partner members and are not directly employed by the ICB.

Other employees

Gender	Count	%
Female	135	80
Male	33	20

There are 168 staff members from Bands 3 to 9. This table and does not include the VSM, clinical leads or non-executives which support the ICB

Staff costs (subject to audit)

	1 July 2022 to 31 March 2023		
	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	7,559	590	**8,149**
Social security costs	794	45	**839**
Employer contributions to the NHS Pensions Scheme	1,196	29	**1,226**
Other pension costs	5	0	**5**
Apprenticeship levy	23	0	**23**
Termination benefits	52	0	**52**
Gross employee benefits expenditure	**9,630**	**665**	**10,294**
Less: recoveries in respect of employee benefits	(85)	0	**(85)**
Net employee benefits expenditure including capitalised costs	**9,544**	**665**	**10,209**
Less: employee costs capitalised	0	0	**0**
Net employee benefits expenditure excluding capitalised costs	**9,544**	**665**	**10,209**

Staff composition

As at 31st March 2023, the distribution of NHS Northamptonshire ICB's staff as per the NHS Digital NHS Occupational Code Manual is as follows. The table below includes 177 permanent/fixed term staff and 13 other members of staff (this figures includes our non-executives and PAYE contractors.

Staff group	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Ad hoc Salary	VSM	Grand Total
Add Prof Scientific and Technic (S2P)						5	7						12
Add Prof Scientific and Technic (S4P)			1	11									12
Additional Clinical Services (G0A)						2	4	4	3	1		5	19
Additional Clinical Services (G0D)									1				1
Additional Clinical Services (G1A)						10	13	6	2				31
Additional Clinical Services (G2A)	2	10	18	17	21	8	1						77
Additional Clinical Services (Z2E)											5		5
Allied Health Professionals (S0J)						1							1
Medical and Dental (921)											10	2	12
Nursing and Midwifery Registered (N0H)					3	2	4	2		1			12
Nursing and Midwifery Registered (N6A)							1						1
Nursing and Midwifery Registered (N6D)				1									1
Nursing and Midwifery Registered (N6H)				2	3	1							6
Grand Total	**2**	**10**	**19**	**31**	**27**	**29**	**30**	**12**	**6**	**2**	**15**	**7**	**190**

Please note this table does not include staff members who have been seconded into the organisation.

Sickness absence data

The following tables outline Northamptonshire CCG's sickness absence data from 1 July 2022 to 31 March 2023

Month	Long-term absence Full Time Equivalent (FTE) %	Short-term absence FTE %
2022 / 04	2.20%	1.05%
2022 / 05	2.72%	0.32%
2022 / 06	2.79%	0.76%
2022/07	3.16%	0.37%
2022/08	3.91%	0.02%
2022/09	3.26%	0.36%
2022/10	3.65%	0.38%
2022/11	3.52%	0.71%
2022/12	2.78%	1.43%
2023/01	2.38%	1.32%
2023/02	3.16%	0.78%
2023/03	2.20%	0.49%

Staff turnover percentages

Staff group	Average headcount	Avg FTE	Starters headcount	Starters FTE	Leavers headcount	Leavers FTE	LTR headcount %	LTR FTE %
Add Prof Scientific and Technic	22.50	15.94	1	1.00	2	1.13	8.89%	7.11%
Additional Clinical Services	1.00	0.95	0	0	0	0	0%	0%
Administrative and Clerical	134.00	125.25	22	20.88	19	18.80	14.18%	15.01%
Allied Health Professionals	0.50	0.50	1	1.00	0	0	0%	0%
Medical and Dental	12.50	3.19	0	0	1	0.30	8.00%	9.40%
Nursing and Midwifery Registered	17.50	16.52	6	5.50	3	2.00	17.14%	12.11%

Staff engagement

The ICB engages with its staff to ensure continuous consultation and engagement on changes that will affect them. This includes:

- Bi-weekly virtual staff briefings led by the Chief Executive and other members of the Executive Leadership Team
- Bi-weekly staff newsletter
- Staff intranet – the aim of this site is to provide staff with access to regular and detailed information such as policies, supporting documents and toolkits alongside a platform to share best practice and good news stories

The National Staff Survey was made available to employees of the ICB to complete in September 2022. This was the second National Staff Survey undertaken for NHS Northamptonshire ICB.

70% of staff completed the survey for 2022 compared to a 71% response rate for the staff survey undertaken in 2021. The national average for 2022 was 79%.

Since 1st February 2023, the ICB has employed a Chief People Officer. Alice McGee is on secondment for 1.5 days a week from Leicester, Leicestershire and Rutland ICB.

Staff policies

The Workforce Disability Equality Standard (WDES) introduced in 2019, is a data-based standard that uses a series of measures (10 metrics) to compare the experiences of disabled and non-disabled staff in the NHS. Results of the annual NHS staff survey show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities. The purpose of the WDES is to improve the experience of disabled staff working in, and seeking employment in, the NHS.

ICBs were not requires required to publish their first WDES results until August 202. As a good practice we have produced WDES report with action plans to address the differences highlighted by the metrics with the aim of improving workforce disability equality. In preparation of publishing the ICB's first WDES report, we have been raising awareness of the WDES, improving disability declaration rates on Employee Staff Records (ESR) encouraging line managers to start conversations with staff as part of the NHS People Plan recommendation, encouraging staff to complete the NHS Staff Survey and setting up WDES engagement with the Age and Ability Staff Champions group.

Northamptonshire ICB produced their WDES report with action planning and published it on the website on 30 October 2022. WDES 2021/22 report captures a wealth of information which demonstrates how we in NHS Northamptonshire ICB are performing against the standard and the action plans in place to improve the metrics. As part of drawing up the plan we have considered best practice examples from other NHS employers.

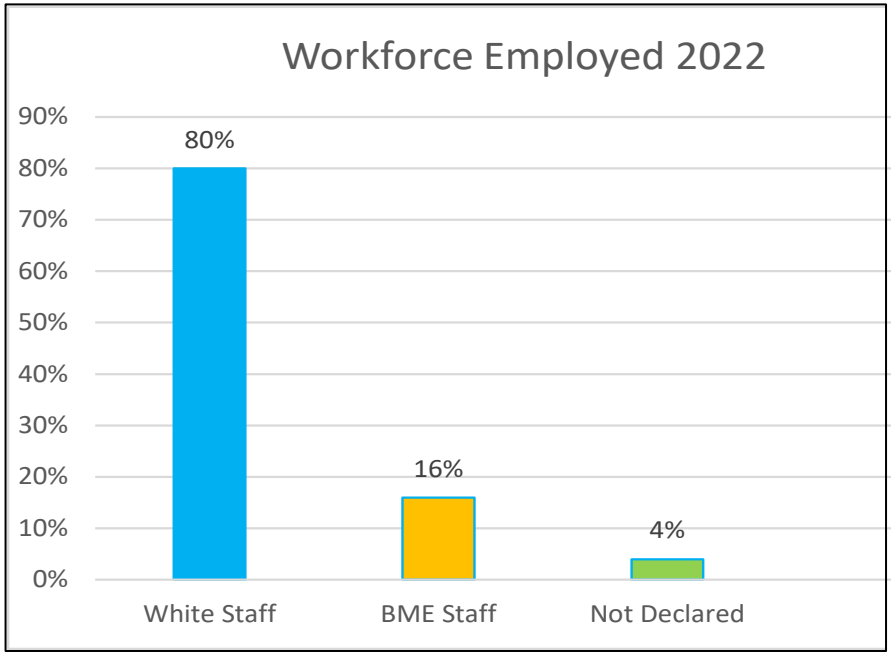
Positive about disability in the workplace

As an employer, NHS Northamptonshire ICB demonstrates a positive commitment to disabled employees and continues to be a recognised disability Confident Employer. This is an annual accreditation given by the Department for Work and Pensions that provides assurance the ICB

welcomes applications from disabled people, and existing staff who have disabilities will have their Reasonable Adjustments reviewed and assessed. We currently have eight employees who are declared disabled, this is the same number as 2020/21.

NHS Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) highlights the differences between the experience and treatment of white and black, Asian and minority ethnic (BAME) staff with the aim of closing any identified gaps. The WRES requires NHS organisations to demonstrate progress against nine race equality indicators.



Evidence shows a motivated, included, and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations. The chart above gives a breakdown of our staff in terms of ethnic origin. In 2022 16% of the workforce were categorised as being from a BAME community which is a slight decreased on 2020/21 which had 16.91% of the workforce categorised from a BAME community. 19% BME staff were appointed from shortlisting's that is significantly higher than the local BME community representation.

Under the NHS Standard Conditions of Contract April 2017/18, all NHS providers holding contracts over £200,000 must implement the Workforce Race Equality Standard (WRES), which is a benchmarking tool to assess an organisation's progress around race equality.

ICBs must show 'due regard 'to the WRES as well as monitor providers on their results. Implementation of the WRES was also reviewed as part of the 'Well-Led' domain of the ICB Improvement and Assessment Framework.

Northamptonshire ICB has gathered data against the nine WRES metrics for the fifth year in 2022. The data will be uploaded on the national Strategic Data Collection Service (DCS) platform and a report with action planning was published on Northamptonshire ICB's website on 30

October 2022.

Using the WRES indicators as a basis, we will report on progress about WRES and closing the gaps and differences of treatment, experiences, and outcomes of white and black and minority ethnic (BME) staff. We will continue to work with NHS provider organisations to seek assurance of effective implementation of WRES and progress against action plans.

Northamptonshire ICB WRES action plan 2022-23

The action plan has key actions which aim to reduce inequality, benchmark performance, and ensure that interventions are taken to address unfair access to training, mentoring or progression. The ICB continues to make good progress and the current action plan with WRES report is published on ICB's website.

Trade union facility time reporting requirements

Under the Trade Union (Facility Time Publication Requirements) regulations 2017, the ICB is required to publish the following information as laid out in Schedule 2 of the regulations.

Table 1: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
X	X

Table 2: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	X
1%-50%	X
51%-99%	X
100%	X

Table 3: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£X
Provide the total pay bill	£X
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	%X

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	%X

Staff policies

Freedom to Speak Up arrangements

The ICB operates a Freedom to Speak Up Policy across the organisation. As part of this policy a Speak Up Guardian is in place, which is Sarah Stansfield, Chief Finance Officer. This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the Chief Executive, or if necessary, outside the organisation. To date there have been no reports from staff under this policy.

Bullying, harassment, and victimisation policy

NHS Northamptonshire ICB is committed to creating a work environment free of harassment, bullying and victimisation for all employees (including those with a protected characteristic) and where everyone is treated with dignity and respect. The ICB believes that harassment, bullying and victimisation at work in any form is completely unacceptable and will not be tolerated, and all allegations are investigated and, if appropriate disciplinary action will be taken.

The ICB does not tolerate victimisation of a person for making the allegations of bullying and harassment in good faith or supporting someone to make such a complaint and will take the necessary steps to achieve this aim. In addition, the ICB will investigate vigorously any allegations of bullying, harassment, or victimisation regardless of whether the matter has been raised formally or informally. Our policy is designed to ensure that any complaints of bullying, harassment or victimisation are dealt with objectively, quickly, sensitively, and confidentially.

Other employee matters

Health and safety

The health and safety of ICB staff is fundamental to the delivery of our vision and objectives. To ensure the ICB has the appropriate level of expertise in this area, the role of Competent Person for Health and Safety is undertaken internally by specialist advisors from AGEM CSU, supported by ICB business continuity staff.

The annual fire health and safety audit was conducted in November 2022, with no areas requiring significant action. This was largely due to the extremely low occupancy levels throughout the year as staff were given the capability to work from home in line with national guidance.

Working safely during COVID-19

The ICB continues to operate the building in line with the latest national guidance using a number of measures such as:

- Wipes are still available to allow staff to clean down their desks before and after use, along with hand sanitiser and masks to support infection prevention and control measures.
- Staff are advised to work from home if symptomatic or positive for Covid-19, unless they are too unwell then usual sickness absence processes apply.

For staff working from home potential health and safety concerns were addressed, particularly Display Screen Equipment (DSE) requirements. This was done by allowing staff to take home IT equipment to prevent prolonged working on laptops and office chairs were also allowed to be taken home for those without appropriate furniture. Other equipment was provided, online DSE self-assessments were promoted, and in some

cases, assessments were carried out via Microsoft Teams. For those staff working in patient facing roles appropriate personal protective equipment (PPE) is provided.

No health and safety incidents were reported in 2022/23, nor as a result were there any reportable under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The COVID-19 pandemic continued to present challenges, but this did not result in any additional incidents and the ICB remains a relatively low-risk work environment.

Expenditure on consultancy

Northamptonshire ICB spent £49,000 on consultancy during this period. Most of the expenditure on consultancy relates to expert VAT consultancy.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2023, for more than £245(1) per day:

		Number
Number of existing engagegments as of 31 March 2023		0
Of which, the number that have existed:		
	for less than 1 year at the time of reporting	0
	for between 1 and 2 years at the time of reporting	0
	for between 2 and 3 years at the time of reporting	0
	for between 3 and 4 years at the time of reporting	0
	for 4 or more years at the time of reporting	0

Note: (1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll workers engaged between 1 July 2022 and 31 March 2023, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	0
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	
Number subject to off-payroll legislation and determined as out of scope of IR35	0
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements	16

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

	2022-23							
	Compulsory Redundancies		Other Agreed Departures		Total		Departures where Special Payments have been made	
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	1	3,426	0	0	**1**	**3,426**	0	0
£10,001 to £25,000	1	20,022	0	0	**1**	**20,022**	0	0
£25,001 to £50,000	0	0	0	0	**0**	**0**	0	0
£50,001 to £100,000	0	0	0	0	**0**	**0**	0	0
£100,001 to £150,000	1	146,828	0	0	**1**	**146,828**	0	0
£150,001 to £200,000	0	0	0	0	**0**	**0**	0	0
Over £200,001	0	0	0	0	**0**	**0**	0	0
Total	**3**	**170,276**	**0**	**0**	3	170,276	**0**	**0**

	2022-23	
	Other Agreed Departures	
	Number	£s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**0**	**0**

Parliamentary accountability and audit report

Northamptonshire ICB 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 143. An audit certificate and report is also included in this Annual Report at page 189.

Annual accounts

This chapter sets out the annual budget for the ICB and a breakdown of how it was spent.

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2023

M4 to M12
2022-23
NHS
Northamptonshire
ICB
Accounts

Statement of Comprehensive Net Expenditure
Period Ending 31 March 2023

	Note	M4 - M12 2022-23 £'000
Income from Sale of Goods and Services	2	(11,208)
Other Operating Income	2	(6,064)
Total Operating Income		**(17,271)**
Staff Costs	4	10,294
Purchase of Goods and Services	5	1,097,309
Depreciation and Impairment Charges	5	270
Provision Expense	5	0
Other Operating Expenditure	5	683
Total Operating Expenditure		**1,108,556**
Net Operating Expenditure		**1,091,285**
Financing	7	21
Other Comprehensive Expenditure		0
Comprehensive Expenditure for the Period Ending 31 March 2023		**1,091,305**

Statement of Financial Position
Period Ending 31 March 2023

	Note	31 Mar 2023 £'000	1 July 2022 £'000
Non-Current Assets			
Property, plant & equipment	9	0	0
Right-of-use assets	10	2,757	2,775
Total Non-Current Assets		**2,757**	**2,775**
Current Assets			
Trade & other receivables	11	9,945	4,852
Cash & cash equivalents	12	0	0
Total Current Assets		**9,945**	**4,852**
Total Assets		**12,702**	**7,627**
Current Liabilities			
Trade & other payables	13	(86,288)	(63,763)
Lease liabilities	10	(341)	(306)
Borrowings	14	(4,578)	(2,681)
Total Current Liabilities		**(91,207)**	**(66,750)**
Total Assets less Current Liabilities		**(78,505)**	**(59,123)**
Non-Current Liabilities			
Trade & other payables	13	0	0
Lease liabilities	10	(2,429)	(2,472)
Borrowings	14	0	0
Total Non-Current Liabilities		**(2,429)**	**(2,472)**
Total Assets Employed		**(80,934)**	**(61,596)**
Financed by Taxpayers' Equity			
General fund		(80,934)	(61,596)
Revaluation reserve		0	0
Other reserves		0	0
Total Taxpayers' Equity		**(80,934)**	**(61,596)**

The balances presented above as at 1 July 2022 relate to the assets and liabilities transferred to NHS Northamptonshire ICB under modified absorption accounting from the previous CCG, NHS Northamptonshire CCG as disclosed in Note 8.

The notes on pages 151 to 188 form part of this statement.

The financial statements on pages 146 to 150 were approved on 22 June 2023 by the Governing Body and signed on its behalf by:

Toby Sanders
Chief Executive

Statement of Changes in Taxpayers' Equity
Period Ending 31 March 2023

M4 - M12 2022-23	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total £'000
Balance at 1 July 2022	**0**	**0**	**0**	**0**
Transfers by modified absorption to (from) other NHS bodies	(61,596)	0	0	**(61,596)**
Adjusted Balance at 1 July 2022	**(61,596)**	**0**	**0**	**(61,596)**
Changes in Taxpayers' Equity for 2022-23				
Net operating costs for the reporting period	(1,091,305)			**(1,091,305)**
Net Recognised Expenditure for the reporting period	**(1,091,305)**	**0**	**0**	**(1,091,305)**
Net parliamentary funding	1,071,967	0	0	**1,071,967**
Balance at 31 March 2023	**(80,934)**	**0**	**0**	**(80,934)**

Statement of Cash Flows
Period Ending 31 March 2023

	Note	M4 - M12 2022-23 £'000
Cash Flows from Operating Activities		
Net operating costs for the reporting period		(1,091,285)
Depreciation and amortisation		270
(Increase)/decrease in trade & other receivables		(5,093)
Increase/(decrease) in trade & other payables		22,525
Net Cash Outflow from Operating Activities		**(1,073,584)**
Net Cash Outflow before Financing		**(1,073,584)**
Cash Flows from Financing Activities		
Net parliamentary funding received		1,071,967
Repayment of lease liabilities		(281)
Net Cash Inflow from Financing Activities		**1,071,686**
Net Increase/(Decrease) in Cash and Cash Equivalents		**(1,897)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		0
Transfer from other public body under modified absorption accounting		(2,681)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0
Cash and Cash Equivalents at the End of the Reporting Period	12	**(4,578)**

Notes to the Financial Statements

1. Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, 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 Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with the items considered material in relation to the accounts.

1.1. ICB Establishment

The Health & Social Care Act 2022 was introduced into the House of Commons on 6 July 2021. It allowed for the establishment of Integrated Care Boards across England and abolished Clinical Commissioning Groups (CCGs). NHS Northamptonshire ICB was approved by NHS England to operate from 1 July 2022 and was created from NHS Northamptonshire CCG. Closing balances from the predecessor CCG were transferred to NHS Northamptonshire ICB on 1 July 2022. The transfer of balances is detailed in Note 8 of these Accounts. As a result of the transfer, other than for the Statement of Financial Position, comparative figures for the previous financial year have not been provided as the ICB did not exist in 2021-22.

Transfers as part of this reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Where assets and liabilities

transfer under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

1.2. Going Concern

These accounts have been prepared on the going concern basis.

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

Where an Integrated Care Board 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.

1.3. 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.

1.4. Joint Arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as Joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture. The classification of a joint arrangement depends on the rights and obligations of the parties to the arrangement.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement and is not structured through a separate vehicle. Where the ICB is a joint operator it

recognises it share of assets, liabilities, income and expenditure in its own accounts. The ICB participation in section 75 arrangements (see note 1.4.1) are considered to be joint operations by ICB Management.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment. The ICB is not party to any joint ventures.

1.4.1. Pooled Budgets

NHS Northamptonshire ICB and North Northamptonshire Council & West Northamptonshire Council have entered into Joint agreements under section 75 of the NHS Act 2006, which were overseen by the local Health and Wellbeing Boards. These agreements established pooled budgets to further the integration of health and social care commissioned services across Northamptonshire. Note 19 provides details of the section 75 agreements and the income and expenditure relating to each arrangement.

1.5. Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1. Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see 1.5.2) that management has

made in the process of applying the Integrated Care Board's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Accounting Treatment of Pooled Budgets

The pooled budget arrangements, including the Better Care Fund, have all been assessed by the ICB against IFRS 11 to establish the classification and accounting treatment of the joint arrangements. The pooled budget arrangements require unanimous consent between partners over relevant decision making and therefore management consider this Joint Control. The parties have the power, exposure and rights to variable returns from their involvement and the ability to use their powers to effect the returns but not through the use of a separate vehicle. Management therefore consider the pooled budgets to be Joint Operations. Where the ICB is a Joint Operator it recognises it share of assets, liabilities, income and expenditure in its own accounts. Note 19 sets out the individual pooled funding arrangements.

1.5.2. Key Sources of Estimation Uncertainty

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the ICB's accounts. Estimations have been made in respect of a number of accruals. Accruals for Prescribing have been calculated based on the best available information and on historic experience. Smaller accruals have been taken for the expected liability of goods or services that were received on or before 31 March 2023.

1.6. Revenue and Funding

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the Integrated Care Board will not disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less;

- The Integrated Care Board is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;

The main source of funding for the Integrated Care Board is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

1.7. Employee Benefits

1.7.1. Short-Term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2. Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that

would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Integrated Care Board commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8. Operating Expenditure

Operating expenditure, including expenditure on healthcare services with NHS and Non-NHS organisations, is 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.

1.9. Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10. Property, Plant & Equipment

1.10.1. 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 Integrated Care Board;
- 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 cost 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,
- Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2. Measurement

All property, plant and equipment are 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. All assets are measured subsequently at valuation.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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 should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3. Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11. Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, 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 Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its tangible 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.

1.12. Leases

A lease is a contract or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1. As Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease. The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments. The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise of fixed payments.

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

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

measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in Note 1.10.

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

1.13. Cash & Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14. Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board 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 Integrated Care Board.

1.15. Non-Clinical Risk Pooling

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

1.16. Financial Assets

Financial assets are recognised when the Integrated Care Board 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 initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through the profit or loss. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

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.

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.

1.16.1. 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 ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB 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 ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB 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.

1.17. Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or expired.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax

Most of the activities of the Integrated Care Board 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.

1.19. 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 Integrated Care Board not been

bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20. Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board. NHS Northamptonshire ICB consider there is only one segment, the commissioning of healthcare services.

1.21. New and Revised IFRS Standards in Issue but Not Yet Effective

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The application of the Standard would not have a material impact on the Accounts for the reporting period were they applied during that period.

Note 2: Other Operating Revenue

	M4 - M12 2022-23 Total £'000
Income from Sale of Goods and Services (Contracts)	
Non-patient care services to other bodies	10,041
Other contract income	1,082
Recoveries in respect of employee benefits	85
Total Income from Sale of Goods & Services	**11,208**
Other Operating Income	
Other non contract revenue	6,064
Total Other Operating Income	**6,064**
Total	**17,271**

Note 3: Contract Income Recognition

3.1 Disaggregation of Income - Income from Sale of Goods and Services (Contracts)

M4 - M12 2022-23	Non-Patient Care Services to Other Bodies £'000	Other Contract Income £'000	Recoveries in Respect of Employee Benefits £'000
Source of Revenue			
NHS	313	0	85
Non NHS	9,728	1,082	0
Total	**10,041**	**1,082**	**85**
Timing of Revenue			
Point in Time	10,041	1,082	85
Over Time	0	0	0
Total	**10,041**	**1,082**	**85**

3.2 Transaction Price to Remaining Contract Performance Obligations

NHS Northamptonshire ICB did not have any balances to declare under this note for 2022-23.

Note 4: Employee Benefits & Staff Numbers

4.1.1 Employee Benefits Expenditure

	M4 - M12 2022-23		
	Permanent	Total Other	Total
	£'000	£'000	£'000
Salaries and wages	7,559	590	**8,149**
Social security costs	794	45	**839**
Employer contributions to the NHS Pensions Scheme	1,196	29	**1,226**
Other pension costs	5	0	**5**
Apprenticeship Levy	23	0	**23**
Termination benefits	52	0	**52**
Gross employee benefits expenditure	**9,630**	**665**	**10,294**
Less: recoveries in respect of employee benefits (Note 4.1.2)	(85)	0	**(85)**
Net employee benefits expenditure including capitalised costs	**9,544**	**665**	**10,209**
Less: employee costs capitalised	0	0	**0**
Net employee benefits expenditure excluding capitalised costs	**9,544**	**665**	**10,209**

4.1.2 Recoveries in Respect of Employee Benefits

	M4 - M12 2022-23		
	Permanent	Other	Total
	£'000	£'000	£'000
Salaries and wages	(67)	0	**(67)**
Social security costs	(9)	0	**(9)**
Employer contributions to the NHS Pensions Scheme	(10)	0	**(10)**
Total recoveries in respect of employee benefits	**(85)**	**0**	**(85)**

4.2 Average Number of People Employed

	M4 - M12 2022-23		
	Permanent	Other	Total
	Number	Number	Number
Total	165	7	**172**
Of the above:			
Number of whole time equivalent people engaged on capital projects	0	0	**0**

4.3 Staff Annual Leave Accrual Balances

	M4 - M12 2022-23			
	Permanent Staff	Temp / Agency	Other	Total
	£'000	£'000	£'000	£'000
Employee accrued benefits liability as at 31 March 2023	(350)	0	0	**(350)**

Note 4: Employee Benefits & Staff Numbers (continued)

4.4 Exit Packages Agreed in the Reporting Period

	M4 - M12 2022-23							
	Compulsory Redundancies		Other Agreed Departures		Total		Departures where Special Payments have been made	
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	1	3,426	0	0	**1**	**3,426**	0	0
£10,001 to £25,000	1	20,022	0	0	**1**	**20,022**	0	0
£25,001 to £50,000	0	0	0	0	**0**	**0**	0	0
£50,001 to £100,000	0	0	0	0	**0**	**0**	0	0
£100,001 to £150,000	1	146,828	0	0	**1**	**146,828**	0	0
£150,001 to £200,000	0	0	0	0	**0**	**0**	0	0
Over £200,001	0	0	0	0	**0**	**0**	0	0
Total	**3**	**170,276**	**0**	**0**	**3**	**170,276**	**0**	**0**

	M4 - M12 2022-23 Other Agreed	
	Number	£s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**0**	**0**

These tables report the number and value of exit packages agreed in the reporting period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the integrated care board has agreed early retirements, the additional costs are met by the integrated care board and not by the NHS Pension Scheme, and are included in the tables. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Note 4: Employee Benefits & Staff Numbers (continued)

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

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

4.5.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member 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 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.

4.5.2 Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 5: Operating Expenditure

	M4 - M12 2022-23 Total £'000
Purchase of Goods and Services	
Services from other ICBs and NHS England	4,486
Services from Foundation Trusts	409,709
Services from Other NHS Trusts	306,604
Purchase of Healthcare from Non-NHS Bodies	143,278
Purchase of Social Care	279
Prescribing costs	95,567
Pharmaceutical services	33
General ophthalmic services	107
GPMS/APMS and PCTMS	110,998
Supplies and services - clinical	1,654
Supplies and services - general	19,150
Consultancy services	49
Establishment	3,647
Transport	1
Premises	1,240
Audit fees	209
Other auditor's remuneration	
● Other services	18
Other professional fees ex audit	224
Legal fees	20
Education and training	37
Total Purchase of Goods and Services	**1,097,309**
Depreciation and Impairment Charges	
Depreciation	270
Total Depreciation and Impairment Charges	**270**
Other Operating Expenditure	
Chair & Non-Executive Members	96
Grants to Other Bodies	120
Expected credit loss on receivables	467
Total Other Operating Expenditure	**683**
Total Operating Expenditure	**1,098,262**

The ICB Statutory Audit Fee for 2022-23 is £140,000 plus £28,000 VAT. The amount disclosed in the line Audit Fees above includes the ICB's 2022-23 Audit Fee and an additional £41,000 which relates to the 2022-23 CCG Statutory Audit Fee. Under absorption accounting, any shortfall in expenditure charged to a prior NHS body (in this instance the previous CCG) becomes a liability for the successor NHS body (the ICB) resulting in the amount disclosed above.

Note 5: Operating Expenditure (continued)

Other Auditor's Remuneration - Other Services is audit-related assurance services provided by the external auditor on the assessment of the achievement of the Mental Health Investment Standard.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the ICB must disclose the principal terms of the limitation of the auditors liability. This is detailed as follows:
For all defaults resulting in direct loss or damage to the property of the other party - £2m limit.
In respect of all other defaults, claims, losses or damages arising from breach of contract, misrepresentation, tort, breach of statutory duty or otherwise - not exceed the greater of the sum of £2m or a sum equivalent to 125% of the contract charges paid or payable to the supplier in the relevant year of the contract.

Note 6: Better Payment Practice Code

6.1 Measure of Compliance

	M4 - M12 2022-23 Number	M4 - M12 2022-23 £'000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the reporting period	24,527	157,305
Total Non-NHS trade invoices paid within target	24,133	155,065
Percentage of Non NHS trade invoices paid within target	**98.39%**	**98.58%**
NHS Payables		
Total NHS trade invoices paid in the reporting period	915	739,319
Total NHS trade invoices paid within target	814	738,476
Percentage of NHS trade invoices paid within target	**88.96%**	**99.89%**

The Better Payment Practice Code requires NHS Northamptonshire ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Note 7: Finance Costs

	M4 - M12 2022-23 £'000
Interest	
Interest on loans and overdrafts	0
Interest on lease liabilities	21
Total Interest	**21**
Other finance costs	0
Provisions: unwinding of discount	0
Total Finance Costs	**21**

7.1 Finance Income

NHS Northamptonshire ICB did not have any balances to declare under this note for 2022-23.

Note 8: Net Gain (Loss) on Transfer by Absorption

Transfers as part of this reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Where assets and liabilities transfer under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

NHS Northamptonshire ICB received the following balances on 1 July 2022 from the predecessor clinical commissioning group of NHS Northamptonshire CCG.

	NHS Northamptonshire CCG £'000
Transfer of Property, Plant and Equipment	0
Transfer of Right of Use Assets	2,775
Transfer of Receivables	4,852
Transfer of Payables	(63,763)
Transfer of Lease Liabilities	(2,779)
Transfer of Borrowings	(2,681)
Net Loss on Transfer by Absorption	**(61,596)**

As NHS Northamptonshire ICB is the recipient in the transfer of a function, it has recognised the assets and liabilities as at the transfer date. These balances are disclosed within the Statement of Financial Position as at 1 July 2022.

Note 9: Property, Plant & Equipment

M4 - M12 2022-23	Plant & Machinery £'000	Information Technology £'000	Fixture & Fittings £'000	Total £'000
Cost or Valuation at 1 July 2022	0	0	0	**0**
Transfer from other public sector body under modified absorption accounting	82	101	230	**413**
Adjusted Cost of Valuation at 1 July 2022	**82**	**101**	**230**	**413**
Disposals other than by sale	0	0	0	**0**
Cost of valuation at 31 March 2023	**82**	**101**	**230**	**413**
Depreciation at 1 July 2022	0	0	0	**0**
Transfer from other public sector body under modified absorption accounting	82	101	230	**413**
Adjusted Depreciation at 1 July 2022	**82**	**101**	**230**	**413**
Disposals other than by sale	0	0	0	**0**
Depreciation at 31 March 2023	**82**	**101**	**230**	**413**
Net Book Value at 31 March 2023	**0**	**0**	**0**	**0**

Note 9: Property, Plant & Equipment (continued)

NHS Northamptonshire ICB did not hold any balances or incur any expenditure under the following categories during 2022-23:

- Revaluation Reserve for Property, Plant & Equipment,
- Additions to Assets Under Construction,
- Donated Assets,
- Government Granted Assets,
- Property Revaluation,
- Compensation to Third Parties,
- Write Down to Recoverable Amount,
- Temporarily Idle Assets,

9.1 Economic Lives

	Minimum Life Years	Maximum Life Years
Plant & machinery	10	10
Information technology	2	2
Furniture & fittings	10	10

9.2 Cost or Valuation of Fully Depreciated Assets

	31 March 2023 £'000
Plant & machinery	82
Information technology	101
Furniture & fittings	230
Total	**413**

Note 10: Leases

Note 10.1: Right-of-Use Assets

M4 - M12 2022-23	Land £'000	Buildings excluding Dwellings £'000	Furniture & Fittings £'000	Total £'000
Cost or Valuation at 1 July 2022	0	0	0	**0**
Transfer from other public sector body under modified absorption accounting	336	2,519	0	**2,854**
Adjusted Cost of Valuation at 1 July 2022	**336**	**2,519**	**0**	**2,854**
Additions	26	211	14	**251**
Cost of valuation at 31 March 2023	**362**	**2,729**	**14**	**3,105**
Depreciation at 1 July 2022	0	0	0	**0**
Transfer from other public sector body under modified absorption accounting	9	70	0	**79**
Adjusted Depreciation at 1 July 2022	**9**	**70**	**0**	**79**
Charged during the reporting period	31	233	5	**270**
Depreciation at 31 March 2023	**40**	**303**	**5**	**349**
Net Book Value at 31 March 2023	**321**	**2,426**	**9**	**2,757**

Note 10.2: Lease Liabilities

	31 March 2023 £'000
Lease Liabilities at 1 July 2022	0
Transfer from other public sector body under modified absorption accounting	(2,778)
Adjusted Lease Liabilities at 1 July 2022	**(2,778)**
Additions	(251)
Interest expense relating to lease liabilities	(21)
Repayment of lease liabilities (capital and interest)	281
Lease Liabilities at 31 March 2023	**(2,769)**

Note 10.3: Maturity Analysis of Undiscounted Future Lease Payments

		Of which:
	31 March 2023 £'000	Leased from DHSC Group Bodies £'000
Within one year	(365)	(358)
Between one and five years	(1,433)	(1,431)
After five years	(1,074)	(1,074)
Balance at 31 March 2023	**(2,872)**	(2,863)
Balance by Counterparty:		
Leased from NHS Property Services		(2,863)
Leased from the NHS England Group		0
Leased from other DHSC Group Bodies		0
Balance as at 31 March 2023		(2,863)

Note 10.4: Amount Recognised in Statement of Comprehensive Net Expenditure

	M4 - M12 2022-23 £'000
Depreciation expense on right-of-use asset	270
Interest expense on lease liabilities	21
Total	**290**

Note 10.5: Amount Recognised in Cashflow

	M4 - M12 2022-23 £'000
Total cash outflow on leases under IFRS16	281
Total cash outflow for lease payments not included within the measurement of lease liabilities	0
Total cash inflows from sale and lease back transactions	0
Total	**281**

Note 11: Trade & Other Receivables

	Current 31 March 2023 £'000	Non-Current 31 March 2023 £'000	Current 1 July 2022 £'000	Non-Current 1 July 2022 £'000
NHS receivables: revenue	501	0	918	0
NHS Prepayments	0	0	7	0
NHS accrued income	4,537	0	173	0
Non-NHS and Other WGA receivables: revenue	4,601	0	1,438	0
Non-NHS and Other WGA prepayments	203	0	1,637	0
Non-NHS and Other WGA accrued income	248	0	100	0
Expected credit loss allowance-receivables	(590)	0	(124)	0
VAT	446	0	703	0
Total	**9,945**	**0**	4,852	0
Total Current and Non-Current	**9,945**		4,852	
Included in NHS receivables are pre-paid pension contributions	**0**		0	

11.2 Receivables Past Their Due Date But Not Impaired

	31 March 2023 Bodies £'000	31 March 2023 Group Bodies £'000
By up to three months	2,527	200
By three to six months	0	46
By more than six months	200	913
Total	**2,727**	**1,159**

NHS Northamptonshire ICB did not hold any collateral against receivables outstanding at 31 March 2023.

Note 11: Trade & Other Receivables (continued)

11.3 Loss Allowance on Asset Classes

	Trade & Other Receivables - Non DHSC Group Bodies £'000	Other Financial Assets £'000	Total £'000
Allowance for credit losses at 1 July 2022	0	0	**0**
Transfer from other public sector body under absorption accounting	(124)	0	**(124)**
Adjusted allowance for credit losses at 1 July 2022	**(124)**	**0**	**(124)**
Lifetime expected credit loss on credit impaired financial assets		0	**0**
Lifetime expected credit loss on trade and other receivables - Stage 2	(467)		**(467)**
Lifetime expected credit loss on trade and other receivables - Stage 3	0		**0**
Credit losses recognised on purchase originated credit impaired financial assets	0	0	**0**
Amounts written off	0	0	**0**
Financial assets that have been derecognised	0	0	**0**
Changes due to modifications that did not result in derecognition	0	0	**0**
Other changes	0	0	**0**
Allowance for credit losses at 31 March 2023	**(590)**	**0**	**(590)**

11.4 Provision Matrix on Lifetime Credit Loss

	31 March 2023		
	Lifetime Expected Credit Loss Rate %	Gross Carrying Amount £'000	Lifetime Expected Credit Loss £'000
Up to 90 days	0%	200	0
Between 90 & 180 days	25%	46	11
Between 180 & 360 days	50%	668	334
Over 360 days	100%	245	245
Total Expected Credit Loss		**1,158**	**590**

Note 12: Cash & Cash Equivalents

	M4 - M12 2022-23 £'000
Balance at 1 July 2022	0
Transfer from other public sector body under absorption accounting	(2,681)
Adjusted balance at 1 April 2020	**(2,681)**
Net Change during the reporting period	(1,897)
Balance at 31 March 2023	**(4,578)**

	31 March 2023 £'000
Made up of:	
Cash with the Government Banking Service	0
Cash with Commercial Banks	0
Cash in Hand	0
Current Investments	0
Cash and Cash Equivalents as in SoFP	**0**
Bank Overdraft: Government Banking Service	(4,578)
Bank Overdraft: Commercial Banks	0
Balance at 31 March 2023	**(4,578)**
Patients' money held by NHS Northamptonshire ICB not included above	**0**

NHS England require ICBs to manage the cleared bank account balance at the end of the month to a target of 1.25% of that month's drawdown. Where ICBs are required to make payments by BACs at the end of the month to meet contractual commitments, the payment will be included in the ICB's cashbook and financial ledger but will not clear the bank account until the following month as it takes 3 working days for the payments to clear the bank account. Where this occurs, NHS England has confirmed that this is acceptable as it only reflects a timing difference in the cash drawdown process and cash being made available by the bank.

Note 13: Trade & Other Payables

	Current 31 March 2023 £'000	**Non-Current 31 March 2023 £'000**	Current 1 July 2022 £'000	Non-Current 1 July 2022 £'000
NHS payables: revenue	1,721	0	3,689	0
NHS accruals	7,517	0	8,354	0
Non-NHS & Other WGA payables: revenue	14,739	0	9,672	0
Non-NHS & Other WGA accruals	60,831	0	40,923	0
Social security costs	136	0	158	0
Tax	120	0	129	0
Other payables	1,222	0	838	0
Total	**86,288**	**0**	63,763	0
Total Current and Non-Current	**86,288**		63,763	

There are no liabilities included above that are due in future years under the arrangements to buy out the liability for early retirement over 5 years as at 31 March 2023. Other Payables includes £1,182,000 of outstanding pension contributions at 31 March 2023.

Note 14: Borrowings

	Current 31 March 2023 £'000	**Non-Current 31 March 2023 £'000**	Current 1 July 2022 £'000	Non-Current 1 July 2022 £'000
Bank overdrafts:				
● Government Banking Service	4,578	0	2,681	0
● Commercial banks	0	0	0	0
Total	**4,578**	**0**	2,681	0
Total Current and Non-Current	**4,578**		2,681	

Note 14: Borrowings (continued)

14.1: Repayment of Principal Falling Due

	31 March 2023		1 July 2022	
	Department of Health & Social Care £'000	**Other £'000**	Department of Health & Social Care £'000	Other £'000
Within one year	0	4,578	0	2,681
Between one and two years	0	0	0	0
Between two and five years	0	0	0	0
After five years	0	0	0	0
Total	**0**	**4,578**	0	2,681

Note 15: Provisions

NHS Northamptonshire ICB did not have any provisions to disclose as at 31 March 2023.

Note 16: Contingencies

NHS Northamptonshire ICB did not have any contingent assets or liabilities to disclose as at 31 March 2023.

Note 17: Financial Instruments

17.1 Financial Risk Management

International Financial Reporting Standard 7: Financial Instrument: Disclosure requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Northamptonshire ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. NHS Northamptonshire ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHS Northamptonshire ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within NHS Northamptonshire ICB's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by NHS Northamptonshire ICB's internal auditors.

17.1.1 Currency Risk

NHS Northamptonshire ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS Northamptonshire ICB has no overseas operations. NHS Northamptonshire ICB therefore has low exposure to currency rate fluctuations.

17.1.2 Interest Rate Risk

NHS Northamptonshire ICB borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. NHS Northamptonshire ICB therefore has low exposure to interest rate fluctuations.

17.1.3 Credit Risk

Because the majority of NHS Northamptonshire ICB's revenue comes from parliamentary funding, NHS Northamptonshire ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

Note 17: Financial Instruments (continued)

17.1.4 Liquidity Risk

NHS Northamptonshire ICB is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. NHS Northamptonshire ICB draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. NHS Northamptonshire ICB is not, therefore, exposed to significant liquidity risks.

17.2 Financial Assets

	Financial Assets Measured at Amortised Cost 31 March 2023 £'000	Financial Assets Measured at Amortised Cost 1 July 2022 £'000
Trade and other receivables with NHSE bodies	2,362	927
Trade and other receivables with other DHSC group bodies	2,924	263
Trade and other receivables with other external bodies	4,601	1,438
Total at end of reporting period	**9,886**	2,629

Note 17: Financial Instruments (continued)

17.3 Financial Liabilities

	Financial Liabilities Measured at Amortised Cost 31 March 2023 £'000	Financial Liabilities Measured at Amortised Cost 1 July 2022 £'000
Loans with external bodies	4,578	2,681
Trade and other payables with NHSE bodies	789	2,048
Trade and other payables with other DHSC group bodies	9,768	13,655
Trade and other payables with other external bodies	78,244	50,551
Total at end of reporting period	**93,379**	68,935

17.4 Maturity of Financial Liabilities

	Payable to DHSC Group Bodies 31 March 2023 £'000	**Payable to Other Bodies 31 March 2023 £'000**	**Total Payable 31 March 2023 £'000**	Total Payable 1 July 2022 £'000
In one year or less	10,557	82,822	**93,379**	68,935
In more than one year but not more than two years	0	0	**0**	0
In more than two years but not more than five years	0	0	**0**	0
In more than five years	0	0	**0**	0
Total at end of reporting period	**10,557**	**82,822**	**93,379**	68,935

Note 18: Operating Segments

NHS Northamptonshire ICB consider there is only one segment: commissioning healthcare services.

Note 19: Pooled Budgets

Note 1.4 Joint Arrangements and Note 1.5.1 *Critical Judgements in Applying Accounting Policies* of these accounts provide further information on Pooled Budgets.

19.1 Children and Adolescent Mental Health Pooled Budget

NHS Northamptonshire ICB is the host of a pooled budget for the commissioning of Children and Adolescent Mental Health Services across the county with North Northamptonshire Council. Under the arrangement, funds are pooled under S75 of the NHS Act 2006 for Children and Adolescent Mental Health commissioning activities. The partners determine the nature of the programmes of work making up the Fund. The ICB's contribution to the Pool in 2022-23, was £5.545m which is included within Note 5 - Operating Expenditure.

19.2 Better Care Fund - North & East Northamptonshire

North Northamptonshire Council host the Better Care Fund (BCF) pooled budget for the North and East of the county. Under the arrangements, funds are pooled under S75 of the NHS Act 2006. NHS Northamptonshire ICB contribute to the pool for services to be delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. The ICB is a party to the Northamptonshire BCF pooled budget, established under Section 75 of the NHS Act 2006. The Fund has been established to further the integration of health and social care services in Northamptonshire. The partners determine the nature of the programmes of work making up the Fund. The ICB's contribution to the Fund in 2022-23, was £19.003m which is included within Note 5 - Operating Expenditure. Partners are solely liable for any overspends to services commissioned in exercise of their statutory functions.

19.3 Better Care Fund - West & South Northamptonshire

West Northamptonshire Council host the Better Care Fund (BCF) pooled budget for the West and the South of the county. Under the arrangements, funds are pooled under S75 of the NHS Act 2006. NHS Northamptonshire ICB contribute to the pool for services to be delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. The ICB is a party to the Northamptonshire BCF pooled budget, established under Section 75 of the NHS Act 2006. The Fund has been established to further the integration of health and social care services in Northamptonshire. The partners determine the nature of the programmes of work making up the Fund. The ICB's contribution to the Fund in 2022-23, was £22.104m which is included within Note 5 - Operating Expenditure. Partners are solely liable for any overspends to services commissioned in exercise of their statutory functions.

Note 19: Pooled Budgets (continued)

NHS Northamptonshire ICB's shares of assets/liabilities and income/expenditure handled by the pooled budgets in the reporting period were:

Name of Arrangement	Parties to the Arrangement	Description of Principal Activities	Amounts Recognised in ICB's Accounts Only M4 - M12 2022-23			
			Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Children and Adolescent Mental Health	NHS Northamptonshire ICB & North Northamptonshire Council (Public Health)	Provision of specialist mental health support for children within the community.	0	0	0	5,545
Better Care Fund - North & East Northamptonshire	NHS Northamptonshire ICB & North Northamptonshire Council	Provision of services which are enablers to reduce non elective admissions, to reduce delayed transfers of care.	0	0	0	19,003
Better Care Fund - West & South Northamptonshire	NHS Northamptonshire ICB & West Northamptonshire Council	Provision of services which are enablers to reduce non elective admissions, to reduce delayed transfers of care.	0	0	0	22,104

Note 20: Related Party Transactions

Senior Manager	Position	Related Party	Relationship to Related Party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts Owed to Related Party £'000	Amounts Due from Related Party £'000
Rob Bridge	Partner Member	North Northamptonshire Council	Chief Executive	5,602	(2,051)	4,410	(1,464)
Jonathan Cox	Partner Member	Northamptonshire Local Medical Committee	Chairman	251	0	0	0
		Wellingborough & District PCN	Clinical Director	638	0	0	0
		Redwell Medical Centre	GP Partner	1,148	0	0	0
		3Sixty Care Partnership	Clinical Director	2,622	0	0	(85)
Anna Earnshaw	Partner Member	West Northamptonshire Council	Chief Executive	14,913	(169)	2,662	(1,857)
Angela Hillery	Partner Member	Northamptonshire Healthcare NHS Foundation Trust	Chief Executive	157,734	(90)	289	(138)
		Leicestershire Partnership NHS Trust	Chief Executive	208	0	0	0
		3Sixty Care Partnership	Director	2,622	0	0	(85)
		NHS Leicester, Leicestershire and Rutland ICB	Voting Member	21	0	0	0
		St Andrews Healthcare	Chair of Buddy Meeting	465	0	52	0
Afzal Ismail	Non Executive Member	University Hospitals Coventry & Warwickshire NHS Trust	Non Executive Director	6,935	0	0	0
Matt Metcalf	Interim Chief Medical Officer	Northampton General Hospital NHS Trust	Chief Medical Advisor	264,393	0	706	0
		Kettering General Hospital NHS Foundation Trust	Chief Medical Advisor	225,112	0	333	0
Andy Rathborne	Partner Member	Springfield Surgery	GP Partner	1,472	0	0	0
		Brackley & Towcester PCN	Clinical Director	286	0	0	0
		Principal Medical	Shareholder	1,673	0	0	0
		Northamptonshire Local Medical Committee	Representative	251	0	0	0
Simon Weldon / Andy Callow / Deborah Needham	Partner Member	Northampton General Hospital NHS Trust	Chief Executive	264,393	0	706	0
		Kettering General Hospital NHS Foundation Trust	Chief Executive	225,112	0	333	0

Note: Andy Callow & Deborah Needham have been Interim Chief Executive, covering for Simon Weldon

The Department of Health & Social Care is regarded as a related party. During the reporting period, NHS Northamptonshire ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England, NHS Arden & GEM CSU
- Kettering General Hospital NHS Foundation Trust, Northamptonshire Healthcare NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust
- Northampton General Hospital NHS Trust, University Hospitals of Leicester NHS Trust, University Hospitals Coventry & Warwickshire NHS Trust, East Midlands Ambulance Services NHS Trust
- NHS Business Service Authority.

In addition, NHS Northamptonshire ICB 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 Northamptonshire Council and West Northamptonshire Council.
NHS Northamptonshire ICB has not received any revenue or capital payments from charitable funds where members of the Governing Body are trustees of the Charitable Funds.

Note 21: Events After the Reporting Period

From 1 April 2023, Integrated Care Boards will take on the commissioning function for pharmaceutical, general ophthalmic and dental services from NHS England. The expected impact on NHS Northamptonshire ICB's Statement of Net Comprehensive Expenditure will be £69,948,000 and the ICB is expecting to receive the corresponding revenue resource funding to enable the commissioning of these services.

Note 22: Losses & Special Payments

NHS Northamptonshire ICB did not have any losses or special payments to disclose as at 31 March 2023.

Note 23: Financial Performance Targets

Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).

NHS Northamptonshire ICB's performance against those duties was as follows:

Duty	M4 - M12 2022-23 Target £'000	M4 - M12 2022-23 Performance £'000
Capital resource use does not exceed the amount specified in Directions	251	251
Revenue resource use does not exceed the amount specified in Directions	1,103,276	1,091,305
Revenue administration resource use does not exceed the amounts specified in Directions	11,468	10,028

Independent auditor's report to the members of the Governing Body of NHS Northamptonshire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Northamptonshire Integrated Care Board (the 'ICB') for the period ended 31 March 2023, 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 a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to

continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

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

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; 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 ICB, or an officer of the ICB, 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 make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 90 to 91, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, 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.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

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.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries posted by senior officers
  - year end accruals

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to prescribing accruals.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

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

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Northamptonshire Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the ICB, 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 ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

29 June 2023

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NHS
Northamptonshire
Clinical Commissioning Group

Northamptonshire CCG Annual Report 2022

1st April 2022 to 30th June 2022

Contents

Performance report

The performance section provides information on the Clinical Commissioning Group (CCG), our main objectives and strategies and how we have discharged our duties and functions.

Within this chapter you will find updates from our Chief Executive and General Practitioner (GP) Chair, information about who we are and what we do as well as the services we commission on behalf of our local population, and how we have performed against the NHS standards.

Toby Sanders
Chief Executive (Accountable Officer)
18 September 2022

Chair's introduction

Welcome to the final NHS Northamptonshire Clinical Commissioning Group's (CCG's) Annual Report, which covers the final three months of the CCG from 1st April up to and including 30th June 2022, when the CCG was disestablished. The statutory duties of Northamptonshire CCG transferred to NHS Northamptonshire Integrated Care Board (ICB) when it was established on 1st July 2022. It is my pleasure to present this report, which details the progress we have made in commissioning high quality health services on behalf of our local population during this period.

The CCG received an allocation of money to be spent on health services for the people registered with a Northamptonshire GP practice. This included the cost of hospital outpatient appointments, inpatient stays and operations, prescribed medicines, investigations, GP practice appointments and care, GP out-of-hours services, Corby Urgent Care Centre, community and mental health facilities and many other services. Please note the amounts presented in the financial statements are not entirely comparable as this report covers a three month period compared to the usual 12 months. We also cooperated with our partners across health and social care, and this includes Kettering General Hospital Foundation Trust (KGH), Northampton General Hospital (NGH), Northamptonshire Healthcare Foundation Trust (NHFT), West Northamptonshire Council (WNC) and North Northamptonshire Council (NNC) as well as the voluntary and charitable sector and other organisations.

This report describes how as we have moved towards being an Integrated Care System and how we have worked closely with patients, partners and stakeholders to understand the needs of our community to continue improving care for the local population.

This is the last time that I will be writing as GP Chair of NHS Northamptonshire CCG and I feel a range of emotions when I reflect on everything the organisation has achieved together. I will really miss working with our teams and being able to support our clinical leads with the service redesign that we are developing with our patients, and this important work will need to continue within the ICB. Being part of the leadership team

of two local CCGs has been a memorable journey for me over the last 10 years, and I continue to admire and respect the wide range of people that I have met and worked with while undertaking these roles.

NHS Northamptonshire CCG came into existence in April 2020 at one of the most difficult times that many of us have known, and I have really appreciated how our teams have worked hard to support each other and our population despite the challenges being faced. Our member practices and system colleagues have continued to support our patients in an environment where demand often exceeds the available capacity, and I am aware that our teams continue to work hard to transform services and mitigate the risks that this poses to our population. I continue to be grateful to our member practices for having elected me into this role in January 2020 and hope that I have been able to fulfil their hopes and expectations of our membership organisation during this time.

With every NHS change there are always opportunities and the transition to ICB under the new leadership team will be an important development. Naomi Eisenstadt and Toby Sanders' new leadership team will work through a variety of challenges in the months ahead and the board-level clinical leadership will transfer to the new Chief Medical Officer and Chief Nursing Officer. I will continue to be a Northamptonshire GP working in Corby and remain committed to the wellbeing of the people of Northamptonshire and our wider health and care teams. I will continue to be involved in system change as part of my Primary Care Network and look forward to continuing to work with the wider health and care system in that capacity.

Thank you to everyone who has supported me during my time as GP Chair of NHS Northamptonshire CCG, it has been a privilege to have worked with you all and to have served our local population.

Dr Joanne Watt
GP Chair
12th July 2022

Foreword

Welcome to the final Annual Report for NHS Northamptonshire Clinical Commissioning Group, which covers the period 1 April 2022 to 30 June 2022 - the final months before the CCG was disestablished and the Northamptonshire Integrated Care Board took over the statutory responsibilities.

This report aims to give you an overview of our organisation, our staff and GP member practices. It shows how we work through robust governance arrangements and how we assure ourselves and others that our services are delivered safely and to a high standard of quality - always working to ensure that the patient experience is positive. We will explain our mission, goals and achievements, highlighting the partnerships that we rely on to ensure the best possible outcomes for patients.

The report is retrospective by nature and showcases the achievements and challenges of our organisation over the period. Although there is a great deal to be proud of, I also need to acknowledge that this has been another challenging period for the NHS. You will see those challenges reflected throughout this report and how we have adapted to ensure patients could continue receiving care when they needed it.

The progress made in Quarter 1 2022/23 has been delivered in a climate of change and external pressure, which in some cases has resulted in us not achieving some of our key constitutional standards and targets. It is also important to note that some of the constitutional standards and targets were suspended to enable the health service to continue focussing on the fight against COVID-19. We have been working with our providers to ensure our local population is able to access the best possible health services available. You can read more about our performance on pages 34 to 63.

At the time of writing this report, Northamptonshire CCG has been decommissioned and Northamptonshire Integrated Care Board (ICB) went live on 1st July 2022. The ICB is part of a set of new arrangements called Integrated Care Systems (ICS) which have been rolled out across England. They aim to bring together hospital, community and mental health trusts, GPs and other primary care services with local authorities and other

care providers to work together and apply their collective strength to addressing their residents' biggest health and care challenges. Northamptonshire has been selected as one of 42 ICSs across England. You can read more about the ICB and ICS on pages 12 to 15 or by visiting the website https://www.icnorthamptonshire.org.uk/

I am delighted to have been appointed as the Chief Executive for Northamptonshire's Integrated Care Board (ICB). I believe working together across health and care as an integrated system gives us a real opportunity to make a positive difference to people's lives in terms of their health outcomes and experience of care.

I'm looking forward to being able to continue building on the positive relationships between partners that have been strengthened over the last two years and to accelerate the development of our local collaborative and place arrangements as the basis of how we will work together to deliver care going forward. I would like to take this opportunity to thank all of the members of the CCG Governing Body and senior management team for all their contributions and commitment over so many years and particularly through such unprecedented recent circumstances.

We hope that you find this Annual Report informative, providing you with an overview of the final three months of the CCG.

Toby Sanders

Chief Executive

30 August 2022

Performance overview

NHS Northamptonshire Clinical Commissioning Group (CCG) was officiated by NHS England and NHS Improvement on 1 April 2020, following the de-establishment of NHS Nene CCG and NHS Corby CCG.

The organisation had a budget of £338,975,000 for Quarter 1, and responsibility for planning and funding the majority of health services in Northamptonshire on behalf of 796,135 registered patients across Corby, Daventry, East Northamptonshire, Kettering, Northampton, South Northamptonshire and Wellingborough.

The only parts of the county not covered by the CCG are the communities of Wansford and Oundle in the east, which are members of Peterborough and Cambridgeshire CCG, although this will come under the new ICB.

Vision and mission

Northamptonshire CCG has chosen to align our Vision and Mission with the Northamptonshire Health and Care Partnership, as outlined below:

Our vision

Through joined-up effort and shared resources we create a positive lifetime for all of health, wellbeing and care in our communities.

Our **mission** in working together, the reason we do what we do, is to **empower positive futures**. Wherever we work and whatever our role is, we all want people in Northamptonshire to be able to **choose well, stay well, live well**.

Constitution

The CCG's Constitution sets out the CCG's governing principles, rules and procedures established to ensure probity and accountability in the day-to-day running of our organisation.

The Constitution applies to all our member practices, our organisation's employees, any individuals working on behalf of our organisation and to anyone who is a member of the governing body or committees established by the organisation.

THE NHS CONSTITUTION
the NHS belongs to us all

NHS Northamptonshire CCG's Constitution sets out

Our corporate objectives and governance structure

The CCG is a clinically led and managerially supported membership organisation made up of 68 member practices. Further detail in relation to the CCG governance structure including a diagram of our arrangements can be found on page 91.

Our corporate objectives, our performance against those outcomes and impact of and management of risk can be found on pages 110 – 116.

Performance summary

NHS Northamptonshire CCG measures its performance against national NHS standards. These are a series of measures which are used to assess the performance of each health service. We, and our providers, have struggled to meet many required standards in 2022/23 as COVID-19 has had a significant impact on both physical capacity for and volume of appointments.

We and our providers successfully delivered many of the required standards in Quarter 1 of 2022/223 including:

- Over 94.12% of patients requiring Psychological Therapies have had their treatment completed within 6 weeks (standard 75%)
- The IAPT recovery rate is 50.43% (standard is 50%)
- Not a single urgent operation was cancelled for the second time
- No mixed accommodation breaches at NHFT

The challenging areas that require our continued focus in Quarter 1 of 2022/23 are:

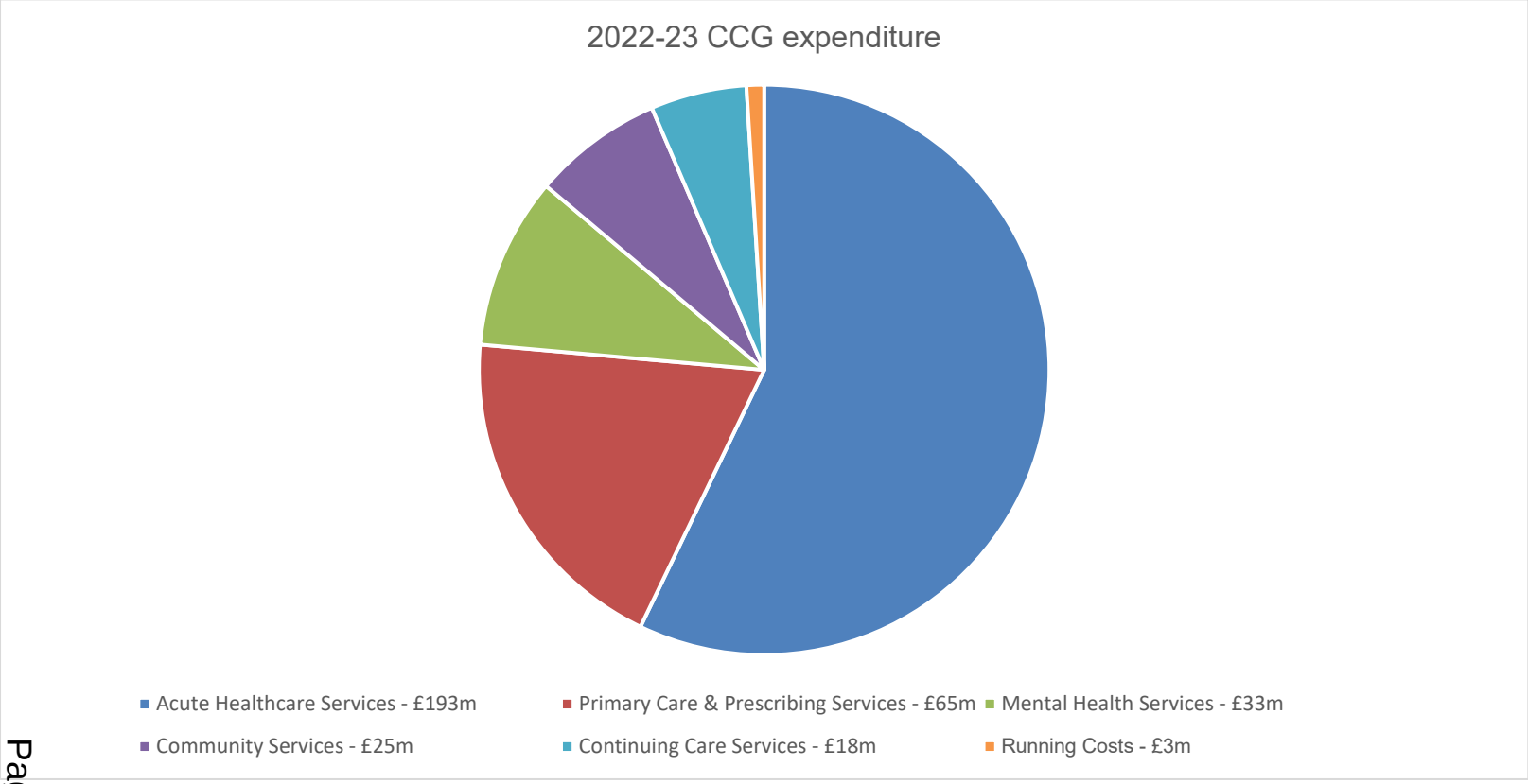
- ED four-hour performance at NGH (KGH does not report on this)
- Delivery of the Ambulance Response Programme waiting times
- 62-day waiting time standards at both of Northamptonshire's acute hospitals
- Meeting the 18-week Referral to Treatment time for planned care
- The number of 52+ week waits for planned care which is still high

- Diagnostic test waiting times
- Patients waiting less than 6 weeks for a dementia diagnosis

A full performance analysis is included on pages 34 to 63.

Finance summary

The pie-chart and table below provides a breakdown of the CCG expenditure during Quarter 1 2022-23.



Working as a system

The following pages describe how the health system has come together to deliver for the local people of Northamptonshire.

The COVID-19 vaccination programme

The Northamptonshire COVID-19 vaccination programme has continued delivery in the first quarter of 2022 with the rollout of spring booster jabs as well as the continuation of the evergreen vaccination offer to all eligible. Spring booster vaccinations launched on 21 March 2022 and 55,508 spring booster jabs have been delivered up to 30 June 2022 to eligible local people across the county. Altogether, in the last quarter (1 April to 30 June) 65,359 doses have been administered in Northants, contributing to the overall total of 1,596,411 doses delivered since the programme began in December 2020*.

Eligible local people across Northamptonshire have been able to take up the offer of a vaccine at general practice and community pharmacy sites, pop-up clinics and the vaccination centre at Moulton Park. General practice colleagues and community pharmacies have also continued to deliver a co-ordinated vaccination programme to care homes and housebound patients across the county, with the home visiting service offering vaccinations to the most vulnerable patients in Northamptonshire.

In collaboration with the Public Health Northamptonshire engagement team, the mobile vaccination service was relaunched on 2 May and has been successfully visiting identified areas of lower uptake across the county. From 2 May to 30 June, the service has vaccinated over 1,386 people.

*NHS Foundry Data – Absolute Vaccinations GP Registrations Report

Integrated Care System

On 1 July 2022, Northamptonshire was disestablished and the statutory duties transferred to NHS Northamptonshire Integrated Care Board (ICB).

The ICB is part of a new statutory integrated care system. This is a new legal requirement not just for our county, but for the whole of England across 42 local areas.

An integrated care system is a partnership of local health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in the area.

Our integrated care system is called **Integrated Care Northamptonshire**. It replaces and builds upon the partnership work undertaken over the last few years by Northamptonshire Health and Care Partnership.

Integrated Care Northamptonshire operates under the combined leadership of two statutory (legally required) bodies: NHS Northamptonshire Integrated Care Board (NICB) and Northamptonshire Integrated Care Partnership (NICP).

Integrated Care Board

NICB is responsible for local NHS services, functions, performance and budgets. This body replaces the old NHS Northamptonshire Clinical Commissioning Group (CCG). It is made up of local NHS trusts (our two general hospital trusts and Northamptonshire Healthcare NHS Foundation Trust, our community and mental health service provider), primary care providers (including GPs), and local authorities.

Integrated Care Partnership

NICP is a statutory committee made up of local health services, local government, the voluntary and community sector, as well as other public sector partners.

What will the Integrated Care Board do?

The Integrated Care Board (ICB) is a statutory body responsible for local NHS services, functions, performance and budgets. It is directly accountable to the NHS and is made up of local NHS trusts, primary care providers, and local authorities.

Northamptonshire Integrated Care Board

The ICB helps bring together hospitals and family doctors, physical and mental health, the NHS, local councils and community and voluntary sector services.

The ICB is responsible for joining up care services to improve patient experience in the community. The Board includes a chair, the chief executive and representatives from NHS organisations, primary care (GPs) and local authorities (councils).

The Integrated Care Partnership (ICP) is a statutory committee that brings together all system partners to produce a health and care strategy. As a forum to support partnership working, the ICP brings together local authorities, health and social care, and housing providers.

How does it work?

The ICB helps bring together hospitals and family doctors, physical and mental health, the NHS, local councils and community and voluntary sector services.

By bringing together partners, it allows for greater input from all those involved in delivering services, resulting in better care wrapped around individuals.

Why do we have an Integrated Care Board?

The ICB ensures that the best possible care is available to people in our communities. It constantly assesses what needs to change to meet the level and complexity of care in the county. The ICB ensures that integrated care improves population health and reduces inequalities between different groups.

Who has been appointed to lead the ICB?

Following a robust recruitment process the following have been appointed to lead the organisation. You can read more about the Board on the Board page of the ICB website

- Naomi Eisenstadt, Chair
- Toby Sanders, Chief Executive
- Eileen Doyle, Chief Operating Officer
- Yvonne Higgins, Chief Nurse
- Dr Matt Metcalfe, Chief Medical Officer
- Sarah Stansfield, Chief Finance Officer

They will be supported by several non-executive members and partner members:

- Afzal Ismail, Non-Executive Member and Chair of ICB Audit Committee
- Andrew Hammond, Non-Executive Member and Chair of Integrated Planning and Resource Committee
- Anna Earnshaw, Partner Member – Local Authorities
- Angela Hillery, Partner Member – NHS and Foundation Trusts
- Janet Gray, Non-Executive Member and Chair of Delivery and Performance Committee and Chair of Quality Committee
- Dr Jonathan Cox, Partner Member – NHS and Foundation Trusts
- Rob Bridge, Partner Member – Local Authorities
- Dr Shade Agboola, Non-Executive Member and Chair of Primary Care Committee
- Simon Weldon, Partner Member – NHS and Foundation Trusts

What will Integrated Care Northamptonshire do?

Being an integrated care system means we can formalise the joint-working arrangements that have already been in place for some time in Northamptonshire.

It will simplify the way health and care organisations work together and improve their ability to make decisions, providing better and more joined-up services.

The four aims of Integrated Care Northamptonshire will be to improve health for all, to reduce health inequalities, to make the best possible use of public funding, and to contribute to the economic and social development of Northamptonshire.

Four clear workstreams have been identified:

- Children and young people
- Mental health, learning disability and autism
- Elective care
- iCAN (services for older people)

Service updates

Reflecting on Quarter 1 2022/23 offers an opportunity to review some of the challenges and successes we've had. You can read more about how we have delivered within each of these workstreams over the next few pages.

Children and young people

This section sets out how we have supported patients from birth into childhood and beyond.

Local maternity and neonatal

The Local Maternity and Neonatal System (LMNS) have completed and submitted version two of the Northamptonshire LMNS Equality and Equity assessment, following feedback. The Equity and Equality submission aims to address the findings of the MBBRACE-UK reports about mothers and babies from the groups most at risk of poor health outcomes. It enables us to understand the local population so that interventions can be targeted at groups of women and families within the community who are more likely to experience poorer outcomes. A co-produced action plan is now being developed which will help guide our work and refresh our approach to help achieve equity and equality for all mothers and babies in Northamptonshire. The action plan is due for submission September 2022.

Midwifery Continuity of Carer (MCoc)

The publication of the Final Ockenden report recommends that all Trusts should review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer unless they can demonstrate staffing meets safe minimum requirements on all shifts. Following completion of a safe staffing risk assessment both Trusts have agreed to cease further roll out of continuity teams, however they have concluded that they can meet the safe minimum staffing requirements for the existing MCoC provision. The existing continuity of carer teams are prioritising rollout of continuity of carer to the most deprived neighbourhoods and those with higher numbers of Black, Asian and Mixed ethnicity women.

Capacity and capability framework

The LMNS Capacity and Capability Framework was launched to help reduce variability between LMNSs. The document identifies five domains of high performing LMNSs alongside characteristics associated with these and potential sources of evidence which may demonstrate an LMNS meets these characteristics. The standards have been developed to align with other asks of systems and trusts including the perinatal quality surveillance model, the move towards new ICB architecture and the (7) immediate and essential actions set out in the interim Ockenden report.

Children and young people

We continue to support a variety of needs for the health and wellbeing of children and young people (CYP) in Northamptonshire. The increase in referrals for services continues and is still impacting our waiting times. We have therefore continued to innovate to improve the standard of service we provide.

The focus has been working together as a system across health, social care, education, the voluntary and community sector and other partners to ensure we improve the health and wellbeing of our youngest community members.

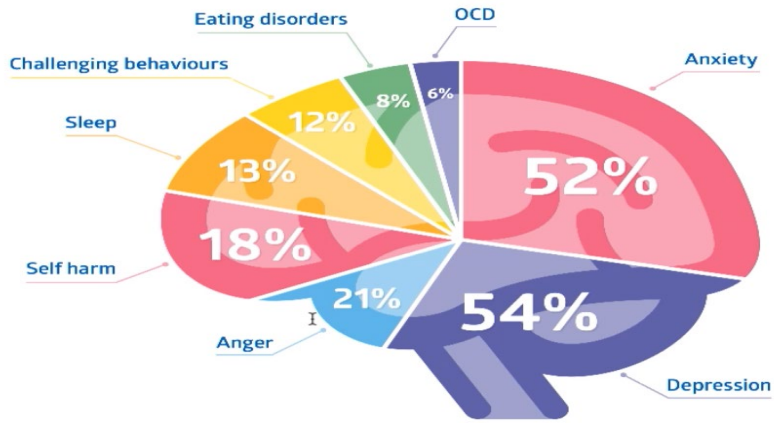
Engagement

- We commissioned a piece of work to understand how we currently capture the views of CYP and involve them in co-production of our work. This piece canvassed the views of families from the ages of 0 – 25 and will be used to inform our partnership work in the Northamptonshire Children's Transformation Programme
- Our partners worked together to better understand how we can improve the access to services for ethnic, disability, LGBTQ+ and traveller communities

These pieces of work will inform how we commission and deliver services across Northamptonshire.

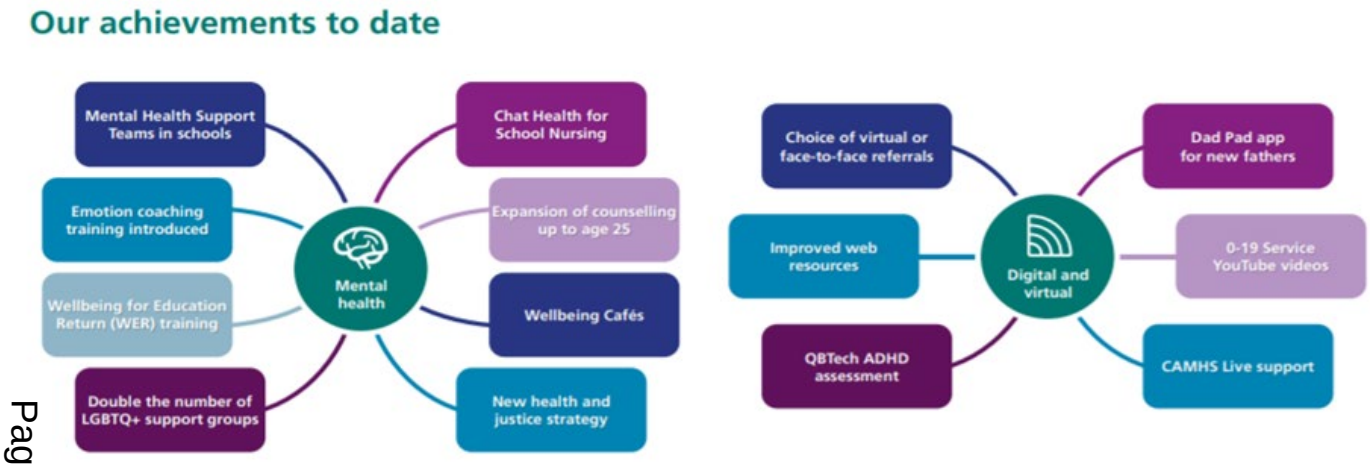
Mental health and wellbeing (young people)

There has been a 140% increase in demand for help for the following areas (see diagram on the right)



To meet that demand we have:

- Implemented the Long-Term Plan for Mental Health Access which has meant that 33% more CYP have been able to get the support they need when compared with last year. This has been recognised as a key success by NHSE/I
- Been working across health, social care and central government to see how we can improve support for CYP in Mental Health In-patient facilities and help them get home sooner, leading to the development of a local action plan that will be developed in 2022/23
- Expanded our capacity to support CYP with dysregulated eating issues and disorders
- Put in additional funding to our REACH collaborative to expand youth counselling support for 18–25-year-olds, particularly reaching out to young people with additional needs.



Mental health

Quarter 1 of 2022-23 has involved three key aspects of work:

- Finalising the Activity, Finance and Workforce Plan for mental health over the coming year
- Consolidating collaborative structures and frameworks to enable mental health to continue working in the context of an Integrated Care system
- Preparing for the delivery of an outcome-based long-term contract for adult and older people's mental health services.

The mental health programme finalised its activity and investment plans for 2022-23, which will support the delivery of all required NHS Long-Term plan ambitions for this year. Psychological talking therapies will be further expanded, creating capacity to deliver therapy to 20,717 people with common mood disorders across the county.

Increased resource will be added to perinatal mental health services, including implementation of assessment and signposting for partners of perinatal women, and sustained delivery of maternal mental health services for wider range of mild/moderate perinatal mental health issues. Services to support people with mental health issues to obtain/ maintain employment will also be expanded.

There will be greater support for mental health embedded within GP practices, supporting residents to identify and access the most appropriate support (both within mental health pathways, but also more widely including housing, debt advice, drug and alcohol treatment, and social prescribing). We will launch a new scheme to significantly increase the number of annual physical health checks and follow-up interventions for people with severe mental health issues – and in doing so help to address a key health inequality in our communities. Finally, we will be developing a new Mental Health Ambulance service, allowing for a more timely, compassion-focussed and person-centred care for those in mental health crisis.

Having launched the Mental Health, Learning Disability and Autism Collaborative Programme in April 2021, we will be strengthening this network of partnerships to help ensure mental health, physical health and social care can work closely together to deliver joined-up care and ensure the most effective pathways of health and social care in the future.

One keyway to enable this is through changing the way contracts are designed and written between our new Integrated Care Board and the organisation who provide health and care to our residents. Northamptonshire has designed an outcome-based collaborative contract for all adult and older people's mental health services, which was signed on 30th June 2022.

This contract will entrust a 'lead provider' (Northamptonshire Healthcare NHS Foundation Trust) to work in coproduction with service users, carers and system partners to transform mental health pathways for the future. By structuring our system in this way, we can ensure resources are focused on providing choice, control and opportunity for person-centred care based on delivering outcomes. In time, this will bring about a more efficient mental health system, which can then reinvest resources into more preventative pathways, reducing inequalities and improving the circumstances that can often determine health and life outcomes.

Learning disabilities and autism

We have continued to work together across the system to further improve outcomes for our learning disabilities and autism communities across all ages. This last quarter has been exciting as we had a series of events across the county to usher in Learning Disabilities Week including a performance by Britain's Got Talent Semi Finalists "Born To Perform" (pictured right) with activities by service users, families, professionals and voluntary sector partners across the county.

We have continued to improve access to annual health checks for people over the age of 14 with learning disabilities. Significantly more people accessed health services compared to the last two years, thanks to the work between our strategic health facilitators, our primary care networks, our Community Team for People with Learning Disabilities (CTPLD), social care, carers and service users understanding how important they are.

This is our first year of including autistic people within our learning disabilities mortality review programme (LeDeR) and this should continue to inform our learning on how we can support people with LDA well and to live longer.

Our Transforming Care Programme continues to ensure we get the right support for the right people at the right time where they are at risk of going into hospital due to their mental health. There has been a slight increase in LDA people requiring hospital care currently, and this is in line with the general population also finding the pandemic has had an adverse impact on their mental health. We are therefore using the learning from this to review our strategy and plan further to try different approaches to supporting people to live their best lives.

Work has been undertaken to enhance how the Northamptonshire system can better work together for our LDA population. The team has been working hard in this area to ensure we improve our co-production with experts by experience and developing a refresh of our strategies and plans in relation to autism.

We are developing how we can:

- Improve our autism and forensic pathways
- Improve inclusivity in our communities including more easy read materials
- Learn from the children and young people LDA workstreams to enhance our all-age offer
- Develop our community hubs across the partnership
- Improve our discharge pathways
- Enhance our sensory offer in inpatients and beyond
- Continue to ensure partners are using tools to better support our LDA community e.g. communication plans, hospital passports, advance care plans etc.

Special educational needs and disabilities (SEND)

There is a need to improve how SEND communities can access the services they need, and therefore we have been undertaking work in the area across our partnership including:

- We have been using the ICS SEND maturity matrix to ensure our local systems are sighted on CYP with SEND and upholding our statutory duties. This self-evaluation has enabled us to assess how well we are doing (and where we need to improve. NHSE/I gave Northamptonshire positive feedback in relation to the work we are undertaking in this area.
- Our health and social care system continue to co-produce our model with CYP and families for short breaks and this will inform our work when we go to market with a new framework in late 2022

Learning disabilities and autism

There have been a number of key areas we have sought to improve, including:

- Recruiting staff for a new key worker and peer support service to assist CYP and families at risk of admission to hospital
- We have been piloting a new approach to fast-track individuals on the waiting list for autism assessments to help us design our new transformation project to improve waiting times
- We have been working with our partners including special schools to ensure more young people from the age of 14 receive their annual health checks

Physical health and complex needs

- Our new support service to improve health outcomes for young offenders are improving the future for this vulnerable group
- We continue to work as a partnership to improve the timeliness of initial and review health checks for children in care
- We are reviewing the improvements that can be made within health services for children and young people, especially in regard to long term conditions such as asthma
- We are using the learning from a recent paediatric palliative care project to inform the design of future palliative and end of life services for children and young people, to support them and their families as they come to the end of their only years of life

None of these pieces of work would not have been possible without the teamwork across the system, and we have a vision for Northamptonshire's children transformation that is a true partnership

Elective care

The start of 2022/23 saw the CCG continue to support the delivery of elective recovery, the development of the system's 2022/23 Operating Plan and Elective Collaborative through the Elective Care Board (ECB).

The 2022/23 Operating Plan for Elective has a key focus on reducing long waits, increasing activity, and reducing health inequalities. CCG staff worked with colleagues from across partners to develop a plan that met all these requirements. To ensure we work together to ensure we can deliver the shortest waits possible for our local population.

The development of the Elective Collaborative sees the progression of the system's work on Elective to a shadow Collaborative arrangement. CCG colleagues have been working with University Hospitals Northamptonshire (UHN), Primary & Community Care and the Independent Sector (IS) to develop a case for change of this new integrated way of working.

Cardiovascular

The system has made progress on implementing a pilot community heart failure service. Keen to build on this through the ECB a refreshed approach to system working on cardiovascular has been agree with three key priorities:

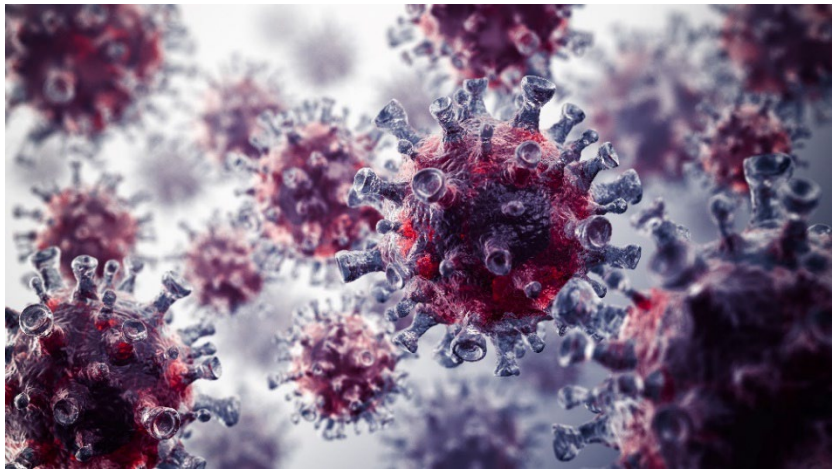
- Heart failure
- Coronary heart disease
- Atrial fibrillation

The CCG worked closely with colleagues in population health management, UHN and primary care to agree an approach to one of the biggest challenges we face locally.

Wheelchair and orthotics

This service has now progressed out of the transition stage into business as usual with all key performance indicators being met and patient feedback continuing to score highly.

Cancer



Both local acute hospital trusts continue to prioritise cancer on behalf of its most vulnerable patients to ensure the best possible outcome and experience. Both trusts are routinely meeting and exceeding the Faster Diagnosis Standard (FDS) to ensure patients who are referred for suspected cancer receive a timely diagnosis. During Quarter 1 the system cancer programme has focussed on key plan priorities as follows:

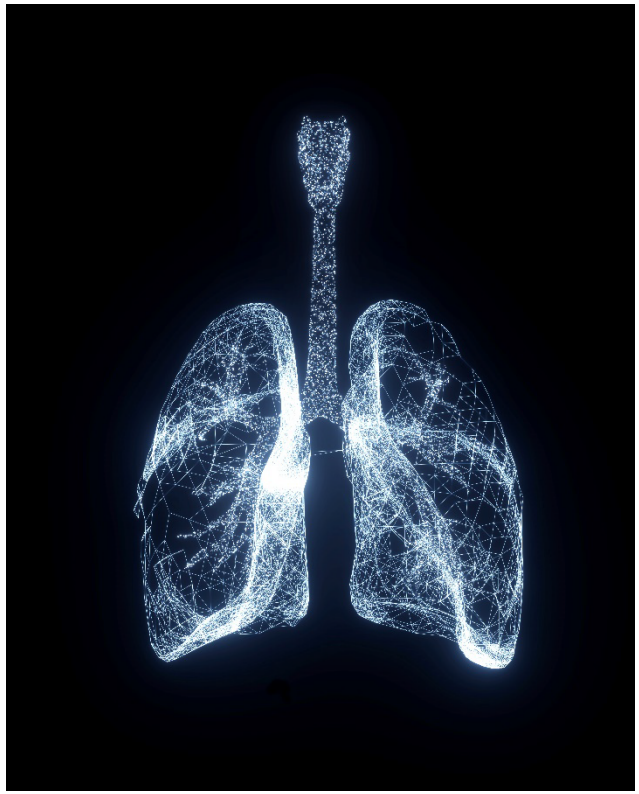
- Development of a GP resource pack supporting implementation of the Network contract Direct Enhanced Service (DES) in Primary Care
- Continuation of Corby Targeted Lung Health checks, on track for completion of baseline low dose CT scans by end Quarter 2 2022/23
- Participation in the national NHS Galleri trial (GRAIL), aiming to detect cancers earlier by looking for abnormal DNA shed from cancer cells into the blood. Baseline tests April-May 2022, with trial completed by 2023
- Planning for acceleration of Rapid Diagnostic Services for FDS pathways and alignment with Community Diagnostic Hubs by end Quarter 2 2022/23
- Planning for the introduction of FIT (Faecal Immunochemical Testing) for all Lower GI FDS pathways, where clinically appropriate, by Quarter 3 2022/23
- Continued delivery of colon capsule endoscopy and cytopsonge innovations in the Lower and Upper GI pathways
- Implementation of breast pain pathway clinics in the community Quarter 2 2022/23
- Planning for the introduction of personalised stratified follow up pathways (PSFU) with remote monitoring for gynaecology, thyroid, endometrial and skin by Quarter 4 2022/23

Diabetes

Over the last quarter work to improve diabetic care has ramped up with the implementation of the DISN programme approved, plans to widen the prevention programme and weight management schemes commenced, a re-start in face-to-face education, a review of continuous glucose monitoring starting and five public diabetes engagement events completed. A transformation group has also been set up with to drive through key priorities.

Long Covid and respiratory

Since forming our new system respiratory programme, underpinned by a core system leadership team, a plan has been developed setting out our key projects for the next period, and taking the learning forward from the pandemic period. To date system partners have met together regularly to focus on several key priorities:



- The continuation of support for long Covid/post Covid syndrome through the further enhancement of workforce, and referral management
- The re-starting of spirometry within primary care for those with new symptoms
- The re-starting of our Pulmonary Rehabilitation Programme offer for those living with COPD, whilst working with national partners to develop our local model of care against the NHS Long Term Plan, and new five-Year Vision for Pulmonary Rehabilitation plan published this year.
- Looking to level up care in the country using several different tools to improve our understanding of local need. This work includes partnership working with other regional systems, national partners, and our local councils.

We have also supported wider system programmes of work in the improvement of care for those living with asthma, by enabling the use of digital technology that facilitates people to either go home earlier or stay within their own homes.

Urgent care

Pressures in the urgent care system continued in to quarter one, compounded by a further wave of COVID-19. Whilst changes in infection, prevention and control policy helped alleviate some of the logistical challenges with cohorting, staff absence remained a challenge. The homecare market continued to be challenging, particularly in the West of Northamptonshire where there was a decrease of 10% in the homecare market.

In April we saw a surge in ambulance delays over 60 minutes at Northampton General Hospital. This was reflective of growing concern nationally with ambulance delays.

Demand for primary care has returned to pre-pandemic levels, outstripping the capacity in the sector. Attendances at ED are on average tracked 10% higher than 2019**,** although the same growth was not seen in admissions. This is partly due to an increased attendance rate from under 18s who have a low admission rate.

We saw and continue to see an increase in the number of patients who have a length of stay of 7,14 and 21 days and increasing numbers of patients that are medically fit for discharge and waiting for pathways in our acute beds.

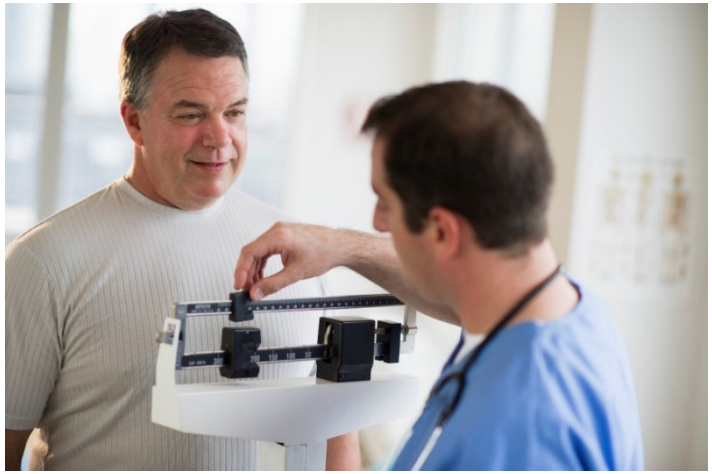
System discussions have been focused on building resilience, capacity and managing risk. In May, the system signed up to a trajectory and a plan to eliminate ambulance handover delays and commenced discussion on a number of transformational integrated health and social care projects to support the forthcoming winter pressures.

Work in our collaboratives has been continuing at pace to support admission avoidance, good system flow and efficient discharge processes and whilst the pressures continue to be high, the benefit of this work is being seen and felt.

Primary care

In the 12 months to July 22 **4.3 million** appointments were provided by GP practices in Northamptonshire including:

- 2.5 million face-to-face appointments or home visits
- 1.6 million telephone appointments
- Over 140,000 video or online appointments



This has meant over **365,000** more appointments being offered than the same period last year, and 3 out of 5 appointments offered the same or next day.

Patient experience also showed:

69% of patients stated that the practice website is easy to use. Further work is underway to improve this and make the practice website the first-place patients go to for information

61% of patients had an in-person appointment, in line with the national average and higher than in 2021

82% of patients rated the practice receptionist as helpful which was the same as in 2021

95% of patients had confidence and trust in the healthcare professional treating them in 2021

97% of patients were asked for information about why they were making an appointment to ensure they received an appointment with the right healthcare professional.

88% of patients stated that they were involved as much as they wanted to be in their care.

Shared decision making is on the increase so this is expected to increase

Care navigation training

Care navigation training has continued throughout the pandemic virtually to support all Care Navigators in implementing the soft skills which support the project. The training agendas include an introductory course for those who may have never navigated before or those needing a refresher, soft skills such as communication, conflict resolution and assertiveness and lastly Reception Plus.

Reception Plus was devised to support staff in a holistic approach by bringing all aspects of the original four agendas into one training course. Training to support the staff builds confidence and skills to enable the staff to effectively care navigate. Another skill the CCG felt would support staff is British Sign Language (BSL) training for care navigators to attend if they wish. This will include the basics of BSL which in turn supports staff and patients.

Another aspect of care navigation is educating the patients on what care navigation is. Therefore, two radio adverts are currently live on Heart and Gold to educate and inform patients on what care navigation is and to remind patients to be kind to all healthcare staff. Alongside this, the primary care team and communications team are working together on a communication social media strategy to support staff.

This includes poster packs which have been sent to all practices, animation films to show what happens after a general practice appointment, filming in practice to support roles within practices, humanising of general practice and impact of abuse and advertising on social media and contingency to push messages during times of pressure.

Restoration of services

Funding was provided at the end of March for practices to conduct a '**Waiting List Risk Stratification & Management'** exercise. The intention was for practices to review patients who were waiting for procedures usually offered by the practice and deferred due to COVID-19.

Due to COVID-19 and delivery of the COVID-19 mass vaccination programme, many GP services were stepped down, and as a result GP practices held waiting lists for patients waiting for operational procedures. There are two parts to the scheme:

- Risk stratification and validation
- Ongoing management of patients waiting for procedures

GP practices have the autonomy to design how they created any extended capacity and flexibility of how they safely manage patients that are identified as a priority.

Digital journey planner

The primary care team have been working closely with Redmoor Health to support practices with their digital presence.

Redmoor has developed their Digital Journey Planner (DJP) system alongside the NHS to optimise the practice knowledge, understanding and process to improve patient experience, thus helping to deliver a more consistent digital journey.

The DJP uses a step-by-step approach, focused on three criteria: baseline / learn / improve, which can be fully supported by the team in the Redmoor support centre. The DJP has been developed with NHSE/I Digital first primary care team to help general practice with digital transformation.

Several pilot sites have already worked through the first available modules, with the support offer open to all practices within Northamptonshire.

Supporting the county Afghan project

In September 2021 the Home Office ran a number of different schemes offering Afghan refugees asylum in the UK. One particular scheme was the Afghan Relocations and Assistance Policy (ARAP) which offered Afghan nationals with ties to the Ministry of Defence (in this instance, workers who have provided translation services for the forces) leave to stay in the UK.

During September the Home Office branched out to hotels across the country to provide short-term accommodation to these Afghan people until permanent accommodation was found. Two hotels were identified in Northamptonshire.

Northamptonshire CCG and other health care partners were quick to respond to the request to facilitate these families and, at very short notice, wrap-around care solutions were put in place including Primary Medical, Maternity and Mental Health Services.

The Home Office completed an audit of these hotels and the health care provision provided was considered a platinum service.

All the Health staff involved in this project has stated that overall the experience has been incredibly positive and all report a huge sense of satisfaction on carrying out their roles.

Workforce

Our most recent data shows continuation of a positive trajectory for the trend in Northamptonshire's workforce numbers. This trajectory indicates a 4.6% increase in permanent GPs between 2019 and 2022. It also includes a 10% increase in GP Registrars indicating a positive outlook for future GPs.

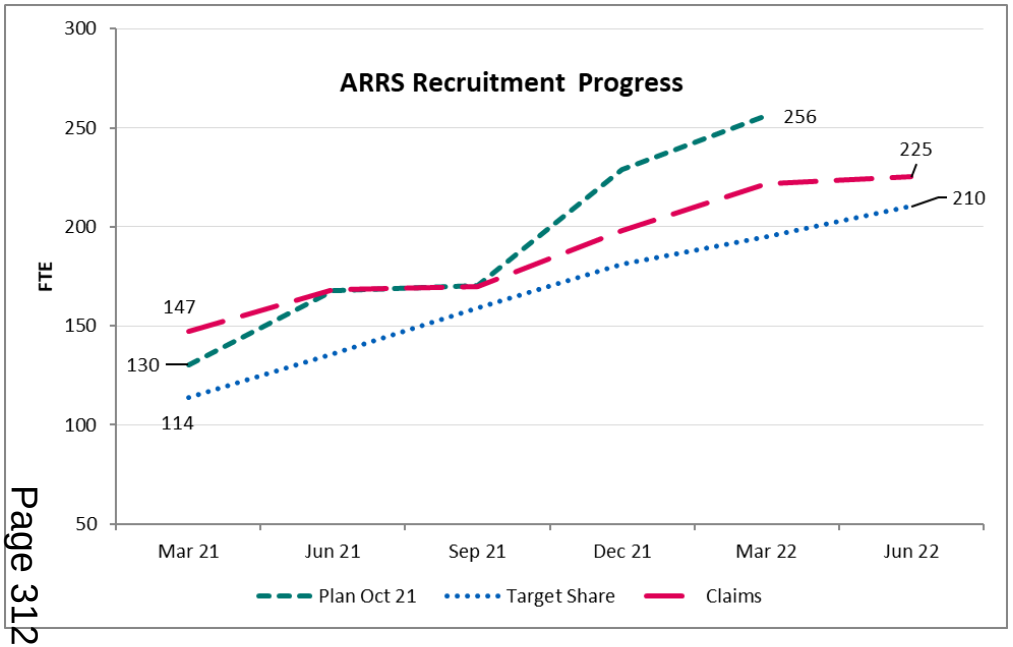
Direct patient care staff in primary care have increased by 19% since 2019. However, when combined with the direct patient staff employed by Primary Care Networks via the Additional Roles Reimbursement Scheme (ARRS) the increase rises to 158.25%. ARRS recruitment in Northamptonshire is tracking above the local share of the government's 26,000 full-time equivalents (FTE) by 2024.

Remote Monitoring in Care Homes

Several care homes and PCNs across Northamptonshire are trying digital tools to improve out of hospital care.

It's too soon to analyse the benefits for this report, but it is hoped data will be available for the next report

The plan was to recruit a greater number but several factors have had an impact on this, the number 1 being available space in primary care settings.



Going concern assessment

NHS Northamptonshire CCG was dissolved on 30 June 2022 and its closing assets and liabilities transferred to NHS Northamptonshire ICB on 1 July 2022. This followed the signing of the ICB establishment order on 27 June 2022 by the NHS England Chief Executive.

Northamptonshire Integrated Care Board (ICB) will integrate care between Health partners and the Local Authorities. All current CCG services have transferred in totality to the successor ICB including all assets and liabilities and therefore the going concern basis of preparation of the CCG financial statements at the end of June 2022 will remain appropriate.

When considering whether Northamptonshire CCG is a going concern for at least 12 months after the accounting period and that its accounts should be prepared on that basis Northamptonshire CCG needs to document its consideration of any material uncertainties that may cast doubt on the body's ability to continue as a business.

The CCG undertakes a review of its status in advance of producing the Annual Report and Statement of Accounts and has procedures in place to make that assessment including the following:

- The Financial Strategy considers the financial position of the authority over the short and medium term and is designed to ensure that the CCG continues as a going concern.
- Internal Audit's work plan provides an on-going review of key elements of the financial controls and delivery of CCG priorities to ensure its delivery or to highlight at an early stage any unforeseen risks.
- Sound financial management and reporting including budget monitoring carried out by the finance department and assured through the Finance Committee so that financial control is carried out to ensure the continuation of the CCG's business.

- As part of the financial resilience and transition process the Readiness to Operate Statement (ROS) (due diligence undertaken by CCG and NHSE) assurance is provided on the functions of the CCG continuing in the ICB.
- The CCG has remained in a financially stable position and is going to deliver a breakeven position at the end of Quarter 1.
- The CCG submitted a balanced financial plan to NHSE for 2022/23.

The CCG is not aware of the existence of any other events or conditions that may cast doubt on the CCG's ability to continue as a going concern.

The Statement of Financial Position has therefore been drawn up at 30 June 2022 on a going concern basis.

Performance analysis

NHS Northamptonshire CCG measures its performance against national NHS standards. These are a series of measures which are used to assess the performance of each health service. We, and our providers, have struggled to meet many required standards in Quarter 1 as COVID-19 has had a significant impact on both physical capacity for and volume of appointments.

This is due to COVID-19 protection measures, social distancing and sanitising equipment between patients leading to challenges, even where standards were being consistently or periodically achieved prior to the pandemic. Examples of the NHS standards are below.

All performance issues are escalated to the CCG Quality Committee and the Governing Body, which considers performance at every meeting. More detail about performance is included in the section on the following pages. Data for 2020/21 (the first year of establishment for the CCG) and 2021/22 has been included for comparison.

Urgent care - patients waiting four hours or less in ED

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
ED waits	Patients to be admitted, transferred, or discharged within four hours of arrival at ED	**95%**	**NGH**	**64.28%**				**64.28%**
			KGH *	Not monitored formally during urgent and emergency care (UEC) Clinical Review of Standards field-testing exercise				N/A

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED waits	Patients to be admitted, transferred, or discharged within four hours of arrival at ED	**95%**	**NGH**	**86.70%**	**74.65%**	**69.78%**	**66.42%**	**75.30%**
			KGH *	Not monitored formally during urgent and emergency care (UEC) Clinical Review of Standards field-testing exercise				N/A

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED Waits	Patients to be admitted, transferred, or discharged within four hours of arrival at ED	**95%**	**NGH**	**90.18%**	**86.50%**	**72.44%**	**74.59%**	**80.46%**
			KGH *	Not monitored formally during UEC Clinical Review of Standards field-testing exercise				N/A

Delivering the Emergency Department (ED) four-hour standard is a national challenge. The ongoing impact of the COVID-19 pandemic is only one of the many reasons the standard has not been achieved. A continuing high demand for emergency care services for patients with complex care needs has challenged the hospitals' capacity, and continuing bed closures both in and outside of the Acute Trusts has affected flow.

These combined pressures have led to ambulances having to wait far longer than the target time to unload patients into ED, and to patients waiting more than 12 hours in ED for a bed to be available: this has not happened in significant volumes, since before this measure was regularly recorded.

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
ED Waits	Waits from decision to admit (DTA) to admission (trolley waits) over 12 hours	**0**	**NGH**	**1415**				**1415**
			KGH	N/A				

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED Waits	Waits from decision to admit (DTA) to admission (trolley waits) over 12 hours	**0**	**NGH**	**0**	**0**	**207**	**1076**	**1283**
			KGH	N/A	N/A	N/A	N/A	N/A

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
ED Waits	Waits from decision to admit (DTA) to admission (trolley waits) over 12 hours	**0**	**NGH**	**0**	**0**	**1**	**2**	**3**
			KGH	N/A	N/A	N/A	N/A	N/A

Ambulance handover

All handovers between ambulance and ED must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Please note data for this measure is from East Midlands Ambulance Service (EMAS), and can differ from the Acute Trusts' ED data.

2022/23 – Quarter 1							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**				**Year**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over 30 minutes)	0	NGH	2690				2690
		KGH	1531				1531
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over one hour)	0	NGH	877				877
		KGH	96				96

2021/22							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over 30 minutes)	0	NGH	693	1677	2299	2505	7174
		KGH	1064	1562	1790	1548	5964
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over one hour)	0	NGH	33	218	478	870	1599
		KGH	56	89	165	102	412

2020/21							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over 30 minutes)	**0**	**NGH**	**544**	**518**	**1150**	**1510**	**3722**
		KGH	**1091**	**1159**	**1321**	**971**	**4542**
Handovers between ambulance and ED within 15 minutes, and crew ready for new call within 15 minutes (delays of over one hour)	**0**	**NGH**	**33**	**41**	**235**	**356**	**665**
		KGH	**53**	**62**	**108**	**80**	**303**

The key driver of delays in ambulance handover is usually that emergency departments are beyond capacity. The actions we are currently taking, detailed in the Urgent Care section of this report, are helping to resolve ambulance handover issues, and the CCG continues to work closely with EMAS to improve processes. Although not seen here for Quarter 1, there have been significant reductions in these delays in July.

Cancer waiting times

Before the COVID-19 pandemic and its knock-on effect on both demand and capacity, KGH was meeting and maintaining the required performance against all cancer standards. This continued in most months throughout the first half of 2021/22, with the exception of the 62-day standards. Subsequently, achievement of the standards has become much more variable, with wide swings from month to month. The length of waiting lists is a cause for concern, and is being tackled within the Cancer Working Group, in discussion with providers, some of whom are out of county. In most cases, in the shorter standards (2WW and 31 days) even where the target is not met, it is close, with performance in the high 80s and 90s

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Cancer waits **Two-week wait**	Maximum two-week wait for first outpatient appointment for suspected cancer	**93%**	Northamptonshire CCG	**92.01%**				**94.01%**
			NGH	**93.66%**				**93.66%**
			KGH	**92.76%**				**92.76%**
	Maximum two-week wait for first outpatient appointment referred urgently with breast symptoms	**93%**	**Northamptonshire CCG**	**88.59%**				**88.59%**
			NGH	**91.79%**				**91.79%**
			KGH	**92.11%**				**92.11%**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits **Two-week wait**	Maximum two-week wait for first outpatient appointment for suspected cancer	**93%**	**Northamptonshire CCG**	**93.41%**	**93.32%**	**89.68%**	**89.73%**	**91.51%**
			NGH	**95.98%**	**94.41%**	**93.02%**	**91.80%**	**93.76%**
			KGH	**93.04%**	**93.27%**	**86.40%**	**89.53%**	**90.55%**
	Maximum two-week wait for first outpatient appointment referred urgently with breast symptoms	**93%**	**Northamptonshire CCG**	**82.98%**	**91.26%**	**79.15%**	**82.59%**	**83.86%**
			NGH	**79.18%**	**90.94%**	**76.97%**	**85.06%**	**82.51%**
			KGH	**97.57%**	**96.71%**	**89.05%**	**89.89%**	**93.56%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer Waits 2-week wait	Maximum two-week wait for first outpatient appointment for suspected cancer	**93%**	**Northamptonshire CCG**	**85.91%**	**85.20%**	**95.09%**	**94.97%**	**90.94%**
			NGH	**77.06%**	**78.11%**	**96.05%**	**95.86%**	**87.99%**
			KGH	**96.08%**	**96.03%**	**96.60%**	**96.07%**	**96.22%**
	Maximum two-week wait for first outpatient appointment referred urgently with breast symptoms	**93%**	**Northamptonshire CCG**	**78.42%**	**74.58%**	**91.77%**	**91.74%**	**86.19%**
			NGH	**62.40%**	**58.82%**	**92.28%**	**94.06%**	**82.01%**
			KGH	**98.10%**	**98.72%**	**97.15%**	**98.00%**	**97.88%**

In contrast, NGH was already struggling with maintaining its performance consistently against these standards: although 2021/22 showed an improvement over 2020/21 in almost all categories which is continuing into 2022/23. However the only standard achieved every month was 31-day wait for radiotherapy treatment. Recovery has been seen in many areas, but volumes of referrals are high, and the Trust does not always have sufficient capacity to treat them within the required time frame.

Please note that the 2WW and 31 day categories are in the process of being replaced by 28 Day Faster Diagnosis Standard (FDS) – and in this category both NGH and KGH are exceeding the target and are achieving among the highest rates in the region. Future versions of this report will include FDS.

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Cancer waits **31 days**	Maximum one-month wait from diagnosis to first definitive treatment for all cancers	**96%**	**Northamptonshire CCG**	**91.43%**				**91.43%**
			NGH	**91.41%**				**91.41%**
			KGH	**96.52%**				**96.52%**
	Maximum one-month wait for subsequent surgical treatment	**94%**	**Northamptonshire CCG**	**73.45%**				**73.45%**
			NGH	**88.46%**				**88.46%**
			KGH	**76.74%**				**76.74%**
	Maximum one-month wait for subsequent anti-cancer drug treatment	**98%**	**Northamptonshire CCG**	**98.33%**				**98.32%**
			NGH	**99.58%**				**99.58%**
			KGH	**96.70%**				**96.70%**
	Maximum one-month wait for subsequent radiotherapy treatment	**94%**	**Northamptonshire CCG**	**96.92%**				**96.92%**
			NGH	**97.45%**				**97.45%**
			KGH	No patients	No patients	No patients	No patients	No patients

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits **31 days**	Maximum one-month wait from diagnosis to first definitive treatment for all cancers	**96%**	**Northamptonshire CCG**	**94.47%**	**95.06%**	**94.89%**	**93.80%**	**94.79%**
			NGH	**95.44%**	**95.25%**	**95.73%**	**93.36%**	**94.93%**
			KGH	**97.61%**	**98.57%**	**97.65%**	**97.97%**	**97.95%**
	Maximum one-month wait for subsequent surgical treatment	**94%**	**Northamptonshire CCG**	**81.69%**	**79.10%**	**76.19%**	**80.21%**	**79.61%**
			NGH	**91.84%**	**90.91%**	**77.27%**	**92.00%**	**89.29%**
			KGH	**100%**	**91.67%**	**100%**	**90.32%**	**95.00%**
	Maximum one-month wait for subsequent anti-cancer drug treatment	**98%**	**Northamptonshire CCG**	**98.68%**	**98.77%**	**97.18%**	**99.67%**	**98.56%**
			NGH	**98.17%**	**98.28%**	**96.57%**	**100%**	**98.24%**
			KGH	**100%**	**100%**	**100%**	**100%**	**100%**
	Maximum one-month wait for subsequent radiotherapy treatment	**94%**	**Northamptonshire CCG**	**95.44%**	**96.93%**	**95.27%**	**94.68%**	**95.58%**
			NGH	**95.05%**	**95.44%**	**96.90%**	**95.88%**	**95.81%**
			KGH	No patients	No patients	No patients	No patients	No patients

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer Waits 31 days	Maximum one-month wait from diagnosis to first definitive treatment for all cancers	**96%**	**Northamptonshire CCG**	**94.37%**	**94.99%**	**95.34%**	**94.36%**	**94.79%**
			NGH	**93.47%**	**94.51%**	**96.03%**	**93.58%**	**94.49%**
			KGH	**97.49%**	**97.31%**	**97.35%**	**98.84%**	**97.77%**
	Maximum one-month wait for subsequent surgical treatment	**94%**	**Northamptonshire CCG**	**80.61%**	**81.90%**	**66.29%**	**78.76%**	**77.40%**
			NGH	**82.14%**	**76.92%**	**72.73%**	**90.24%**	**81.54%**
			KGH	**85.19%**	**83.33%**	**93.33%**	**100%**	**90.53%**
	Maximum one-month wait for subsequent anti-cancer drug treatment	**98%**	**Northamptonshire CCG**	**97.64%**	**98.38%**	**98.87%**	**98.08%**	**98.28%**
			NGH	**96.30%**	**97.88%**	**98.48%**	**97.80%**	**97.67%**
			KGH	**100%**	**100%**	**100%**	**100%**	**100%**
	Maximum one-month wait for subsequent radiotherapy treatment	**94%**	**Northamptonshire CCG**	**94.27%**	**96.02%**	**96.32%**	**96.10%**	**95.72%**
			NGH	**94.65%**	**95.08%**	**95.59%**	**95.45%**	**95.21%**
			KGH	No patients	No patients	No patients	No patients	No patients

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Cancer waits 62 days	Maximum two-month wait from urgent GP referral to first definitive treatment	**85%**	**Northamptonshire CCG**	**63.04%**				**63.04%**
			NGH	**64.69%**				**64.69%**
			KGH	**63.10%**				**63.10%**
	Maximum two-month wait from referral from an NHS screening service to first definitive treatment	**90%**	**Northamptonshire CCG**	**66.25%**				**66.25%**
			NGH	**82.89%**				**82.89%**
			KGH	**51.14%**				**51.14%**
	Maximum two-month wait for first definitive treatment following a consultant's decision to upgrade	**No std**	**Northamptonshire CCG**	**69.49%**				**69.49%**
			NGH	**73.62%**				**73.62%**
			KGH	**71.84%**				**71.84%**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer waits 62 days	Maximum two-month wait from urgent GP referral to first definitive treatment	**85%**	**Northamptonshire CCG**	**78.38%**	**74.86%**	**68.82%**	**67.54%**	**72.36%**
			NGH	**77.50%**	**72.73%**	**69.13%**	**67.54%**	**71.54%**
			KGH	**82.06%**	**81.49%**	**70.98%**	**67.58%**	**75.62%**
	Maximum two-month wait from referral from an NHS screening service to first definitive treatment	**90%**	**Northamptonshire CCG**	**91.36%**	**83.82%**	**75.64%**	**66.67%**	**79.34%**
			NGH	**93.44%**	**88.00%**	**88.89%**	**90.12%**	**90.15%**
			KGH	**87.39%**	**76.92%**	**63.16%**	**41.33%**	**69.61%**
	Maximum two-month wait for first definitive treatment following a consultant's decision to upgrade	**No std**	**Northamptonshire CCG**	**78.75%**	**83.24%**	**79.02%**	**70.22%**	**77.73%**
			NGH	**79.40%**	**80.69%**	**83.51%**	**76.42%**	**79.87%**
			KGH	**83.58%**	**88.89%**	**68.25%**	**79.31%**	**81.23%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Cancer Waits 62 days	Maximum two-month wait from urgent GP referral to first definitive treatment	**85%**	**Northamptonshire CCG**	**68.99%**	**70.77%**	**78.49%**	**71.91%**	**72.90%**
			NGH	**63.86%**	**62.61%**	**77.40%**	**74.15%**	**70.43%**
			KGH	**75.00%**	**80.33%**	**80.41%**	**69.03%**	**76.11%**
	Maximum two-month wait from referral from an NHS screening service to first definitive treatment	**90%**	**Northamptonshire CCG**	**83.33%**	**77.78%**	**80.49%**	**92.96%**	**86.25%**
			NGH	**88.24%**	**69.23%**	**91.89%**	**93.62%**	**89.31%**
			KGH	**74.19%**	**72.97%**	**72.46%**	**93.07%**	**81.51%**
	Maximum two-month wait for first definitive treatment following a consultant's decision to upgrade	**No std**	**Northamptonshire CCG**	**78.99%**	**88.68%**	**83.78%**	**78.36%**	**82.73%**
			NGH	**80.69%**	**84.26%**	**83.51%**	**80.88%**	**82.35%**
			KGH	**78.85%**	**97.44%**	**97.47%**	**72.22%**	**88.59%**

There has still been no consistency in achievement of these 62 day standards, on either site or across the CCG. In sporadic months they have been achieved at one Trust or the other, but these have not been maintained. Referral levels are significantly above the same period in 2019/20, and show no sign of abating.

Planned care: referral to treatment (RTT)

This standard requires that at least 92% of patients waiting for consultant-led treatment have been waiting less than 18 weeks. The recovery from the COVID-19 related low point in May 2020 was gradual but consistent for around 18 months, and levels have remained stable for the subsequent 6 months, although still some way off pre-Covid performance for both Trusts.

While the formal standard of 18 week wait % has remained relatively constant, the long waits (52ww and above) have been steadily decreasing. The small recent rises have been related to both NGH and KGH offering mutual aid to UHL for their 104ww patients. The plan for 2022/23 shows these long wait patients decreasing significantly.

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		Std	Organisation	Q1				Year
Referral to Treatment 18-week wait	Patients on incomplete non-emergency pathways for less than 18 weeks (yet to start treatment)	92%	Northamptonshire CCG	69.46%				69.46%
			NGH	75.12%				75.12%
			KGH	68.92%				68.92%

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment 18-week wait	Patients on incomplete non-emergency pathways for less than 18 weeks (yet to start treatment)	**92%**	**Northamptonshire CCG**	**75.26%**	**77.03%**	**75.90%**	**68.98%**	**74.14%**
			NGH	**78.80%**	**82.16%**	**81.02%**	**76.55%**	**79.56%**
			KGH	**76.69%**	**77.48%**	**74.85%**	**69.84%**	**74.57%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment 18-week wait	Patients on incomplete non-emergency pathways for less than 18 weeks (yet to start treatment)	**92%**	**Northamptonshire CCG**	**66.27%**	**57.66%**	**72.56%**	**71.88%**	**67.21%**
			NGH	**65.86%**	**59.04%**	**73.71%**	**75.59%**	**68.46%**
			KGH	**64.40%**	**51.89%**	**73.69%**	**73.32%**	**65.72%**

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Referral to Treatment **52-week wait**	No patient should wait over 52 weeks from Referral to Treatment (incomplete pathways)	**0**	**Northamptonshire CCG**	**868**				**868**
			NGH	**127**				**127**
			KGH	**73**				**73**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment **52-week wait**	No patient should wait over 52 weeks from Referral to Treatment (incomplete pathways)	**0**	**Northamptonshire CCG**	**1354**	**1100**	**1130**	**773**	**773**
			NGH	**218**	**79**	**44**	**84**	**84**
			KGH	**0**	**5**	**8**	**22**	**22**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Referral to Treatment **52-week wait**	No patient should wait over 52 weeks from Referral to Treatment (incomplete pathways)	**0**	**Northamptonshire CCG**	**257**	**768**	**1101**	**2158**	**2158**
			NGH	**210**	**591**	**553**	**723**	**723**
			KGH	**0**	**0**	**0**	**85**	**85**

Diagnostics

This standard requires that no more than 1% of patients wait over six weeks for a diagnostic test. While NGH has not met this standard since March 2019, the issue in 2019/20 was internal, relating to an estates issue in a single department. Despite this the percentage achievement did not fall below 93.5%. In 2020/21, COVID-19 related capacity shortfall led to performance dropping below 50% for several months, and then showing gradual improvement, but recovery has still not reached pre-Covid levels.

At KGH, the standard was being fully achieved before the COVID-19 pandemic and recovery has been proportionally faster, but only until Quarter 1 of 2021/22. Subsequent capacity issues, mainly within CT and Echocardiography have led to a further decline in this performance through 2021/22 and into Quarter 1 of 2022/23, while possibilities to offer further capacity are being investigated.

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Diagnostic test waiting times	Patients waiting less than six weeks for a diagnostic test	**99%**	**Northamptonshire CCG**	**75.20%**				**75.20%**
			NGH	**85.41%**				**85.41%**
			KGH	**66.93%**				**66.93%**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Diagnostic test waiting times	Patients waiting less than six weeks for a diagnostic test	**99%**	**Northamptonshire CCG**	**88.46%**	**86.58%**	**81.54%**	**79.00%**	**83.57%**
			NGH	**82.04%**	**82.91%**	**83.64%**	**86.46%**	**83.79%**
			KGH	**99.01%**	**91.35%**	**79.74%**	**72.30%**	**83.71%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Diagnostic Test Waiting Times	Patients waiting less than six weeks for a diagnostic test	**99%**	**Northamptonshire CCG**	**51.83%**	**69.04%**	**79.66%**	**83.46%**	**71.62%**
			NGH	**44.66%**	**59.51%**	**74.91%**	**77.65%**	**64.69%**
			KGH	**57.65%**	**81.99%**	**86.88%**	**95.13%**	**81.51%**

The Northamptonshire healthcare system is in the process of designing the implementation of community diagnostic centres (CDC) which will allow one stop diagnostic facilities for patients closer to home within the community.

This will also facilitate shorter wait times for patients and a reduced footfall onto acute hospital sites, allowing for focused provision of diagnostics for urgent care and elective inpatients within hospital. A phased approach to delivery is currently being worked up by the system with the proposal for initial locations currently being ratified.

Mental health: care programme approach

No figures are available for 2021/22 or 2020/21 as data-collection has been suspended due to the COVID-19 pandemic.

Dementia diagnosis

Achievement has been close to, although failing to achieve, the 66.7% target throughout the last three years. Northamptonshire is, however, above the regional average. Timely access to brain scans is a concern, and the aftercare pathway is currently under review

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Dementia	Diagnosis prevalence rate, ages 65+	**66.7%**	**Northamptonshire CCG**	**62.79%**				**62.79%**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Dementia	Diagnosis prevalence rate, ages 65+	**66.7%**	**Northamptonshire CCG**	**62.29%**	**63.12%**	**63.25%**	**62.96%**	**62.91%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Dementia	Diagnosis prevalence rate, ages 65+	**66.7%**	**Northamptonshire CCG**	**65.52%**	**63.51%**	**62.83%**	**61.67%**	**63.39%**

Improved access to psychological therapies (IAPT)

There are two performance standards for IAPT; one relates to ensuring appropriate access and the other to recovery rates following IAPT. Recovery and completed treatment rates are being consistently achieved. However the access standards have not been consistently met since the increase in the standard in 2019/20, however it has now risen to above pre-Covid levels. The main issue is generating sufficient referrals.

2022/23 – Quarter 1								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**				**Year**
Improved Access to Psychological Therapies (IAPT)	IAPT access (monthly)	**2.08% mth**	**Northamptonshire CCG**	**5.13%**				**1.89%**
	IAPT access proportion (rolling)	**25% FY**		**19.27%**				**19.29%**
	IAPT recovery rate	**50%**		**50.13%**				**50.43%**
	% completed treatment six weeks	**75% by year end**		**94.39%**				**94.12%**
	% completed treatment 18 weeks	**95% by year end**		**99.51%**				**99.16%**

2021/22								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Improved Access to Psychological Therapies (IAPT)	IAPT access (monthly)	**2.08% mth**	**Northamptonshire CCG**	**4.65%**	**4.35%**	**4.56%**	**5.22%**	**18.78%**
	IAPT access proportion (rolling)	**25% FY**		**17.67%**	**17.88%**	**18.42%**	**18.78%**	**18.78%**
	IAPT recovery rate	**50%**		**57.28%**	**52.81%**	**50.65%**	**50.75%**	**52.81%**
	% completed treatment six weeks	**75% by year end**		**99.03%**	**99.39%**	**98.86%**	**95.97%**	**97.77%**
	% completed treatment 18 weeks	**95% by year end**		**99.68%**	**100%**	**99.06%**	**100%**	**99.69%**

2020/21								
NHS Constitution measures – quarterly		**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Improved Access to Psychological Therapies (IAPT)	IAPT Access (monthly)	**1.83% mth**	**Northamptonshire CCG**	**2.86%**	**4.14%**	**4.03%**	**4.85%**	**15.89%**
	IAPT access proportion (rolling)	**22% FY**		**15.95%**	**15.80%**	**15.36%**	**15.89%**	**15.89%**
	IAPT recovery rate	**50%**		**53.24%**	**52.67%**	**54.58%**	**55.52%**	**53.95%**
	% completed treatment 6 weeks	**75% by year end**		**99.18%**	**98.37%**	**98.96%**	**98.66%**	**98.81%**
	% completed treatment 18 weeks	**95% by year end**		**100%**	**100%**	**100%**	**99.33%**	**99.84%**

Performance against other NHS measures

NHS services are also required to meet the following standards from the NHS Constitution:

The mixed sex accommodation standard is being impacted by the overall capacity issues since beds are at a premium.

2022/23 – Quarter 1							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**				**Year**
No mixed-sex accommodation breaches	0	Northamptonshire CCG	72				72
		NGH	64				64
		KGH	1				1
		NHFT	0				0

2021/22							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
No mixed-sex accommodation breaches	0	Northamptonshire CCG	National reporting recommenced only October 2021		13	103	116
		NGH	4	7	8	92	111
		KGH	Reporting suspended during pandemic		0	0	0
		NHFT	0	0	0	0	0

2020/21							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
No mixed-sex accommodation breaches	**0**	**Northamptonshire CCG**	**Reporting suspended during the pandemic**				**N/A**
		NGH	**0**	**4**	**2**	**1**	**7**
		KGH	**Reporting suspended during pandemic**				**N/A**
		NHFT	**0**	**0**	**0**	**0**	**0**

2022/23 – Quarter 1							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**				**Year**
No urgent operation to be cancelled for a second time	**0**	**NGH**	**0**				**0**
		KGH	**0**				**0**

2021/22							
NHS Constitution measures – quarterly	Std	Organisation	Q1	Q2	Q3	Q4 (to date)	Year
No urgent operation to be cancelled for a second time	0	NGH	0	0	0	0	0
		KGH	0	0	0	0	0

2020/21							
NHS Constitution measures – quarterly	Std	Organisation	Q1	Q2	Q3	Q4	Year
No urgent operation to be cancelled for a second time	0	NGH	0	0	0	0	0
		KGH	0	0	0	0	0

2022/23 – Quarter 1							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**				**Year**
Operations cancelled on or after the day of admission to be offered another binding date within 28 days	**0**	**NGH**	**0**				**0**
		KGH	**2**				**2**

2021/22							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4 (to date)**	**Year**
Operations cancelled on or after the day of admission to be offered another binding date within 28 days	**0**	**NGH**	**3**	**0**	**0**	**0**	**3**
		KGH	**0**	**1**	**1**	**1**	**3**

2020/21							
NHS Constitution measures – quarterly	**Std**	**Organisation**	**Q1**	**Q2**	**Q3**	**Q4**	**Year**
Operations cancelled on or after the day of admission to be offered another binding date within 28 days	**0**	**NGH**	**0**	**1**	**13**	**9**	**23**
		KGH	**0**	**1**	**0**	**0**	**1**

Environmental matters

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long-term, even in the context of a rising cost of natural resources.

We are committed to providing high quality sustainable healthcare in Northamptonshire and embedding sustainability into operations as well as encouraging key partners and stakeholders to do the same. The CCG is committed to embedding sustainability into staff behaviour and other partners in shared premises, concentrating on the reduction of paper, increased recycling, car sharing and use of local public transport where possible. The diagram below outlines some of the schemes in place within our buildings or currently being investigated.

The CCG is committed to embedding sustainability into staff behaviour and other partners in shared premises, concentrating on the reduction of paper, increased recycling, car sharing and use of local public transport where possible. We continue to work with NHS Property Services and CCG staff to reduce power and water consumption, and we are working with our landlords to ensure sustainable practices are adopted such as recycling and good use of energy in our CCG headquarters. As a priority for 2022 we explored the possibility of increasing the range of recycling available in our buildings.

The implementation of the Agile Working Policy has also provided the opportunity for staff to combine working from home with working in the office, and therefore reduce our impact from commuting, and power and water consumption.

Social value

Social value commitments are evaluated as required by Planning Policy Note (PPN) 06/20 (Social value in effect from 1st January 2021). PPN 06/20 sets out how to take account of social value in the award of contracts by using the Social Value Model. Policy themes are:

- Covid-19 recovery;
- Tackling economic inequality;
- Fighting climate change;
- Equal opportunity; and
- Wellbeing.

Business continuity

All business continuity plans and policies were reviewed to ensure they are fit for purpose when the CCG transitioned to the Integrated Care Board (ICB) on 1 July 2022. The CCG had no business continuity issues from 1st April 2022 to 30th June 2022.

Social value is considered as early as possible in a procurement, ideally when the requirement is still in the pre-procurement stage. As a first step, we suggest consulting with key stakeholders, supply market, and customer base, to reach a common understanding of what social value might look like within the service being contracted. This is done through a Market Engagement Questionnaire (MEQ) where the CCG can set out the questions (in relation to the policy themes listed above) it believes would be applicable for the procurement and seek market feedback. Based on the feedback, social value requirements are included in the standard suite of procurement documents.

Northamptonshire Green Plan 2022

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system. The net zero target for the NHS carbon footprint in England is by 2040, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028-2032, and in 2022, the Northamptonshire Green Plan was published.

Our ambition is to have a true system partner approach to all aspects of our response; our actions to respond to the climate change extreme events locally, and our actions to lower our carbon footprint and encourage and support healthier lifestyles in our communities.

Improving quality

In the last year the CCG quality team has developed quality governance processes to ensure successful transition into an Integrated Care Board (ICB). This has included the development of a Place Quality Group, System Quality Group, and Quality Committee in line with National Guidance.

Moving forward all partners will take responsibility for improving the quality of care and the development of a system quality risk register to ensure oversight and agreement by the system of any risks to quality and the actions taken to mitigate these.

Prior to becoming an ICB in July 2022, the Quality Surveillance and Assurance Group played a vital role in ensuring quality remained at the heart of CCG decision-making. The committee reporting directly to the governing body promoted collaborative working to improve the quality and safety service delivery.

Many of the new ways of working developed by the team during Covid have become business as usual. Review and analysis of national and locally available data on provider performance has ensured that we continue to meet our three overarching strategic quality priorities:

- Patient safety is monitored across the county to ensure the risk of adverse outcomes for patients are minimised and, when they occur, lessons are learnt, shared, and embedded
- Patient experience of NHS care across the county is monitored to ensure lessons are learnt, shared, and embedded
- We secure continuous improvement in the quality of services provided and in the outcomes that are achieved.

Further to this and to promote quality development and initiatives throughout the system the quality team have been delivering Quality Service Improvement and Redesign Training (QSIR). We have delivered training:

- Falls prevention
- Infection protection control
- Identification of the deteriorating patient

Serious incidents

Serious incidents in health care are defined as “adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.” [1]

Serious incidents continue to be reported, under the NHSE Serious Incident Framework, 2015. During the COVID-19 pandemic, NHSE suspended the 60-day deadline for the completion of Serious Incidents. Locally it was agreed to implement a 90-day timescale which was monitored by the CCG quality team, (now ICB).

As the 60-day timescale will not be reinstated the quality team are working collaboratively with system partners to ensure that there is an agreement on timescales going forward whilst awaiting the publication of the Patient Safety Incident Response Framework (PSIRF). This is expected to be published in August 2022 and will require a change in oversight structures and ways of working that will come into place over the year following publication.

Whilst visits to providers were challenged through 2021/22 due to COVID-19 a system to gain assurance regarding the implementation of actions from all Never Events was established and assurance gained. 60 of the reported incidents had a direct link to COVID-19. The most common cause of incident aside from healthcare associated infection was diagnostic delay, review of these incidents showed no common thematic learning.

Healthcare Safety Investigation Branch (HSIB) take responsibility for investigations that meet the ‘Each Baby Counts criteria’ or their defined criteria for maternal deaths and led investigations into maternity Serious Incidents during 2021/22. The quality team have worked collaboratively with Local Maternity Neonatal Service colleagues to develop a peer review process for maternity incidents and a quarterly system wide Maternity Serious Incident Assurance Meeting has been established.

58

serious incidents

1

serious incidents downgraded as did not meet criteria

0

serious incidents were recorded as never events

[1] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf, p.7&8

Safeguarding

During this reporting period the country continued to be impacted by COVID-19 and in turn the pandemic has affected people, in particular children and adults with care and support needs on their health and well-being as well as the ongoing impact on public sector services. This has been a challenge to all key stakeholders and remains so as we learn to live with the virus which remains active within society. The safeguarding team has worked with its respective statutory partners and key commissioned providers to support the children's and adults' partnership/board work. This has included audit work, sub-group activity and training.

There have been several legislative safeguarding reviews across both adults and children which the team supported. Learning from the reviews is followed up by the Northamptonshire Safeguarding Children's Partnership (NSCP), Northamptonshire Safeguarding Adults Board (NSAB) and the community safety partnerships and agencies respond to multi-agency and individual agency action plans.

An internal audit of the safeguarding function of the CCG was completed. The audit found that there were robust safeguarding processes in place with ensured that the team were working towards embedding a sound safeguarding assurance function within the new Integrated Care Board (ICB) for readiness in July 2022.

The safeguarding team worked with partners of the NSAB to strengthen the adult risk management (ARM) process and raise awareness across the health economy. This ensured that there was a multi-agency risk management plan for adults at risk who have capacity.

The Liberty Protection Safeguards (LPS) are a legal framework which is anticipated to be introduced in Spring 2024. The LPS applies to people aged 16 and over and will have a significant impact on the ICB and across both health and social care. The safeguarding team are and will continue to work with partners across health and social care for the introduction of the LPS to ensure that the appropriate processes are in place.

Supporting care homes

The quality team restarted physical visits to care homes in March 2021 following the second Covid lockdown. Care homes continue to have outbreaks of Covid and the quality team support providers with advice to include donning and doffing and personal protective equipment.

Each provider receives an annual quality review visit complete with a report and recommendations where required. Providers complete self-assessment forms prior to each annual announced review. The visits offer support, ideas, information and ensure quality outcomes are sustained. Unannounced visits took place where concerns warranted them.

The Northamptonshire Institutional Risk Assessment Tool (NIRIT) initiative developed during lockdown continues now as business as usual. This tool is completed monthly by providers and produces an overview and indication of risk levels within each care home. Following Covid the quality team have identified an increase to agency hours within the independent sector; to further support to providers, we have increased our supplementary visits.

The Quality Improvement Nurses have undertaken Frailty training which going forward will support care homes to implement Frailty Scores; joining up the system to support the care of this vulnerable cohort of people.

The team work very closely with all stakeholders to include Care Quality Commission, West Northants Council and North Northants Councils quality and safeguarding teams to ensure shared learning, communication and partnership working. Information sharing meetings chaired monthly by the quality team make sure joint risks are identified reviews and shared.

We follow the same processes for our care at home providers (domiciliary care) and where appropriate, telephone reviews and virtual monitoring has been utilised. Further to that the quality team has delivered training on:

- Deteriorating patient
- Observation and falls

Complaints

The CCG is responsible for investigating all complaints or concerns raised in relation to services that we commission. Our complaints procedure is consistent with the Parliamentary Health Service Ombudsman's guidance.

The CCG welcomes complaints as a valuable means of receiving feedback, and we aim to use information gathered from complaints as a means of improving services and the effectiveness of our organisation, and the organisations we commission.

Themes from complaints received this year included Continuing Healthcare (CHC) and Individual Funding Request (IFR). A full complaints report should be submitted later this year once all cases have been processed for the period. This will offer an overview to include outcomes and learning.

Summary of the total 115 cases received

Complaints – 7	Enquiries – 92
Covid related enquiries – 8	MP complaints/concerns – 0
Ombudsman – 0	Non-statutory – 0
	Logged only – 4

Handling enquiries

There were a total of 115 enquiries and complaints received during the 3 months analysed. This is an average of 38 per month.

Most of these queries were time sensitive, as it was important to provide accurate information in response to these queries as quickly as possible.

An analysis of the 115 enquiries and complaints showed that:

- 7 complaints and enquiries were acknowledged within three working days

This means that 100% of enquiries were acknowledged within three working days and signposted to the appropriate service/provider/individual to provide a response, or the CCG responded directly to the enquiry where they could.

Engaging people and communities

The CCG has a legal duty under The Health and Social Care Act 2012 to ensure that individuals to whom our services are provided, or may be provided, are involved in the planning, development and operation of commissioning arrangements.

In preparation for the launch of our ICB in July 2022 and in line with proposed legislative changes to the Health & Social Care Act, through March to June 2022 we worked together to co-produce our Community Engagement Framework: a strategic approach for working together with people and communities. This framework and our approach was developed by and for members of Integrated Care Northamptonshire (ICN), in partnership with Traverse – an independent social purpose consultancy – and with a wide range of local partners and people through a co-production process. Progress against its delivery will be monitored and owned by Northamptonshire's Integrated Care Board (ICB).

Working in partnership with people and communities forms the foundations of our strategic approach to developing integrated care for all Northamptonshire's citizens. The objective of our Community Engagement Framework is to enable ICN partners to work more effectively together, as it provides a clear expectation for working with people and communities in the design, delivery and improvement of health and care systems. This framework also supports ICN (monitored via the ICB) to meet its obligations as set out in the NHS 'Working in Partnership with People and Communities Statutory Guidance'.

You can read more about the Community Engagement Framework via the ICS website https://www.icnorthamptonshire.org.uk/involvement

Reducing health inequality

Under section 14T of the Health and Social Care Act 2012 each clinical commissioning group must, in the exercise of its functions, have regard to the need to:

(a) Reduce inequalities between patients with respect to their ability to access health services and

(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

Promoting equality is at the heart of the CCG's values, ensuring that we commission services fairly and that no community or group is left behind when we make commissioning decisions on behalf of our population, especially in relation to meeting the challenges the NHS faces, as outlined in the NHS Long Term Plan.

We are committed to taking Equality, Diversity and Inclusion, and human rights into account in everything we do through commissioning services, employing people, developing policies, communicating and engaging with local people in our work. As a public body, we work to ensure we meet our Public Sector Equality Duty (PSED), as set out in the Equality Act 2010 and our obligations under the Human Rights Act 1998. The CCG published Public Sector Equality Duty (PSED) report on its website in April 2022.

We will continue to promote and protect people's dignity and rights by upholding the values set out in the NHS Constitution.

In addition, the CCG implements the NHS Equality Delivery System 2 (EDS2) to support its work to tackle discrimination and health inequalities within local communities and for staff. We have a positive culture toward employing disabled people and developing a more diverse, inclusive and engaged workforce. You can read more about this in the Staff Report on pages 137 -139

The Public Sector Equality Duty

The CCG has worked to show how it is meeting the aims of the Public Sector Equality Duty as set out in the Equality Act to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between different people when carrying out their activities

This means the CCG must work to prevent discrimination as well as harassment and victimisation from happening. We also take steps to meet the health needs of people with certain protected characteristics.

As set out in the Equality Act 2010, the Protected Characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race and ethnicity
- Religion or belief
- Gender
- Sexual orientation

The CCG's staff members participate in mandatory Equality, Diversity and Inclusion training. The Equality Act requires public bodies to publish information about how it has met the Equality Duty each year and to set specific measurable equality objectives. This information is published on our website annually on CCG's Website.

Equality objectives and leadership

The CCG has developed and published its refreshed Equality and Inclusion Strategy 2019 – 2022, which outlines the ongoing approach to equality and inclusion, and serves as a basis to inform how we will implement our equality objectives 2019-2022. To ensure that our equality objectives remain relevant to the CCG's business and changing priorities, they are refreshed annually. We also prepare a progress report, which outlines how the equality objectives are met and embedded across CCG activities (where appropriate).

Our Equality and Inclusion Strategy is published on the website. A programme of work underpins our strategy and serves as a basis for delivering our Statutory Equality Objectives 2019 – 2022. These objectives are outlined left.

Equality objective 1: Integrate inclusion & equality conditions into our decisions

Equality objective 2: Continue to develop as an inclusive employer

Equality objective 3: Continue to focus on understanding gaps in health outcomes for the diverse local communities and working to reduce inequality

Equality analysis and due regard

The CCG has embedded equality and human rights by developing an integrated Quality and Equality Integrated Impact Assessment (QEIIA) tool. This continues to ensure the CCG considers quality, equality and human rights when undertaking decisions on what healthcare to buy and what services it might change to meet local needs. We have developed and delivered training in Equality Impact Assessment/Equality Analysis to senior managers and staff who are directly involved in commissioning work and service reviews to ensure the CCG gives appropriate due regard at every level of decision-making.

Implementing the NHS Equality Delivery System (EDS2)

The CCG adopted the EDS2 Framework from an early stage, which supports our work to understand and reduce health inequalities. During 2021/22, we continued to work towards improving our performance and outcomes against the four goals of the EDS2 (pictured on next page) by undertaking additional self-assessment and grading against Goal 3. We are waiting for NHSE/I to publish revised EDS.

What other actions are being taken to tackle health inequalities?

There are a number of activities the public health team and partners are working on to reduce health inequalities. For example, the stop smoking service is undertaking targeted work in both of the acute trusts to offer support and with specific GP practices where smoking prevalence is high.

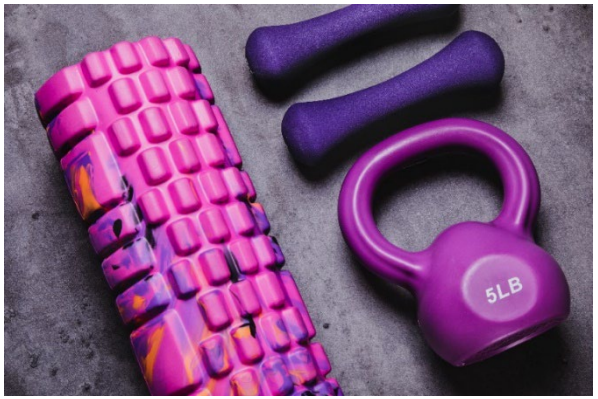
The NHS health check programme targets people who are at high risk of having a heart attack or stroke in the next 10 years. It is currently offered across the county in GP practices. It can help to tackle health inequalities, as the burden of early death from cardiovascular disease is higher in the most deprived communities compared with the least deprived. A new delivery model is currently being developed to improve uptake.

To tackle inequalities by helping people to be more physically active, Northamptonshire Sport continues to provide a universal, countywide activity programme. A range of activities are offered to encourage people to be more active.

These include the provision of behavioural change training and approaches, making better use of green open space for physical activity and making PE and school sport inclusive to all which helps to build a resilient physical activity habit for life. These actions have a focus across the county, but with an increased emphasis on those living in the most deprived areas where healthy life expectancy is known to be much worse. Eight geographical hotspots have been identified where there will be an increased focus of energy and effort across the system, led by Public Health Northamptonshire.

Health and wellbeing

Section 116B of The Health and Social Care Act 2012 sets out the responsibilities of local authorities and integrated care boards for preparing joint health and wellbeing strategies.



The CCG was an active member of West Northamptonshire's Health and Wellbeing Board and North Northamptonshire's Health and Wellbeing Board, which both consist of senior leaders and stakeholders from across Northamptonshire who provide a strategic lead for the health, care and wellbeing system.

The overall purpose of each Board is to secure:

- Better health and wellbeing outcomes for the local population
- Better quality of care for all patients and care users
- Better value for the taxpayer
- A reduction in the health and wellbeing outcomes gap (inequalities) between different groups

The Boards should work with local people to identify health and wellbeing needs of the population, agree priorities, and ensure that the NHS, local government and partners work together in a more joined-up way.

The Boards drives a more joined-up approach to the commissioning and delivering of health and social care services alongside services that provide the building blocks for health (such as housing, leisure, planning).

It also provides a key forum to increase democratic legitimacy in the shaping of health and care services through its elected members.

Each Board must ensure the preparation and delivery of a Joint Local Health and Wellbeing Strategy.

A Joint Local Health and Wellbeing strategy will provide a jointly agreed and locally determined set of priorities for West Northamptonshire and North Northamptonshire .

Outcomes from the Local Joint Health and Wellbeing Strategy will be contained within the Northamptonshire Integrated Care Strategy.

Integrated Care Northamptonshire has launched a 10 year strategy, Live Your Best Life. The strategy sets out how we can achieve better outcomes throughout all stages of life: From pregnancy, birth and early years, followed by improved education and better employment opportunities, plus an ambition of better access to health and care services, right through to the end of life.

It has been developed by NHS providers, local councils, voluntary and community organisations and others, aiming to work together to address challenges and improve the health and wellbeing of those who live and work in the area.

Our local population

West Northamptonshire council serves the areas of Daventry District, Northampton and South Northamptonshire, and North Northamptonshire council serves Wellingborough, Kettering, Corby and East Northamptonshire.

The diagrams below dated February 2021 provides a snapshot of health and wellbeing outcomes across a person's lifetime in North Northamptonshire and West Northamptonshire.

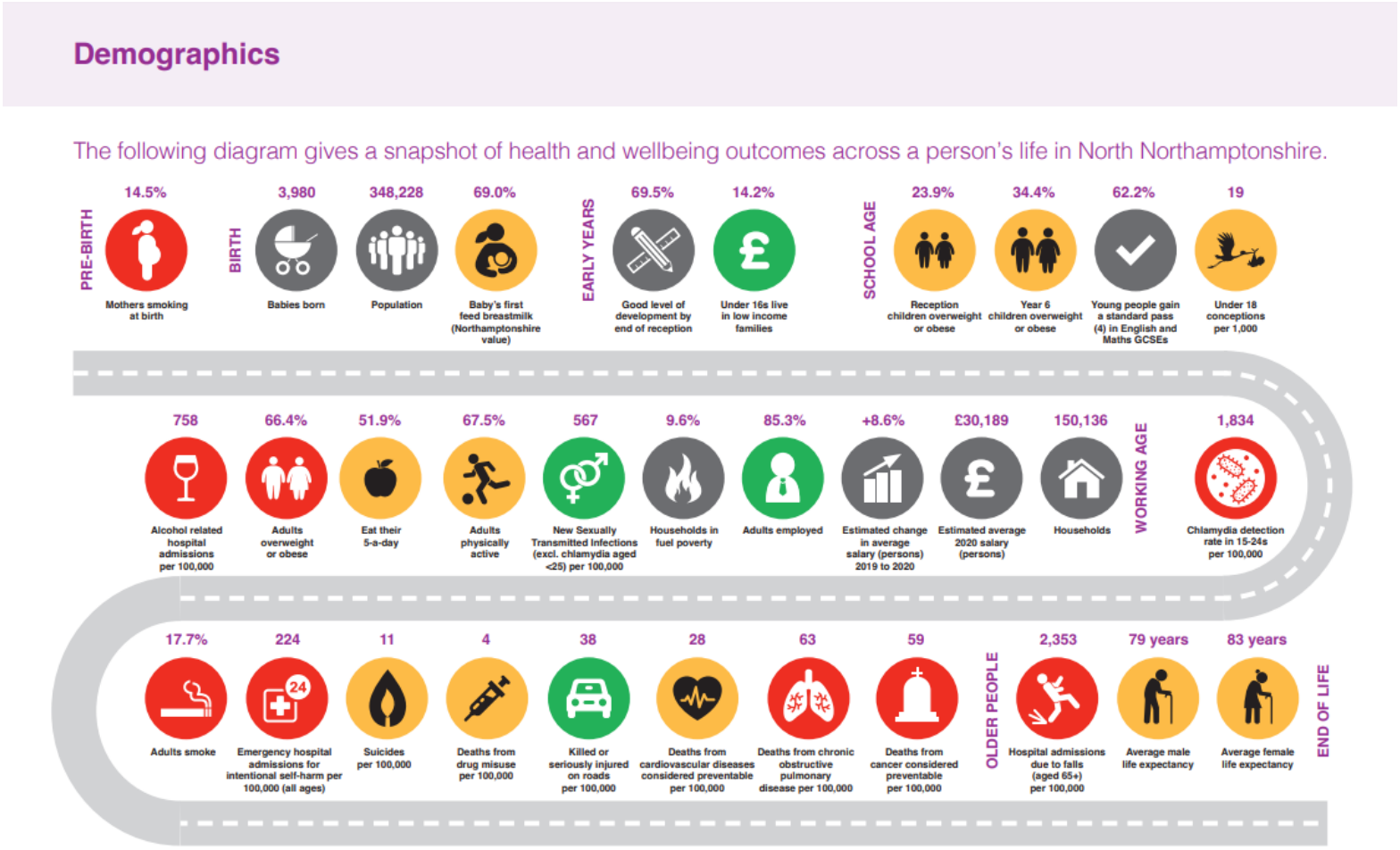


Figure 1. Health and Wellbeing in North Northamptonshire, February 2021
Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Demographics

The following diagram gives a snapshot of health and wellbeing outcomes across a person's life in West Northamptonshire.

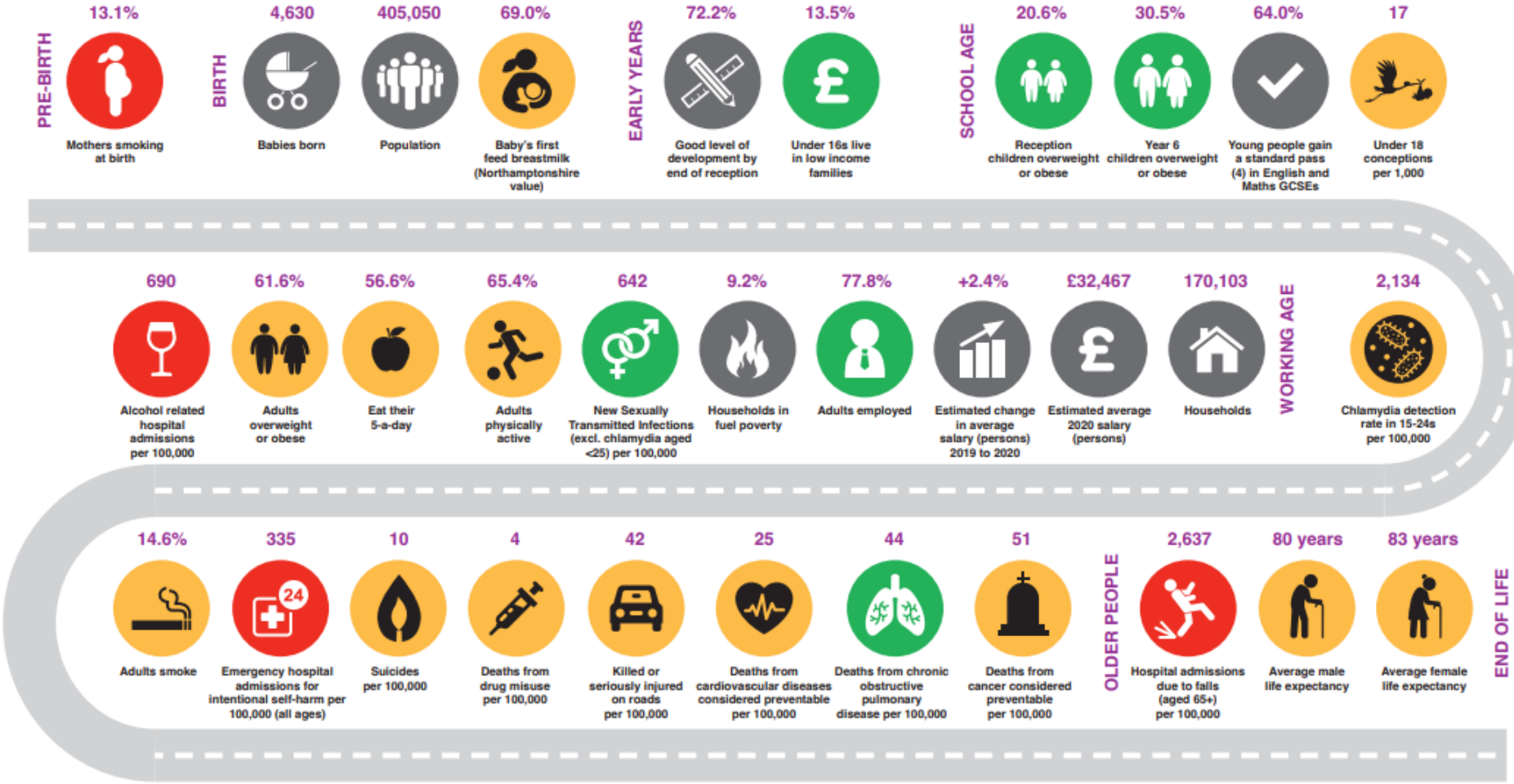


Figure 2. Health and Wellbeing in West Northamptonshire, February 2021

Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Compared to England average:

BETTER | SIMILAR | WORSE | NOT COMPARED

What actions are being taken to tackle health inequalities?

There are several activities the public health team and partners are working on to reduce health inequalities. For example, the stop smoking service is undertaking targeted work in both acute trusts to offer support and with specific GP practices where smoking prevalence is high.

The NHS health check programme targets people who are at high risk of having a heart attack or stroke in the next 10 years. It is currently offered across the county in GP practices. It can help to tackle health inequalities, as the burden of early death from cardiovascular disease is higher in the most deprived communities compared with the least deprived. A new delivery model is currently being developed to improve uptake.

To tackle inequalities by helping people to be more physically active, Northamptonshire Sport continues to provide a universal, countywide activity programme. A range of activities are offered to encourage people to be more active.

These include the provision of behavioural change training and approaches, making better use of green open space for physical activity and making PE and school sport inclusive to all which helps to build a resilient physical activity habit for life. These actions have a focus across the county, but with an increased emphasis on those living in the most deprived areas where healthy life expectancy is known to be much worse.

Eight geographical hotspots have been identified where there will be an increased focus of energy and effort across the system, led by Public Health Northamptonshire.

How have we consulted with the Health and Wellbeing Boards?

We requested the North Northamptonshire Health and Wellbeing Board and the West Northamptonshire Health and Wellbeing Board delegate review of the content included in the annual report to the respective Chair of the Health and Wellbeing Boards in consultation with the Executive members for Adults, Health and Wellbeing, the Directors of Public Health and Wellbeing and the Executive Directors for Adults, Health Partnerships and Housing, in order to ensure that required timescales are met.

Accountability report

The Accountability Report sets out how our organisation is structured and governed. In this chapter you can find out more about the people who sit on our governing body, our member practices and our committees.

This chapter also includes information about how we meet our duties as an employer and support our staff, as well as information about the people who work for us.

Toby Sanders
Chief Executive (Accountable Officer)
18th September 2022

Corporate governance report

Member's report

The following section contains information about how we are structured and governed.

Governing Body composition

Dr Joanne Watt, GP Chair

Dr Joanne Watt has been a GP at Great Oakley Medical Centre since 2005, and has been senior partner since 2010. In July 2012, Dr Watt was elected to the governing body of Corby CCG as the clinical executive leading on quality. In April 2016, she became Clinical Chair of Corby CCG's governing body before being elected as GP Chair, Northamptonshire CCG in April 2020.

Dr Watt has a focus on ensuring that the people of Northamptonshire receive equitable access to high quality care, and that their needs are considered in future plans for Northamptonshire. She is committed to working in collaboration with colleagues across health and care within Northamptonshire to provide optimal integration of care for our population.

Toby Sanders, Chief Executive

With over 15 years of experience in the NHS, Toby was previously the Managing Director of West Leicestershire Clinical Commissioning Group, an organisation which he successfully helped set up and lead for seven years.

Toby has a strong appreciation of how the NHS and wider public sector touches and impacts on most of our lives. He is passionate about the value of clinical leadership and patient involvement, working with health and care professionals across public services to achieve the best value and outcomes for local people and places.

Toby has been appointed as the Designate Chief Executive for Northamptonshire's Integrated Care Board (ICB).

Stuart Rees, Chief Finance Officer

Stuart has previously been Director of Finance, Contracting and Performance of Shropshire Community Health Trust and Director of Finance & Performance of Shropshire County PCT, having previously held a number of senior positions in the NHS.

Stuart has had significant experience in finance, including Deputy Director of Finance in both secondary and primary care settings after joining the NHS as part of the National Finance Management Training Scheme.

Angela Dempsey, Chief Nurse & Quality Officer

Angela is a passionate and committed nurse leader with over 30 years of experience delivering and/or overseeing acute, community and primary care.

She is an experienced Governing Body Nurse with six years' experience of holding the position for Enfield CCG.

Graham Felston, Lay Member for Audit and Governance

Graham is a qualified Chartered Insurer and a Chartered Director and is currently a Director of a number of pension schemes, either as a Professional Trustee or as the Chair of the Trustees.

Previous NHS roles include Deputy Chair, Audit Chair and Lay Member for Governance for CCG's in South and South West Lincolnshire.

Andrew Hammond, Lay Member for Primary Care

Andrew is an experienced Executive and Non-Executive Director working in charity, commercial and public sectors.

He spent his early career establishing a national awareness charity, and is now Chief Executive of Instructus, an education charity working in skills development and apprenticeships.

Janet Gray, interim Lay Member for Patient and Public Involvement

Janet is currently a Non-Executive Director at University Hospitals Northamptonshire and is Chief Executive and Registrar at the Academy for Healthcare Science.

Her previous roles have included Director of the Department of Health's Modernising Scientific Careers Programme and Director of Workforce for the East Midlands Strategic Health Authority.

Sam Turner, Lay Member for Finance and Planning

Sam is a qualified management accountant (Chartered Institute Management Accountants) and has held a number of executive roles at Network Rail including Finance Director roles in Property and Strategy and Transformation before taking on the role of Route Finance Director overseeing one of the busiest sections of railway track in the country.

Dr Chris Ellis, Locality Chair for Wellingborough and East Northants

Dr Ellis has been a GP at Queensway Medical Centre for 21 years as well as being a longstanding GP Registrar Trainer and has been involved in commissioning since 2014.

Outside of general practice, he is a Versus Arthritis Musculoskeletal Trainer and on the steering group for the Primary Care Rheumatology and Musculoskeletal Medicine Society.

Dr Ammar Ghouri, Locality Chair for Kettering and Corby

Dr Ghouri read medicine at the University of Leicester. In 2019, he joined Lakeside surgery as a partner and has been involved in the development of the practice.

He is keen to build positive working relationships between constituent practices and the CCG to help deliver better health outcomes for the local population. Dr Ghouri believes listening to the needs of primary care will help to coordinate the delivery of high quality patient centred care. He is committed to providing a safe and accessible service which is sustainable and well led.

Dr Darin Seiger, Locality Chair for Northampton

Dr Seiger has been heavily involved in the management of local NHS commissioning and provider organisations since 2000, having previously been the Medical Director of the GP out of hours service and the GP Chair for NHS Nene CCG.

He has also previously held the role of vice-chair of Northamptonshire's Health & Wellbeing Board.

Dr Phillip Stevens, Locality Chair for Daventry & South Northants

Philip is a GP who is committed to primary care delivery and the development of community based care.

He has worked in South Northants as a GP since completing GP training and has been involved with local CCGs since 2016. Philip is enthusiastic about continuing and developing this role.

Member practices		
Abbey House Medical Centre	Abbey Medical Practice	Abington Medical Centre
Abington Park Surgery	Albany House	Brackley Medical Centre
Brook Medical Centre	The Brook Health Centre	Bugbrooke Medical Practice
Burton Latimer Health Centre	Byfield Medical Centre	The Cottons Medical Centre
County Surgery	The Crescent Medical Centre	Crick Medical Practice
Danes Camp Surgery	Danetre Medical Practice	Denton Village Surgery
Dryland Medical Centre	Dr Sumira	Earls Barton and Penvale Park Medical Centre
Eleanor Cross Healthcare	Eskdaill Medical Centre	Favell Plus Surgery
Great Oakley Medical Centre	Greens Norton & Weedon Medical Practice	Greenview Surgery
Harborough Field Surgery	Headlands Surgery	Higham Ferrers Surgery
Irchester Medical Centre	King Edward Road Surgery	Kingsthorpe Medical Centre
Lakeside Surgery	Langham Place Surgery	Leicester Terrace Healthcare Centre
Linden Medical Group	Long Buckby Practice	Maple Access Partnership
Marshalls Road Surgery	Mawsley Surgery	Mayfield Surgery
The Meadows Surgery	Moulton Surgery	The Mounts Medical Centre
Nene Valley Surgery	Park Avenue Medical Centre	Parklands Medical Centre
The Parks Surgery	The Pines Surgery	Queensview Medical Centre
Queensway Medical Centre	The Redwell Medical Centre	Rillwood Surgery
Rothwell & Desborough Health Care Group	Rushden Medical Centre	The Saxon Spires Practice
Spinney Brook Medical Centre	Springfield Surgery	St Lukes Primary Care Centre
Studfall Partnership	Summerlee Medical Centre	Towcester Medical Centre
Weavers Medical	Wollaston Medical Practice	Woodsend Medical Centre
Woodview Medical Centre	Wootton Medical Centre	

Committee(s), including Audit Committee

- Audit and Risk Committee
- Primary Care Commissioning Committee
- Remuneration and Terms of Service Committee
- Strategy and Planning Committee
- Finance, Procurement and Contracting Committee
- Integrated Quality, Safeguarding and Performance Committee

Membership of the Audit and Risk Committee can be found on pages 99 - 101

Register of interests

The CCG is aware of the importance of its obligation to identify and address any potential or actual conflict of interest when transacting its business. The CCG has an embedded and robust system for:

- Registering interests of the governing body, its sub-committees and staff
- Publication of its register of interests
- Updating the register on a quarterly basis
- Taking any actual or potential conflicts into account when transacting the business of NHS Northamptonshire CCG

The CCG's register of interests is available on its website via the link.

Personal data related incidents

There have been 0 personal data breaches during the period 1 April 2021 – 31 March 2022, none requiring reporting to the Information Commissions Office (ICO).

We have an established Data Security and Protection Management Framework and have developed processes and procedures in line with the Data Security and Protection Toolkit (DSPT). We place high importance on ensuring there are robust data security and protection systems and processes in place to help protect patient and corporate information alike and as such these processes are under continued review.

We recognise that having technical and operational security mechanisms in place to protect the data we process goes a long way. However, it is essential that we ensure the same level of rigour is placed on our staff. All staff are therefore required to undertake annual information governance training to ensure their awareness of data security and protection roles and responsibilities.

Modern Slavery Act

Northamptonshire 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 Executive to be the Accountable Officer of Northamptonshire 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.

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

Toby Sanders
Chief Executive (Accountable Officer)
NHS Northamptonshire CCG

Governance statement

NHS Northamptonshire CCG is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

The Clinical Commissioning Group's (CCG) 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 required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

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

Governance arrangements and effectiveness

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

In accordance with this, we acknowledge within our Constitution the following principles:

The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business by adopting:

- The Good Governance Standard for public services
- The standards of behaviour published by the committee on Standards in Public Life (1995) known as the Nolan Principles

Scope of Responsibility

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

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

- The seven key principles set out in the NHS Constitution
- The Equality Act 2010
- Standards for members of NHS Boards and Governing Bodies in England

The roles and responsibilities of the Governing Body and statutory and mandated sub-committees of the CCG are detailed within the CCG's Constitution including the committee terms of reference.

The CCG's governance arrangements are supported by the CCG's governance handbook which contains terms of reference of all CCG committees, including the statutory and mandated committees as well as the non-statutory/non-mandated sub-committees. The handbook also details the CCG's governance structure which can be found in the diagram on page 91.

NHS Northamptonshire CCG governance structure

The CCG is a clinically led and managerially supported membership organisation made up of 68 member practices. Further detail in relation to the CCG membership can be found in the Members' Report on page 84.

The CCG was established on 1 April 2020.

The CCG Governing Body leads the organisation at the most senior level. Further detail on Governing Body membership can be found in the Annual Report on pages 81 to 83.

The Corporate Management Team (CMT) provides the executive leadership for the organisation. The CMT structure enables health population strategy/planning developments, transformational delivery of the plans, increasing performance, efficiency and quality through contracting for outcomes, focusing on integration of primary and community services to support delivery of care in the community/closer to home and enables us to monitor and drive quality, safety and equity of services throughout the organisation.

The governance structure as set out below, details the Governing Body and committees for the organisation. Statutory and mandated committees are defined, as well as non-statutory/non-mandated committees which are locally determined by the CCG. Further detail on the remit of the Governing Body and sub-committees can be found later in the Governance Statement.

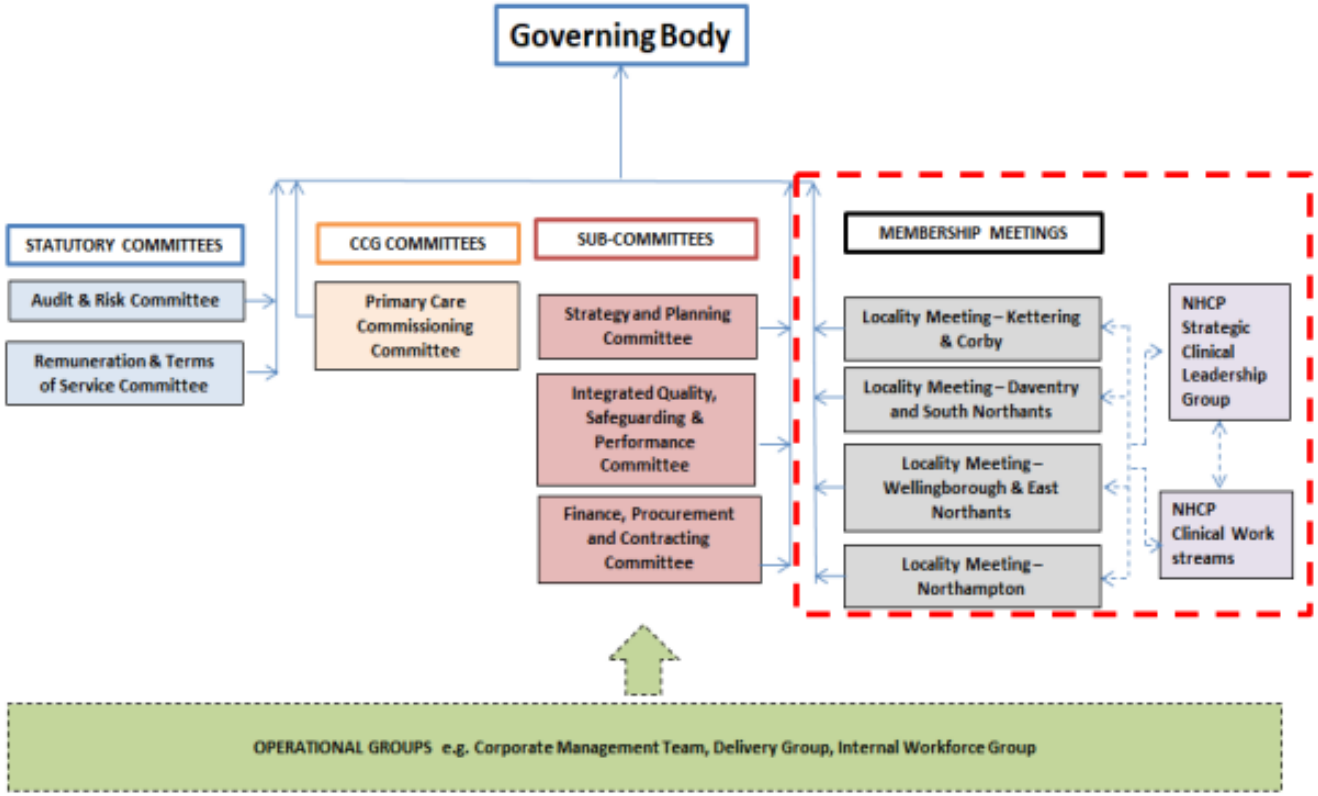


Diagram 1: NHS Northamptonshire CCG governance structure

There are four established Locality Boards which are the membership meetings of the CCG. The Locality Boards cover the four localities of the CCG, which are:

- Kettering and Corby
- Daventry and South Northamptonshire

Page 372

- Wellingborough and East Northamptonshire
- Northampton

The Locality Boards are referenced on the governance structure diagram (delineated by red dotted line) for information. These membership meetings sit outside the formal governance structure of the CCG, due to the nature and purpose of these meetings.

CCG governance arrangements

The CCG has established robust governance arrangements and a system of internal control. Corporate governance is the system by which the CCG Governing Body directs and controls the organisation at the most senior level in order to achieve its objectives and meet the necessary standards of accountability and probity.

The CCG's Constitution sets out the organisation's commitment to good governance and the arrangements the CCG has in place to help to deliver the vision, mission, objectives and aims. The Constitution also sets out how the CCG will discharge the organisation's legal obligations and to engage with our members, our patients and our community, and other key stakeholders and partners to achieve this. It states that the Governing Body of the group will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure principles of good governance are reflected. This includes reviewing the effectiveness and the operation of Governing Body meetings and the sub-committees of this meeting.

Responsibilities and decision-making are defined in the CCG's prime financial policies and scheme of delegation, which are reviewed annually to maintain accuracy and relevance.

The key features of the CCG Constitution in relation to governance are:

- Discharge of functions - the arrangements made to discharge the functions of the CCG and the Governing Body. The Constitution describes how we operate, the role of the Governing Body, the appointment of committees and the specific duties of the GP Chair, Chief Executive (Accountable Officer) and Chief Finance Officer.

- Primary decision-making processes - the primary decision-making processes and procedures to be followed by the CCG and the Governing Body including the arrangements for securing transparency in decision-making such as the provision for Governing Body meetings to be held in public.
- Conflict of interest management – how the CCG deals with conflicts of interest, including the arrangements we have made to maintain and grant public access to registers of interest and ensure that declarations of conflicts or potential conflicts of interests are made. This is to ensure that conflicts or potential conflicts do not and do not appear to affect the integrity of the decision-making process. A copy of the CCG's register of interests is available on the CCG website.
- Governing Body membership - details of how appointments are made to the Governing Body and how the membership of the organisation is involved in these appointments.
- Scheme of Reservation and Delegation - sets out the decisions that are the responsibility of the Governing Body and its committees, alongside the decisions delegated to individual members and employees.

The Constitution sets out the arrangements the CCG has made for the discharge of the Governing Body's functions, including the following:

- Established committees of the Governing Body:
    - Statutory committees
        - Audit & Risk committee
        - Primary Care Commissioning committee
        - Remuneration and Terms of Service committee
    - Locally determined committees
        - Strategy and Planning committee
        - Finance, Procurement and Contracting committee
        - Integrated Quality, Safeguarding and Performance committee
- Delegated Governing Body functions for the approval of policies to the Integrated Quality, Safeguarding and Performance committee, Audit and Risk committee and Finance, Procurement and Contracting committee, as committees of the Governing Body
- The Standing Orders and Scheme of Reservation and Delegation (SORD)

Interim Governance arrangements in response to COVID-19

Due to the unprecedented COVID-19 pandemic, during 2021/22 the CCG took steps to work as flexibly as possible to ensure effective and efficient decision making and providing parameters to work in as agile a way as possible.

From April 2021, the Governing Body approved a number of interim governance arrangements for the frequency and interim arrangements of individual Committees. These arrangements have continued into the first quarter of 2022/23 whilst the CCG remained as the statutory organisation. Further detail on the Governing Body meeting arrangements and individual committee arrangements from 1 April to 30 June 2022 is detailed later in the Governance Statement.

Interim Governance arrangements moving towards establishment of the NHS Northamptonshire Integrated Care Board (ICB)

From 1 April 2022 the CCG approved shadow governance arrangements for the organisation as Northamptonshire looked to establish the new NHS Northamptonshire Integrated Care Board (ICB). From 1 April 2022 a Shadow ICB Board meeting was established to meet alongside the CCG Governing Body meeting. The Shadow Board was established to enable the appointed Designate ICB Board members to meet and consider items of business under shadow arrangements and in alignment to the CCG Governing Body, during the period of April to June 2022, acknowledging that the statutory body remained as the CCG.

Shadow Committee arrangements were established to support a blended arrangement running within the CCG established governance framework but with appointed designate ICB members as part of those committees. The approach taken ensured that the required CCG Committees (both Statutory and locally determined) continued to meet to undertake CCG business whilst establishing the future committee arrangements for the ICB.

These shadow arrangements included the following:

- the CCG's Audit and Risk Committee supported the establishment of the Shadow ICB Audit Committee.
- the CCG's Integrated Quality, Safeguarding & Performance Committee established the Shadow ICB Quality Committee.
- The CCG's Strategy and Planning Committee and Finance, Procurement and Contracting Committee supported the establishment of the Shadow ICB Integrated Planning & Resources Committee.

- The CCG's Finance, Procurement and Contracting Committee and Integrated Quality, Safeguarding and Performance Committee supported the establishment of the Shadow ICB Delivery & Performance Committee.
- The CCG's Primary Care Commissioning Committee supported the establishment of the Shadow ICB Primary Care Committee.
- Remuneration and Terms of Service Committee (REMCOM) – during shadow arrangements the REMCOM continued to meet as the established CCG Committee.

For the purposes of reporting for the Quarter 1 of 2022/23 the Committees described below are the established CCG Committees with attendance registers based on the established Committees.

CCG assessment of committee effectiveness and improvement

The Governing Body throughout each year have an ongoing role in reviewing the CCG's governance arrangements, and effectiveness of these, to ensure principles of good governance are reflected. The Governing Body reporting structures have embedded and communicated codes of conduct and defined standards of behaviour for CCG members and staff by:

- Having a code of conduct for the Governing Body members showing mutual trust, respect and honesty
- Members of the Governing Body adhere to the Nolan Principles for public life
- Each committee is authorised by and accountable to the Governing Body
- Each committee is responsible for approving and keeping under review the terms of reference and membership, and the Governing Body seek regular assurance that this duty is discharged accordingly

The Governing Body members are subject to statutory and mandatory training. Training and development is provided on a group basis through Governing Body workshops and through individual need as identified through the annual appraisal process.

The Governing Body is provided with a range of information and using risk management mechanisms, the Governing Body brings together the various aspects of governance; corporate, clinical, financial and information to provide assurance on its direction and control across the whole organisation.

The Governing Body

The Governing Body is committed to assessing and improving its own performance. All members of the Governing Body are able to demonstrate the

leadership skills necessary to fulfil the responsibilities of these key roles and have established credibility with all stakeholders and partners. The CCG understands that the Governing Body must be in tune with its member practices and must secure and maintain their confidence and engagement.

The Governing Body sets the strategic direction for the CCG and focuses on gaining assurance of the delivery of the CCG's priorities, corporate objectives and statutory duties. The Governing Body has focused on key performance issues throughout the year, ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the CCG's principles of good governance. The Governing Body brings together the various aspects of governance to provide assurance on the CCG's direction of travel and control across the whole organisation.

Quarter 1 of 2022/23 has continued to be a challenging time for the NHS as a whole with the unprecedented COVID-19 global pandemic, and as such has been a challenging time for the CCG. During Quarter 1 of 2022/23 he organisational focus for the CCG has been the establishment of the new NHS Northamptonshire Integrated Care Board (ICB) as part of the wider Northamptonshire Integrated Care System (ICS) and Northamptonshire Integrated Care Partnership (ICP) and the Northamptonshire system response to the COVID-19 pandemic, whilst maintaining the statutory duties of the CCG. This has meant that governance arrangements have had to be flexible to allow for the system response. Detail of the interim governance arrangements in response to COVID-19 put in place for the organisation is described above. Interim arrangements as the CCG has moved to the establishment of the ICB are also described below. Alongside these areas of focus the CCG has also reviewed the following areas:

- COVID-19 system and organisational response
- Assurance of the COVID-19 vaccination programme
- Development of the ICS and assurance of the establishment of the ICB
- System collaboration with system partners
- Development of strategy
- Ensuring commissioning arrangements in place across Northamptonshire
- Monitoring performance including the financial position, activity and progress against key standards including NHS Constitutional Standards, contract performance
- Obtaining assurance the risk management process is effective to manage and mitigate risk
- Ensuring effective clinical leadership

- Ensuring meaningful patient and public involvement in commissioning decisions
- Seeking assurance on safeguarding
- Monitoring of quality and performance of services
- Monitoring and seeking assurance on patient safety
- Ensuring transparent remuneration arrangements are in place for employees and others
- Assurance of the CCG's governance arrangements, including the CCG Constitution and interim arrangements agreed during 2021/22

The CCG values the opportunities provided by the holding of Governing Body meetings in public, ensuring that we hear and respond to our public voice and provide assurance on the work we are undertaking on behalf of the population of Northamptonshire.

Challenges brought by the national response to the COVID-19 pandemic required the CCG to adapt the way we conduct our meetings in public. To ensure that the national guidance in relation to COVID-19 was followed, the CCG conducted our meetings virtually utilising remote teleconferencing platforms to enable members to be present. This arrangement has continued for the meetings held in the first quarter of 2022/23.

During these unprecedented times the CCG has remained committed to adapting our approach to maintain public engagement with the Governing Body. We have maintained this through:

- Ensuring Governing Body papers were published on the CCG website 7 days in advance of the meeting. Full Governing Body papers and recordings are available on the CCG website
- Minutes of Governing Body meetings in public were made available within 7 days of the meeting
- Northamptonshire HealthWatch has been invited to attend Governing Body meetings in public
- Virtual Governing Body meetings in public were recorded and subsequently made available to view by the public via a link placed on the CCG's website within the relevant Governing Body meeting papers
- The public were able to submit questions in advance of the Governing Body meetings in public and responses to these questions provided at the meeting and included within the minutes of the meeting.

The Governing Body has met in public on a bi-monthly basis during Quarter 1 of 2022/23. Governing Body Thinking Time sessions are held on the alternate months to the formal meetings in public, which provide protected time to develop understanding of key strategic issues. Two Governing Body meetings were held in public from 1 April to 30 June 2022.

Governing Body membership attendance is detailed in the table below and demonstrates that each meeting was quorate with good attendance from members from 1 April 2022 – 30 June 2022.

Name	Job Title	26/04/22	28/06/22	Total	Percentage
Dr Joanne Watt	GP Chair	1	1	2	100%
Janet Gray	Lay Member Patient and Public Involvement and Deputy Lay Chair	1	1	2	100%
Andrew Hammond	Lay Member Primary Care	1	1	2	100%
Sam Turner	Lay Member Finance and Planning	0	0	0	0%
Graham Felston	Lay Member Audit and Governance	1	0	1	50%
Angela Dempsey	Chief Nurse and Quality Officer/Registered Nurse	1	1	2	100%
Toby Sanders	Chief Executive	1	1	2	100%
Stuart Rees	Chief Finance Officer	1	1	2	100%
Dr Chris Ellis	Locality Chair, Wellingborough and East Northants	1	1	2	100%
Dr Ammar Ghouri	Locality Chair, Kettering and Corby	1	1	2	100%
Dr Darin Seiger	Locality Chair, Northampton	1	1	2	100%
Vacant	Secondary Care Doctor				NA

Dr Philip Stevens	Locality Chair, South Northants and Daventry	1	0	1	50%
Governing Body meeting quoracy		**Yes**	**Yes**		

Committees of the Governing Body

The established committees of the Governing Body are:

- Statutory/mandated committees
- Audit and Risk committee
- Remuneration and Terms of Service committee
- Primary Care Commissioning committee

Non-statutory/non-mandated committees (locally determined)

- Strategy and Planning committee
- Finance, Procurement and Contracting committee
- Integrated Quality, Safeguarding and Performance committee

Audit and Risk committee

The Audit and Risk committee's work focuses on ensuring the organisation has appropriate governance and internal control in place, and oversees the management of risk. The committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG. The committee seeks to provide assurance to the Governing Body that an appropriate system of internal control is in place.

From 1 April – 30 June 2022 the CCG Audit and Risk committee supported the establishment of the Shadow ICB Audit Committee and has regularly monitored the following:

- Oversight and assurance of the risk management processes within the CCG
- Reviewed and approved the Risk Management and Governing Body Assurance Policy
- Seeking assurance of decision making and COVID-19 expenditure in line with the interim governance arrangements
- Assurance of the development of the ICS
- Head of Internal Audit presented the Head of Internal Audit Opinion to the Audit and Risk committee
- Internal and external audit reports with focus on the implementation of agreed management actions
- Updates on the work of the Local Counter Fraud Specialist
- Management of conflicts of interest and Register of Interests and Register of Gifts and Hospitality
- Sources of assurance in support of the Annual Governance Statement and the Annual Report and Accounts
- Financial controls and monitoring correct application of the Standing Financial Instruction and Scheme of Delegation
- Single tender waivers correct use monitoring
- Progress against and compliance with the General Data Protection Regulations 2018 and the Data and Security Protection Toolkit submission

The membership of the Audit and Risk committee as at 30 June 2022:

- Lay Member for Audit & Governance (chair)
- Lay Member for Primary Care (deputy chair)
- Lay Member for Patient and Public Involvement
- Secondary Care Doctor
- Governing Body Clinical Representative

From 1 April – 30 June 2022, the Audit and Risk committee met twice. Membership attendance is detailed in the table below, and demonstrates that each meeting of the committee was quorate with good attendance from members. The Chief Finance Officer, external and internal auditors, as well as the Local Counter Fraud Specialist are regular attendees at the committee but do not form part of the membership.

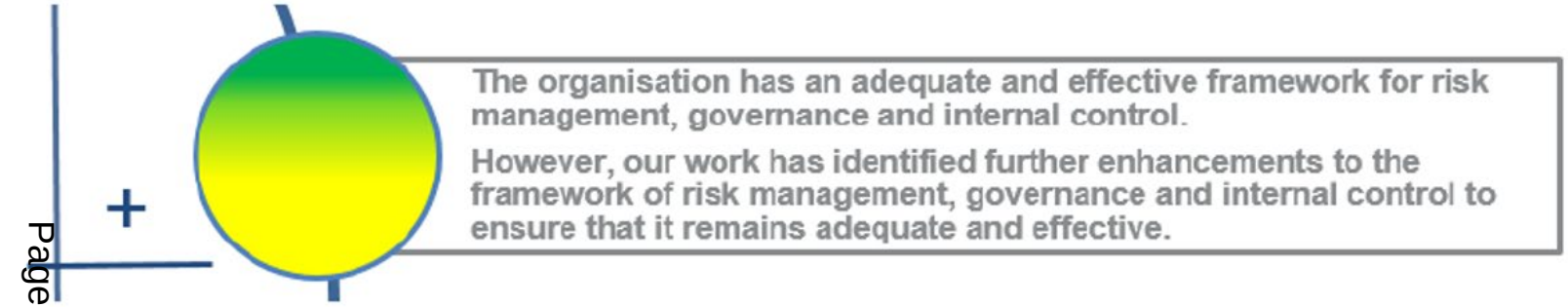
The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required.

Audit and Risk committee membership attendance is detailed below from 1 April – 30 June 2022.

Name	Title	19/04/2022	16/06/2022	Total	Percentage
Graham Felston	Lay Member Audit and Governance (Chair)	1	1	2	100%
Andrew Hammond	Lay Member Primary Care (Deputy Chair)	0	1	1	50%
Dr Darin Seiger	Locality Chair Northampton	1	1	2	100%
Vacant	Secondary Care Doctor	NA	NA	NA	NA
Janet Gray	Lay Member Patient and Public Involvement	NA	NA	NA	NA
Committee meeting quoracy		**Yes**	**Yes**		

Governance, risk management and internal control

Head of Internal Audit presented the Head of Internal Audit Opinion to the Audit and Risk committee on 18 August 2022, which concluded that: For the 3 months ended 30 June 2022, our head of internal audit opinion for Northamptonshire CCG is as follows:



Remuneration and Terms of Service Committee

The Remuneration and Terms of Service committee makes recommendations to the Governing Body regarding the remuneration, fees and other allowances for senior employees and for people who provide services to the Group.

The Remuneration and Terms of Service committee membership is made up of the following:

- Lay Member Finance and Planning (chair)
- Lay Member Primary Care
- Lay Member Patient and Public Involvement
- Chief Nurse and Quality Officer
- Secondary Care Doctor

Where members are conflicted the following provisions are made:

- The Chief Nurse and Quality Officer and the Secondary Care Doctor will be required to withdraw from the meeting or part of it that relates to their remuneration and conditions of service
- Lay Member remuneration and conditions of service will be determined by the Lay Member Remuneration sub-committee. No Lay Member shall be present at any meeting of the Lay Member Remuneration sub-committee

From 1 April – 30 June 2022 the committee met three times. The Remuneration and Terms of Service committee membership attendance is detailed below for Quarter 1 of 2022/23.

Name	Title	24/04/2022	19/05/2022	21/06/2022	Total	Percentage
Sam Turner	Lay Member Finance and Planning (Chair)	0	0	1	1	33%
Andrew Hammond	Lay Member Primary Care	1	1	1	3	100%
Janet Gray	Lay Member for Patient and Public Involvement	1	1	0	2	67%

Angela Dempsey	Chief Nurse and Quality Officer GB Reg Nurse	1	0	1	2	67%
Vacant	Secondary Care Doctor	NA	NA	NA	NA	NA
Committee meeting quoracy		**Yes**	**Yes**	**Yes**		

Primary Care Commissioning committee

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHSE/I has delegated the exercise of these functions to the CCG. The committee functions as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

The committee membership includes:

- Lay Member Primary Care (chair)
- Lay Member Patient and Public Involvement (deputy chair)
- Chief Executive
- Lay Member Finance and Planning
- Chief Nurse and Quality Officer
- Chief Finance Officer
- Director of Primary and Community Integration

The CCG Primary Care Commissioning Committee supported the establishment of the Shadow ICB Audit Committee. The committee considered the following items during 2021/22:

- General Practice Forward View
- Reimbursement of COVID-19 related funding for general practice

- Finance update
- Delegated contracts
- COVID-19 vaccination programme
- Internal audit on delegated commissioning
- Primary Care Quality Report

From 1 April – 30 June 2022, the committee met three times. The committee usually meets in public on a bi-monthly basis, during Quarter 1 of 2022/23 the committee met in public each month. Primary Care Commissioning committee development sessions are held on the alternate months.

The committee meetings in public were conducted virtually utilising remote teleconferencing platforms to enable members to be present. The Primary Care Commissioning committee meets in public and papers for the meeting can be found on the CCG website. The virtual committee meetings in public were recorded and subsequently made available to view by the public via the CCG's website.

The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required.

The Primary Care Commissioning Committee membership attendance is detailed below from 1 April – 30 June 2022.

Name	Title	19/04/2022	17/05/2022	21/06/2022	Total	Percentage
Andrew Hammond	Lay Member Primary Care (Chair)	0	1	1	2	67%
Julie Curtis	Director of Primary and Community Integration	1	NA	NA	1	100%
Janet Gray	Lay Member Patient and Public Involvement	1	1	1	3	100%
Stuart Rees	Chief Finance Officer	1	0	1	2	67%
Ammar Ghouri	Locality Chair, Kettering and Corby	1	1	0	2	67%
Sam Turner	Lay Member Finance and Planning	NA	NA	NA	NA	NA

Angela Dempsey	Chief Nurse and Quality Officer	NA	NA	NA	NA	NA
Committee meeting quoracy		**Yes**	**Yes**	**Yes**		

Strategy and Planning Committee

The Strategy and Planning Committee provides assurance to the Governing Body on the development of the strategic and operational plans; development and approval of short, medium and long-term CCG commissioning plans/strategies; support of the development of system short/medium and long term plans/strategies; oversight for Business Intelligence (BI).

The Strategy and Planning Committee supported the establishment of the Shadow ICB Integrated Planning and Resources Committee

Matters considered by the committee in 2021/22 included but were not limited to the following:

- COVID-19 pandemic response
- Operational Plan
- ICS development
- Patient and public engagement

The committee membership is made up of:

- Lay Member for Patient and Public Involvement (chair)
- Lay Member for Finance and Planning (vice chair)
- Lay Member for Audit and Governance
- Director of Population Health Strategy
- Director of Transformation Delivery
- Clinical Representative

From 1 April – 30 June 2022, the committee met three times. Membership attendance is detailed in the table below and demonstrates that each meeting of the committee was quorate with good attendance from members.

The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required. The Strategy and Planning committee membership attendance is detailed below from 1 April – 30 June 2022.

Name	Title	05/04/2022	03/05/2022	07/06/2022	Total	Percentage
Janet Gray	Lay Member for Patient and Public Involvement (Chair)	1	1	1	3	100%
Sam Turner	Lay Member for Finance and Planning (Deputy Chair)	1	1	1	3	100%
Graham Felston	Lay Member for Audit and Governance	1	1	1	3	100%
Alison Gilbert	Director of Transformation Delivery	1			1	100%
Eileen Doyle	Fulfilling the role of the Director of Population Health Strategy	1	1	1	3	100%
Dr Chris Ellis	Locality Chair Wellingborough and East Northants	1	1	1	3	100%
Committee meeting quoracy		**Yes**	**Yes**	**Yes**		

Integrated Quality, Safeguarding and Performance committee

The Integrated Quality, Safeguarding and Performance committee provides assurance to the Governing Body on the quality of services commissioned in accordance with section 14R of the Health and Social Care Act 2012, and promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience to the Governing Body.

The Integrated Quality, Safeguarding and Performance Committee supported the establishment of the Shadow ICB Quality Committee and Shadow ICB Delivery and Performance Committee.

Key issues debated and reviewed by the committee during Quarter 1 of 2022/23 included but were not limited to:

- Quality and Safeguarding Report

- Quality Directorate Risk Register
- Equality and inclusion updates
- Patient stories
- Never events and serious incidents
- Quality Strategy
- Workforce Race Equality Standard Report

The committee membership is made up of:

- Secondary Care Doctor (chair)
- Lay Member for Patient and Public Involvement (deputy chair)
- Chief Nursing and Quality Officer
- Director of Outcome Based Contracting
- Deputy Director of Quality
- Head of Nursing and Safeguarding
- Head of Performance
- GP Chair

From 1 April – 30 June 2022, the committee met two times. Membership attendance is detailed in the table below, and demonstrates that each meeting of the committee was quorate with good attendance from members. The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required.

The Integrated Quality, Safeguarding and Performance committee membership attendance is detailed below from 1 April – 30 June 2022.

Name	Title	03/05/2022	07/06/2022	Total	Percentage
Janet Gray (Chair)	Lay Member Patient and Public Involvement	1	0	1	50%
Sam Turner (Deputy Chair)	Lay Member for Finance and Planning	0	1	1	50%

Angela Dempsey	Chief Nurse and Quality Officer	1	1	2	100%
Rachel Holloway	Head of Performance	1	1	2	100%
Gabriella O'Keefe	Interim Deputy Director of Quality	1	1	2	100%
Sarah Stansfield	Director of Outcomes Based Contracting	1	1	2	100%
Tracy Keats	Interim Head of Safeguarding	1	0	1	50%
Dr Joanne Watt	GP Chair	1	1	2	100%
Vacant	Secondary Care Doctor	NA	NA	NA	NA
Committee meeting quoracy		**Yes**	**Yes**		

Quality objectives

The Quality Priorities (objectives) were published on the CCG website in 2020. The priorities cover the period from 2020 until the CCG was disestablished on 30th June 2022.

Finance, Procurement and Contracting committee

The Finance, Procurement and Contracting committee monitors contract activity, performance and budgets and makes recommendations to the Governing Body regarding achievement of financial and performance objectives. The committee also makes recommendations on business cases for the delivery of new investments.

The Finance, Procurement and Contracting Committee supported the establishment of the Shadow ICB Integrated Planning and Resources Committee.

Matters considered by the committee in Quarter 1 of 2022/23 included but were not limited to the following:

- Financial reporting
- Contracting and performance reporting

- Procurement activity and assurance reporting
- Planning update
- Financial allocations and financial plan
- Consideration of financial and procurement risks

The committee membership is made up of the following:

- Lay Member for Finance and Planning (chair)
- Lay Member for Primary Care (deputy chair)
- Lay Member for Audit and Governance
- Chief Finance Officer
- Director of Outcome Based Contracting
- Governing Body Clinical Representative

From 1 April – 30 June 2022 the committee met three times. Membership attendance is detailed in the table on the next page and demonstrates that each meeting of the committee was quorate with good attendance from members.

The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required.
The Finance, Procurement and Contracting committee membership attendance is detailed below from 1 April – 30 June 2022.

Name	Title	05/04/2022	03/05/2022	07/06/2022	Total	Percentage
Sam Turner	Lay Member for Finance and Planning (Chair)	1	1	1	3	100%
Andrew Hammond	Lay Member for Primary Care (Deputy Chair)	1	1	1	3	100%
Stuart Rees	Chief Finance Officer	1	1	1	3	100%
Sarah Stansfield	Director of Outcome Based Contracting	1	1	1	3	100%
Dr Philip Stevens	Locality Chair South Northants and Daventry	1	1	1	3	100%
Graham Felston	Lay Member for Audit and Governance	1	1	1	3	100%
Alison Gilbert	Director of Transformation Delivery	1			1	100%

Janet Gray	Lay Member for Patient and Public Involvement	1	1	1	3	100%
Committee meeting quoracy		**Yes**	**Yes**	**Yes**		

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance; however, the CCG draws upon best practice available, including those aspects of the UK Code of Corporate Governance that we consider relevant to the CCG and best practice. We comply with the key principles of the code, which set out good practice in the areas of leadership, effectiveness, accountability, remuneration and relationships with key stakeholders.

Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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 CCG's statutory duties.

Risk management arrangements and effectiveness

The CCG is committed to having a risk management culture that underpins and supports the business of the CCG. The CCG's Risk Management and Governing Body Assurance Policy sets out managing risk, identifies accountability arrangements, resources available and provides guidance on what may be regarded as acceptable risk within the CCG. The policy recognises that for the CCG to successfully manage risk, the CCG must:

- Identify and assess risks
- Take action to anticipate or manage risk

- Monitor and regularly review risk to assess for the potential for further action
- Ensure effective controls and contingencies are in place

Risk management is part of the strategic planning process and managed operationally through a robust process of governance around decision-making, set out in the organisation's scheme of delegation. Staff have received training and support through group training and focussed one to one sessions, especially with those responsible for maintaining risk registers. All employees are encouraged to highlight risks and report incidents and are provided with risk management training as required within their roles.

The Governing Body and employees receive training in Equality and Diversity, and Equality and Human Rights considerations are included in the development of all strategies, policies and business cases to ensure impacts on protected groups are understood and taken into account when making decisions.

The Local Counter Fraud Specialist ensures awareness and provides training for the organisation as a deterrent to fraud risks arising. Further detail on counter fraud arrangements can be found later in this report. During Quarter 1 of 2022/23 the Counter Fraud Risk Register was further maintained in line with national guidelines and incorporates all business areas.

The Governing Body are accountable and responsible for ensuring that the CCG has an effective programme of managing all types of risks, which is achieved via review of the GBAF that reflects strategic risks and the Corporate Risk Register (CRR) that identifies high scoring operational risks.

In the first quarter of 2022/23, the CCG has continued to ensure an effective risk management process is in place, and the Governing Body continues to recognise risk management as an important development area to improve internal controls and its own effectiveness, particularly in light of the internal audit findings during the financial year and the Head of Internal Audit Opinion received.

Each Directorate is responsible for reviewing and maintaining their risk register on a regular basis, ensuring that the risk register accurately and appropriately reflects the level of risk, the actions taken to manage the risks and records the effectiveness of controls and the level of assurance that can be given. The Directorate Risk Registers are usually reviewed by the Audit and Risk committee on a rolling annual basis, with the relevant executive risk lead in attendance at the committee to provide assurance and undertake scrutiny and challenge from the committee. In the first quarter of 2022/23 the impact of the pandemic has continued to interrupt the process but this is currently being brought back on track. The Directorate Risk Registers are reviewed in light of the CRR to ensure that risks are escalated appropriately. The Directorate Risk Registers are all linked to relevant committees.

Risk Management reporting was undertaken to the Audit and Risk Committee and Governing Body through formal reporting, led by the Chief Finance Officer with support from Executive colleagues, setting out the key prevailing risks facing the CCG. The reporting of risk focussed on the delivery of the agreed CCG's corporate objectives and CCG and system response to the COVID-19 pandemic. In addition and to support the identification, management and assurance of risks each agenda item presented to the Governing Body ensured that the executive summary highlighted the prevailing risks for that item and where no risk was identified the report provided assurance of this to the relevant meeting.

The CCG's Corporate Objectives are set out below, each of the five priority deliverables is supported by a number of workstreams against which the CCG has sought to allocate resources.

Capacity to handle risk

In 2022/23 the CCG has continued to maintain the management of risk as detailed above. The Governing Body continues to recognise risk management as an important development area to improve internal controls and its own effectiveness.

Risk assessment

The CCG's Risk Management and Governing Body Assurance Policy clearly sets out how to assess risk. The policy and documentation ensures that each risk has a clearly identified executive risk lead, who is supported by the relevant clinical executive linked to that area. Each strategic risk is mapped to the corporate objective to which is relates.

As previously noted, the GBAF comprises the CCG's strategic risks, which would impact the whole organisation and the achievement of the CCG's objectives. The most significant operational risks, which are identified from key business activity at an operational level, which would have an impact upon the whole organisation from an operational point of view, are managed via the CRR.

Other sources of assurance

Internal control framework

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

The Audit and Risk committee has oversight of the internal control mechanisms on behalf of the Governing Body. Executive Directors oversee the management and delivery of internal control mechanisms. The Audit and Risk committee bases its assessments, and therefore assurances, on the effectiveness of the CCG's controls on assurances provided by the Governing Body and committees' work programmes;

- Review of the GBAF which provides an oversight of the effectiveness of controls in place to manage the CCG's principle risks
- Reviews of CCG policies and procedures
- Provision of assurance from internal and external audit and other identified sources of assurance the committees of the Governing Body oversee the management and delivery of the internal control mechanisms.

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 and its members recognise the importance of managing conflicts of interest. Accordingly, a register of interests is maintained and updated regularly. A copy of the register of interests is available on the CCG's website. All meeting agendas of the Governing Body and committees include guidance and definitions of interests and time is allocated at the start of each meeting for such declarations to be made.

Control measures are in place to ensure that all of the CCG's obligations under equality, diversity and human rights legislation are complied with.

Annual audit of conflicts of interest management

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

The CCG undertook its annual conflict of interest audit in December 2021, which resulted in a substantial assurance opinion. The implementation of the audit recommendations has been reported to the Audit and Risk committee in April 2022, as part of the audit implementation oversight of the committee.

Data quality

Information used by the Governing Body and its committees enables the CCG to carry out our responsibilities and discharge our statutory functions. This information relates to operational, financial, performance, quality and patient experience.

The Governing Body and its committees are committed to improving the quality of the information received. There has been an improvement in the quality of data received and the Governing Body has taken action to continue to improve this position.

Information governance

All organisations that have access to NHS patient data and systems must complete the Data Security and Protection Toolkit (DSPT); an online self-assessment tool that enables health and social care organisations to measure and publish their performance annually against the National Data Guardian's (NDG) ten data security standards. By providing evidence and judging that they meet the mandatory assertions, organisations demonstrate that they are practising good data security and that personal information is handled in line with national standards within their organisation.

We have an established Data Security and Protection Management Framework and have developed processes and procedures in line with the DSPT. We place high importance on ensuring there are robust data security and protection systems and processes in place to help protect patient and corporate information alike and as such these processes are under continued review.

We recognise that having technical and operational security mechanisms in place to protect the data we process goes a long way however, it is

essential that we ensure the same level of rigour is placed on our staff. All staff are therefore required to undertake annual information governance training to ensure their awareness of data security and protection roles and responsibilities.

The Information Governance Working Group (IGWG) supports and drives the broader data security and protection agenda and provides the Audit and Risk committee and ultimately the Governing Body with the assurance that effective data security and protection best practice mechanisms are in place within the organisation.

There are vigorous processes in place for incident reporting and investigation of serious incidents that have been developed in collaboration with other services to provide greater assurance. We have strengthened our information risk assessment and management procedures, and a programme has been established to continue to fully embed an information risk culture throughout the organisation against identified risks.

Business critical models

In the Macpherson report 'Review of Quality Assurance of Government Analytical Models' published in March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance Framework is in place and is used for all business-critical models. Business critical models were deemed to be analytical models that informed government policy. The CCG can confirm that in the first quarter of 2022/23 it has not developed any analytical models, which have informed government policy.

The CCG receives Service Auditor Reports on the business-critical systems operated by organisations that provide services to the CCG, which includes Shared Business Services, the North East London Commissioning Support Unit (NELCSU) and Arden GEM Commissioning Support Unit. This enables the CCG to place reliance on the quality controls established relating to the business-critical systems and models delivered through the Service Level Agreement in place for the first quarter of 2022/23. Further detail is described below.

Third party assurances

The CCG relies on the NELCSU as a third-party provider of commissioning support services. CSUs are part of NHSE/I and therefore the CCG relies on NHSE/I-led internal and external audit of CSUs. The CCG holds quarterly contract performance meetings with NELCSU.

Control issues

The Head of Internal Audit Opinion has identified that the organisation *has an adequate and effective framework for risk management, governance and internal control.*

However, the work of the Head of Internal Audit has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. This is further detailed in the Head of Internal Audit Opinion Section of the Governance Statement further on.

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

The CCG successfully managed its financial allocation throughout 2021/22 and into Quarter 1 of 2022/23. The Financial Strategy and Budgets for 2021/22 were considered and approved by the Governing Body at the start of the financial year of 2021/22, alongside the strategic and operational plans for the CCG.

The CCG has an established system of financial control, which is led by the Chief Finance Officer with oversight from the Finance, Procurement and Contracting committee, the Audit and Risk committee and the Governing Body. The Finance, Procurement and Contracting committee considers financial risks, including risk opportunities, which are reported to the Governing Body via the Finance Report and risks are detailed within the Governing Body Assurance Framework. This process is supported by the CCG's prime and detailed financial policies. Matters of concern are reviewed by the Governing Body and assurance sought. Full copies of the Governing Body papers can be found on the CCG website.

The Chief Finance Officer and the Finance Team have worked closely with managers throughout the year to ensure that a robust annual budget has been prepared and delivered. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. The processes to achieve this are examined by internal and external audit as part of their annual activities, with a focus on the strategic risks and key financial control processes. The CCG also ensures that an annual fraud risk assessment is undertaken by an independent party, providing key actions. Further detail on the counter fraud arrangements can be found later in this report.

NHSE/I has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The CCG does not yet have a CCG Improvement and Assessment Framework (IAF). The last assessment undertaken was in 2019/20 for which the two former CCGs NHS

Corby CCG and NHS Nene CCG were both rated as good for the CCG (IAF) 2019/20. More detail on the individual indicators is available via the NHSE/I website. Further detail with regards to the CCG's performance can be found in the Performance Report of this annual report.

The CCG also works closely with health and social care providers and partners to achieve financial balance and sustainability across the Northamptonshire health and social care economy. The CCG works with our Regulators and Trusts to gain assurance on processes to address areas of poor performance, the standard NHS contracts used with providers include detailed financial, activity and quality schedules and require providers to innovate to improve quality and efficiency. More detail of delivery of key performance indicators and constitutional standards are detailed within the Performance Report of this annual report.

Delegation of functions

The CCG undertakes a regular process of review of its internal control mechanisms, including an annual internal audit plan. All internal audit reports are agreed by senior officers of the CCG and reviewed by the Audit and Risk Committee.

A review of the effectiveness of the CCG governance structure and processes has been undertaken during the year, including a review of each committee's terms of reference. This has formed part of the work undertaken to further strengthen the good governance arrangements in place within the CCG, learning from the two former CCGs to streamline the CCG's governance arrangements as much as possible to make best use of resources and senior leadership's time.

The CCG ensures that where functions are delegated either internally or externally, that this is done in line with the CCG's Scheme of Reservation and Delegation, which sets out the decisions that are the responsibility of the Governing Body and its committees, alongside the decisions that are delegated to individual members and employees.

Where functions are formally delegated by the Governing Body to one of its sub-committees, this is formally recorded by the Governing Body through the minutes, which are presented as a true and accurate record of the meeting.

Counter fraud arrangements

The Counter Fraud service for the CCG is provided by RSM UK, who supply a dedicated Local Counter Fraud Specialist (LCFS) to deliver an on-going

programme of work to counter fraud, bribery and corruption. This in line with the NHS Counter Fraud Authority (NHSCFA) requirements, which have been interpreted from 'Government Functional Standard 013: Counter Fraud', as applicable for NHS bodies. The programme is designed to ensure our staff are fully aware of the fraud and bribery risks that the organisation faces and how to report concerns, as well as ensuring relevant preventative and detection exercises are undertaken to mitigate those risks. The Chief Finance Officer provides executive leadership and responsibility for the programme.

During 2022/23 (Quarter 1), the LCFS has conducted a variety of tasks, ranging from awareness initiatives through to undertaking fraud detection exercises and reviews of the CCG's Counter Fraud Risk Register, which spans all key business areas.

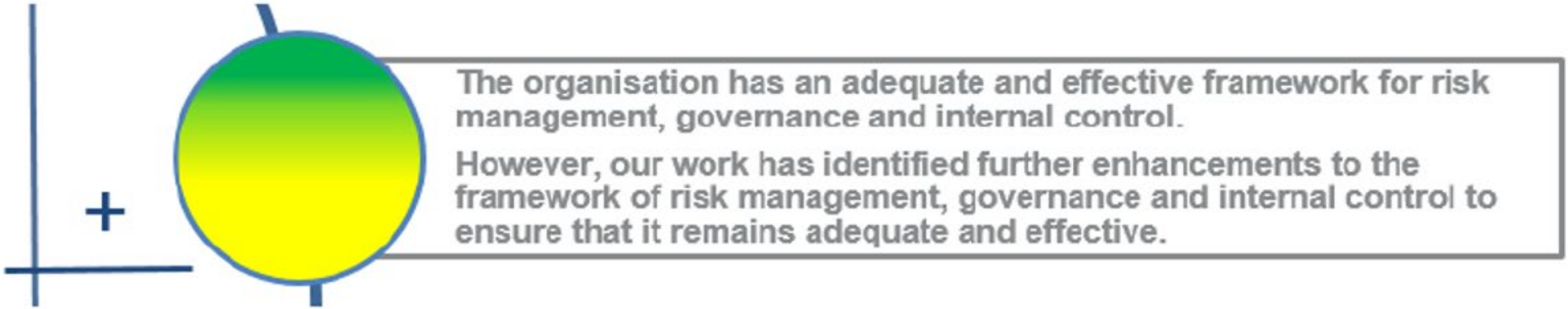
The Audit and Risk committee receives regular progress updates on the delivery of the counter fraud work plan and an annual report which summarises activity undertaken during the period. The CCG also completes an annual counter fraud functional standard return (CFFSR) which is a self-assessment against the Government Functional Standard NHSCFA requirements to monitor compliance and address any areas of identified risk.

Head of internal audit opinion

This report provides a three-month internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

The opinion takes into consideration the framework in place in the period up to and including 30 June 2022; and RSM UK's cumulative knowledge of Northamptonshire CCG. The opinion does not consider the arrangements of the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP).

For the three months ended 30 June 2022, the head of internal audit opinion for Northamptonshire CCG is as follows:



Scope and limitations of our work

The formation of the opinion is achieved through a risk-based plan of work, agreed with management and approved by the Audit committee. The opinion is subject to inherent limitations, as detailed below:

- Internal audit has reviewed all risks and assurances relating to the organisation
- The opinion is substantially derived from the conduct of risk-based plans generated from a robust organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS)
- The opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with the management/lead individual
- Where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance
- Due to the limited scope of the audits, there may be weaknesses in the control system with RSM UK are not aware of, or which were not brought to their attention, and
- Our opinion is limited to the internal audit work for the three-month period of 1 April 2022 to 30 June 2022; it also takes into consideration the cumulative knowledge of the client

Factors and findings which have informed the draft opinion:

RSM UK have issued two reports with a substantial assurance (positive) opinion, these being:

- CCG close down and ICB establishment due diligence checklist
- Additional roles reimbursement scheme (Draft)

We have issued no “minimal assurance” opinions or “partial assurance” (negative) opinions.

There are no issues identified from RSM UK’s work that the CCG should consider as part of the annual governance statement. However, the CCG may also wish to consider whether any other issues have arisen, including the results of any external reviews which it might consider for inclusion in the Annual Governance Statement.

Below is a table of the audits completed to date and their assurance levels:

Audit Area	Assurance Level
CCG Close Down and ICB Establishment Due Diligence Checklist	Substantial assurance
Additional Roles Reimbursement Scheme (Draft)	Substantial assurance

Approval of Annual Accounts and Annual Report

The Audit and Risk Committee held on 15 June 2023 received the Letter of Representation and noted that other than the standard disclosures the CCG were not asked to make any further disclosures. At the meeting of the Board meeting of the NHS Northamptonshire Integrated Care Board held on 22 June 2023 the annual accounts and annual report for the period 1 April – 30 June 2022 were received and approved.

Accountable Officer: 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 CCG, 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 CCG achieving its principles objectives have been reviewed.

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

- Governing Body
- Audit and Risk committee
- Internal audit
- Assurance mechanisms including the Governing Body Assurance Framework (GBAF) and quality assurance processes

In the second year of operation as a single CCG for Northamptonshire, the CCG has continued to develop governance maturity. I am satisfied that the CCG has developed appropriate plans to address weaknesses through the continued development programme.

Conclusion

As the Accountable Officer, and based on the review processes outlined above, I can confirm that the Governance Statement is a balanced reflection of the actual control position within the CCG, apart from those issues raised under the Head of Internal Audit Opinion.

Toby Sanders

Chief Executive (Accountable Officer)

NHS Northamptonshire CCG

Remuneration and staff report

As a commissioner of health services, the CCG believes health and wellbeing applies as much to our employees as it does to our local population.

During 2021/22 and under the shadow of the COVID-19 pandemic, we have continued to remain fully committed to the health and positive wellbeing of our employees and understand that the health and wellbeing of the workforce is crucial to the delivery of the improvements in-patient care of local people.

Remuneration report

Remuneration Committee

More information about the committee, including attendance, is available on pages 102 - 103

Policy on the remuneration of senior managers

NHS Northamptonshire CCG's remuneration policy sets out the organisation's policy for directors, senior managers and other staff. Where necessary we follow the recommendations of the Senior Salaries Review Body on senior managers' pay. This includes information about:

- Exit packages, severance packages and off payroll engagements
- Compensation on early retirement or for loss of office
- Payments to past directors
- Pay multiples
- Other staff information (numbers, composition, sickness absence data, consultancy, etc.). Staff policies for giving full and fair consideration for the application, employment and ongoing training/career development of disabled persons

Remuneration of very senior managers

The CCG has established a Remuneration and Terms of Service Committee to approve the remuneration and terms of service for the executive directors, other staff on very senior manager (VSM) pay terms and conditions and other appointments to the CCG governing body. The Committee also approves the pay rates offered to clinicians that work for the CCG on a contract for services basis. It was established under the Constitution and operates within terms of reference approved by our governing body.

Senior manager remuneration (including salary and pension entitlements)

The NHS Northamptonshire CCG includes members (directors) of the Corporate Management Team (CMT) in the Remuneration Report as well as the governing body members. The CCG believes in complete openness and as important decisions are taken at CMT it is considered appropriate to include CMT members in the Remuneration Report.

Salary and allowances (subject to audit)

The NHS Northamptonshire CCG includes members (Directors) of the Corporate Management Team (CMT) in the Remuneration Report as well as the Governing Body members. The CCG believes in complete openness and as important decisions are taken at CMT it is considered appropriate to include CMT members in the Remuneration Report.

April 2022 – June 2022	Salary (bands of £5,000) £000	Expense Payments (Taxable) to nearest £100 £	Performance Pay and Bonuses (bands of £5,000) £000	Long Term Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Julie Curtis - Director of Primary & Community Integration	35 - 40	0	0	0	0	35 -40
Angela Dempsey - Chief Nurse & Quality Officer	30 - 35	0	0	0	52.5 - 55	80 - 85
Chris Ellis - Locality Chair for Wellingborough & East Northants	5 - 10	0	0	0	0	5 - 10
Graham Felston - Lay Member for Audit & Governance	0 - 5	0	0	0	0	0 - 5
Ammar Ghouri - Locality Chair for Kettering & Corby	5 - 10	0	0	0	0	5 - 10
Alison Gilbert - Director of Transformation Delivery	30 - 35	0	0	0	0	30 - 35
Andrew Hammond - Lay Member for Primary Care	5 - 10	0	0	0	0	5 - 10
Stuart Rees - Chief Finance Officer	30 - 35	0	0	0	20 - 22.5	50 - 55
Toby Sanders - Chief Executive	40 - 45	0	0	0	22.5 - 30	65 - 70
Darin Seiger - Locality Chair for Northampton	5 - 10	0	0	0	0	5 - 10
Sarah Stansfield - Director of Outcome Based Contracting and Deputy Chief Executive	35 - 40	0	0	0	20 - 22.5	60 - 65
Philip Stevens - Locality Chair for Daventry & South Northants	20 - 25	0	0	0	0	20 - 25
Sam Turner - Lay Member for Finance & Planning	0 - 5	0	0	0	0	0 - 5
Joanne Watt - GP Chair	15 - 20	0	0	0	0	15 - 20

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.

April 2021 – March 2022	Salary (bands of £5,000) £000	Expense Payments (Taxable) to nearest £100 £	Performance Pay and Bonuses (bands of £5,000) £000	Long Term Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Julie Curtis - Director of Primary & Community Integration	115 - 120	0	0	0	0	115 - 120
Angela Dempsey - Chief Nurse & Quality Officer	125 - 130	0	0	0	27.5 - 30	150 - 155
Chris Ellis - Locality Chair for Wellingborough & East Northants	25 - 30	0	0	0	0	25 - 30
Graham Felston - Lay Member for Audit & Governance	10 - 15	0	0	0	0	10 - 15
Ammar Ghouri - Locality Chair for Kettering & Corby	25 - 30	0	0	0	0	25 - 30
Alison Gilbert - Director of Transformation Delivery	125 - 130	0	0	0	0	125 - 130
Andrew Hammond - Lay Member for Primary Care	10 - 15	0	0	0	0	10 - 15
Julie Lemmy - Interim Director of Primary & Community Integration	50 - 55	0	0	0	35 - 37.5	85 - 90
Bev Messinger - Lay Member for Patient & Public Involvement and Lay Deputy Chair	20 - 25	0	0	0	0	20 - 25
Stuart Rees - Chief Finance Officer	125 - 130	0	0	0	35 - 37.5	160 - 165
Toby Sanders - Chief Executive	160 - 165	0	0	0	75 - 77.5	235 - 240
Darin Seiger - Locality Chair for Northampton	25 - 30	0	0	0	0	25 - 30
Sarah Stansfield - Director of Outcome Based Contracting and Deputy Chief Executive	135 - 140	0	0	0	40 - 42.5	175 - 180
Philip Stevens - Locality Chair for Daventry & South Northants	25 - 30	0	0	0	0	25 - 30
Sam Turner - Lay Member for Finance & Planning	10 - 15	0	0	0	0	10 - 15
Joanne Watt - GP Chair	60 - 65	0	0	0	0	60 - 65
Lucy Wightman - Director of Population Health Strategy (Note 1)	45 - 50	0	0	0	0	45 - 50

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Note 1: Lucy Wightman was employed by North Northamptonshire Council and as such the CCG was recharged 35% of salary costs. The salary figure included in the table above reflects the costs attributable to NHS Northamptonshire CCG with total costs shown in the second table below.

Total costs	Salary (bands of £5,000) £000	Expense Payments (Taxable) to nearest £100 £	Performance Pay and Bonuses (bands of £5,000) £000	Long Term Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Lucy Wightman - Director of Population Health Strategy	125 - 130	0	0	0	0	125 - 130

Staff costs (subject to audit)

	M1 to M3 2022-23			2021-22		
	Permanent Employees	**Other**	**Total**	Permanent Employees	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Salaries and wages	2,244	94	**2,338**	7,531	689	8,219
Social security costs	271	11	**282**	840	49	889
Employer contributions to the NHS Pensions Scheme	383	4	**387**	1,275	30	1,305
Other pension costs	2	0	**2**	6	0	6
Apprenticeship levy	8	0	**8**	23	0	23
Termination benefits	328	0	**328**	27	0	27
Gross employee benefits expenditure	**3,235**	**109**	**3,344**	9,701	768	10,469
Less: recoveries in respect of employee benefits	0	0	**0**	0	0	0
Net employee benefits expenditure including capitalised costs	**3,235**	**109**	**3,344**	9,701	768	10,469
Less: employee costs capitalised	0	0	**0**	0	0	0
Net employee benefits expenditure excluding capitalised costs	**3,235**	**109**	**3,344**	9,701	768	10,469

Pension benefits (subject to audit)

2022-23	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 30 June 2022	Lump sum at pension age related to accrued pension at 30 June 2022	Cash Equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Julie Curtis - Director of Primary & Community Integration	Opted out							
Angela Dempsey - Chief Nurse & Quality Officer	2.5 - 5	5 - 7.5	15 - 20	40 - 45	333	53	393	0
Chris Ellis - Locality Chair for Wellingborough & East Northants	Non pensionable							
Graham Felston - Lay Member for Audit & Governance	Non pensionable							
Ammar Ghouri - Locality Chair for Kettering & Corby	Non pensionable							
Alison Gilbert - Director of Transformation Delivery	Opted out							
Janet Gray - Lay Member for Patient & Public Involvement	Non pensionable							
Andrew Hammond - Lay Member for Primary Care	Non pensionable							
Stuart Rees - Chief Finance Officer	0 - 2.5	0 - 2.5	45 - 50	85 - 90	856	21	889	0
Toby Sanders - Chief Executive	0 - 2.5	0 - 2.5	40 - 45	70 - 75	629	17	657	0
Darin Seiger - Locality Chair for Northampton	Non pensionable							
Sarah Stansfield - Director of Outcome Based Contracting and Deputy Chief Executive	0 - 2.5	0	25 - 30	0	265	9	282	0
Philip Stevens - Locality Chair for Daventry & South Northants	Non pensionable							
Sam Turner - Lay Member for Finance & Planning	Non pensionable							
Joanne Watt - GP Chair	Non pensionable							

2021-22	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Julie Curtis - Director of Primary & Community Integration	Opted out							
Angela Dempsey - Chief Nurse & Quality Officer	0 - 2.5	0 - 2.5	15 - 20	30 - 35	292	22	333	0
Chris Ellis - Locality Chair for Wellingborough & East Northants	Non pensionable							
Graham Felston - Lay Member for Audit & Governance	Non pensionable							
Ammar Ghouri - Locality Chair for Kettering & Corby	Non pensionable							
Alison Gilbert - Director of Transformation Delivery	Opted out							
Andrew Hammond - Lay Member for Primary Care	Non pensionable							
Julie Lemmy - Interim Director of Primary & Community Integration	0 - 2.5	0 - 2.5	25 - 30	15 - 20	398	29	470	0
Bev Messinger - Lay Member for Patient & Public Involvement and Lay Deputy Chair	Non pensionable							
Stuart Rees - Chief Finance Officer	2.5 - 5	0 - 2.5	45 - 50	85 - 90	798	37	856	0
Toby Sanders - Chief Executive	2.5 - 5	2.5 - 5	35 - 40	70 - 75	549	54	629	0
Darin Seiger - Locality Chair for Northampton	Non pensionable							
Sarah Stansfield - Director of Outcome Based Contracting and Deputy Chief Executive	2.5 - 5	0	25 - 30	0	230	14	265	0
Philip Stevens - Locality Chair for Daventry & South Northants	Non pensionable							
Sam Turner - Lay Member for Finance & Planning	Non pensionable							
Joanne Watt - GP Chair	Non pensionable							
Lucy Wightman - Director of Population Health Strategy	n/a							

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. The CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

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

Compensation on early retirement of for loss of office (subject to audit)

Nil

Payments to past members (subject to audit)

Nil

Percentage change in remuneration of highest paid director (subject to audit)

Reporting bodies are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director.

The table on the next page discloses the percentage change of the mid point Salary & Allowances and Performance Pay & Bonus of the highest paid Director of NHS Northamptonshire CCG. This is compared to the percentage change of the CCG's workforce. Total workforce includes both directly employed staff and staff employed through employment agencies.

	2022-23		2021-22	
	Percentage change for highest paid director	Percentage change for employees as a whole	Percentage change for highest paid director	Percentage change for employees as a whole
Salary and allowances	6.15%	-4.75%	3.17%	1.23%
Performance pay/bonuses	0.00%	0.00%	0.00%	0.00%

The percentage increase for the highest paid director reflects the establishment and recruitment to of designate senior manager role for the ICB which is due to be established on 1 July 2022. This is in line with NHS England and NHS Improvement guidance on the appointment of senior roles for the ICB.

The percentage decrease for employees reflects the reduction in specialist agency staff that has reduced the average salary and allowances for employees when comparing 2022-23 average to 2021-22.

Pay ratios (subject to audit)

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

The banded remuneration of the highest paid director in NHS Northamptonshire CCG in the financial year 2022-23 was £170,000 to £175,000 (2021-22: £160,000 to £165,000). The relationship of the organisation's workforce is disclosed in the table on the next page.

	25th Percentile	Median	75th Percentile
2022-23			
Total Remuneration (£)	£39,027	£49,975	£68,216
Salary Component of Total Remuneration (£)	£39,027	£49,975	£68,216
Pay Ratio Information	4.42 : 1	3.45 : 1	2.53 : 1
2021-22			
Total Remuneration (£)	£39,027	£53,219	£81,074
Salary Component of Total Remuneration (£)	£39,027	£53,219	£81,074
Pay Ratio Information	4.16 : 1	3.05 : 1	2 : 1

In 2022-23, no employee (2021-22: 0) received remuneration in excess of the highest-paid Director. Remuneration ranged from £21,777 to £163,043 (2021-22: £368 to £136,236).

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.

Staff report

Number of senior managers

The CCG employs a total of 185 staff. On 30 June 2022, Northamptonshire CCG had 6 senior managers at VSM grade.

Number of senior managers

Gender	Count	%
Female	4	67
Male	2	33

(The tables includes those at VSM level who routinely attend Governing Body meetings)

Governing body members

Gender	Count	%
Female	4	33
Male	8	67

(This number includes six members of staff (two males and four females) who are also included in the senior managers table above)

Other employees (excluding staff in the two tables on the previous page)

Gender	Count	%
Female	125	78
Male	36	22

(Please note this table only includes staff on bands 3 to 8D and does not include the 10 GPs that support the CCG)

Staff composition

As at 30 June 2022, the distribution of Northamptonshire CCG's staff as per the NHS Digital NHS Occupational Code Manual is as follows. This table is subject to audit.

Staff group	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Ad hoc Salary	VSM	Grand Total
Add Prof Scientific and Technic			1	11		5	8					25
Additional Clinical Services												
Administrative and Clerical	2	8	16	16	20	18	18	12	9	4	5	128
Allied Health Professionals												
Medical and Dental										14		14
Nursing and Midwifery Registered				2	6	3	3	3			1	18
Grand Total	**2**	**8**	**17**	**29**	**26**	**26**	**29**	**15**	**9**	**18**	**6**	**185**

Sickness absence data

The following tables outline Northamptonshire CCG's sickness absence data from 1 April 2022 to 30 June 2022

Month	Long-term absence Full Time Equivalent (FTE) %	Short-term absence FTE %
2022 / 04	2.20%	1.05%
2022 / 05	2.72%	0.32%
2022 / 06	2.79%	0.76%

Labour turnover rate

Staff group	Average headcount	Avg FTE	Starters headcount	Starters FTE	Leavers headcount	Leavers FTE	LTR headcount %	LTR FTE %
Add Prof Scientific and Technic	23.00	16.28	0	0	0	0	0%	0%
Additional Clinical Services	1.00	0.90	0	0	0	0	0%	0%
Administrative and Clerical	129.00	120.61	27	2.00	1	0.50	0.78%	0.41%
Allied Health Professionals	0.50	0.50	0	0	1.000	1.0000	200.00%	200.00%
Medical and Dental	14.00	3.89	0	0	4	1.00	28.57%	25.69%
Nursing and Midwifery Registered	17.00	15.80	0	0	0	0	0%	0%

Staff polices

The Workforce Disability Equality Standard (WDES) introduced in 2019, is a data-based standard that uses a series of measures (10 metrics) to compare the experiences of disabled and non-disabled staff in the NHS. Results of the annual NHS staff survey show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities. The purpose of the WDES is to improve the experience of disabled staff working in, and seeking employment in, the NHS.

CCGs and sustainability and transformation plans (STPs) were required to publish their first WDES results by August 2021 and to develop action plans to address the differences highlighted by the metrics with the aim of improving workforce disability equality. In preparation of publishing the CCG's first WDES report, we have been raising awareness of the WDES, improving disability declaration rates on Employee Staff Records (ESR) encouraging line managers to start conversations with staff as part of the NHS People Plan recommendation, encouraging staff to complete the NHS Staff Survey and setting up WDES engagement with the Age and Ability Staff Champions group.

Northamptonshire CCG produced their first WDES report with action planning and published it on the website on 30 October 2021. WDES 2020/21 report captures a wealth of information which demonstrates how we in NHS Northamptonshire CCG are performing against the standard and the action plans in place to improve the metrics. As part of drawing up the plan we have considered best practice examples from other NHS employers. We are in process of producing our next WDES report 2021/22 that will be published on Website in October 2022.

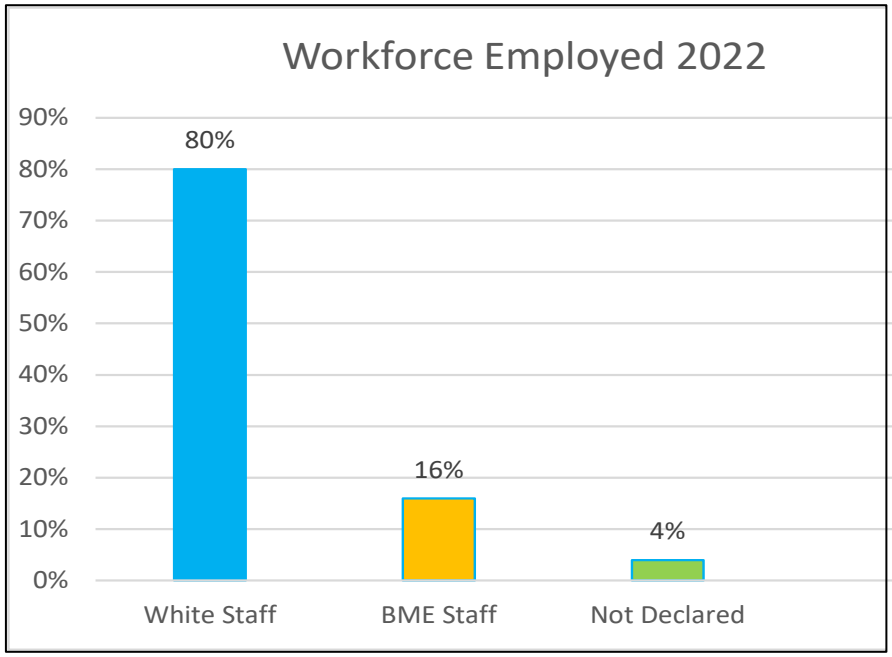
Positive about disability in the workplace

As an employer, NHS Northamptonshire CCG demonstrates a positive commitment to disabled employees and continues to be a recognised Disability Confident Employer. This is an annual accreditation given by the Department for Work and Pensions that provides assurance the CCG welcomes applications from disabled people, and existing staff who have disabilities will have their Reasonable Adjustments reviewed and assessed. We

currently have eight employees who are declared disabled, this is the same number as 2020/21 (the first year NHS Northamptonshire CCG was established, and information is comparable).

NHS Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard (WRES) highlights the differences between the experience and treatment of white and black, Asian and minority ethnic (BAME) staff with the aim of closing any identified gaps. The WRES requires NHS organisations to demonstrate progress against nine race equality indicators.



Evidence shows a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations. The chart above gives a breakdown of our staff in terms of ethnic origin. In 2021/22 16% of the workforce were categorised as being from a BAME community which is a slight decreased on 2020/21 which had 16.91% of the workforce categorised from a BAME community. 19% BME staff were appointed from shortlistings that is significantly higher than the local BME community representation.

Under the NHS Standard Conditions of Contract April 2017/18, all NHS providers holding contracts over £200,000 must implement the Workforce Race Equality Standard (WRES), which is a benchmarking tool to assess an organisation's progress around race equality.

CCGs must show 'due regard' to the WRES as well as monitor providers on their results. Implementation of the WRES was also reviewed as part of the 'Well-Led' domain of the CCG Improvement and Assessment Framework.

Northamptonshire CCG has gathered data against the nine WRES metrics for the fifth year in 2021. The data was uploaded on the national Strategic Data Collection Service (DCS) platform and a report with action planning was published on Northamptonshire CCG's website on 30 October 2021.

Using the WRES indicators as a basis, we will report on progress with regard to WRES and closing the gaps and differences of treatment, experiences and outcomes of white and black and minority ethnic (BME) staff. We will continue to work with NHS provider organisations to seek assurance of effective implementation of WRES and progress against action plans.

Northamptonshire CCG WRES Action Plan 2021-22

The action plan has four key actions which aim to reduce inequality, benchmark performance and ensure that interventions are taken to address unfair access to training, mentoring or progression. The CCG continues to make good progress and the current action plan with WRES report is published on CCG's website. WRES report and action planning for 2022 will be published on website in September 2022

Trade union facility time reporting requirements

Under the Trade Union (Facility Time Publication Requirements) regulations 2017, the CCG is required to publish the following information as laid out in Schedule 2 of the regulations.

Table 1: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
X	X

Table 2: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	X
1%-50%	X
51%-99%	X
100%	X

Table 3: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£X
Provide the total pay bill	£X
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	%X

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	%X

Freedom to Speak Up arrangements

The CCG operates a Freedom to Speak Up Policy across the organisation. As part of this policy a Speak Up Guardian is in place, which is Sarah Stansfield, Deputy Chief Executive. This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the Chief Executive, or if necessary, outside the organisation. To date there have been no reports from staff under this policy.

Bullying, harassment and victimisation policy

NHS Northamptonshire CCG is committed to creating a work environment free of harassment, bullying and victimisation for all employees (including those with a protected characteristic) and where everyone is treated with dignity and respect. The CCG believes that harassment, bullying and victimisation at work in any form is completely unacceptable and will not be tolerated, and all allegations are investigated and, if appropriate disciplinary action will be taken.

The CCG does not tolerate victimisation of a person for making the allegations of bullying and harassment in good faith or supporting someone to make such a complaint, and will take the necessary steps to achieve this aim. In addition, the CCG will investigate vigorously any allegations of

bullying, harassment or victimisation regardless of whether the matter has been raised formally or informally. Our policy is designed to ensure that any complaints of bullying, harassment or victimisation are dealt with objectively, quickly, sensitively, and confidentially.

Other employee matters

Health and safety

The health and safety of CCG staff is fundamental to the delivery of our vision and objectives. To ensure the CCG has the appropriate level of expertise in this area, the role of Competent Person for Health and Safety is undertaken internally by specialist advisors from NEL CSU, supported by CCG business continuity staff.

The annual fire health and safety audit was conducted in October 2021, with no areas requiring significant action. This was largely due to the extremely low occupancy levels throughout the year as staff were given the capability to work from home in line with national guidance.

Working safely during COVID-19

The CCG continues to operate the building in line with the latest national guidance using a number of measures such as:

- Wipes are still available to allow staff to clean down their desks before and after use, along with hand sanitiser and masks to support infection prevention and control measures.
- Staff are advised to work from home if symptomatic or positive for Covid-19, unless they are too unwell then usual sickness absence processes apply

For staff working from home potential health and safety concerns were addressed, particularly Display Screen Equipment (DSE) requirements. This was done by allowing staff to take home IT equipment to prevent prolonged working

on laptops and office chairs were also allowed to be taken home for those without appropriate furniture. Other equipment was provided, online DSE self-assessments were promoted, and in some cases, assessments were carried out via Microsoft Teams. For those staff working in patient facing roles full personal protective equipment (PPE) is provided.

No health and safety incidents were reported in 2021/22, nor as a result were there any reportable under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The COVID-19 pandemic resulted in another very challenging year but this did not result in any additional incidents and the CCG remains a relatively low-risk work environment.

Staff engagement

The CCG engages with its staff to ensure continuous consultation and engagement on changes that will affect them. This includes:

- Weekly virtual staff briefings led by the Chief Executive and other directors
- Bi-weekly staff newsletter
- Monthly staff forums providing staff with the opportunity to raise concerns
- Staff intranet – the aim of this site is to provide staff with access to regular and detailed information such as policies, supporting documents and toolkits alongside a platform to share best practice and good news stories

National staff survey

The National Staff Survey was made available to employees of the CCG to complete in November 2021. This was the second National Staff Survey undertaken for NHS Northamptonshire CCG.

71% of staff completed the survey for 2021 compared to a 77% response rate for the staff survey undertaken in 2020. The national average for 2021 was 79%.

Expenditure on consultancy

Nil

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 30 June 2022, for more than £245 per day

	Number
Number of existing engagegments as of 30 June 2022	0
Of which, the number that have existed:	
for between 1 and 2 years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Note:

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll workers engaged between 1 April 2022 and 30 June 2022, for more than £245 per day

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	0
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility between 1 April 2022 and 30 June 2022

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements	15

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

	M1 to M3 2022-23								2021-22	
	Compulsory Redundancies		Other Agreed Departures		Total		Departures where Special Payments have been made		Total	
	Number	£s	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	0	0	**0**	**0**	0	0	0	0
£10,001 to £25,000	1	14,667	0	0	**1**	**14,667**	0	0	0	0
£25,001 to £50,000	0	0	0	0	**0**	**0**	0	0	1	26,689
£50,001 to £100,000	0	0	0	0	**0**	**0**	0	0	0	0
£100,001 to £150,000	0	0	0	0	**0**	**0**	0	0	0	0
£150,001 to £200,000	0	0	0	0	**0**	**0**	0	0	0	0
Over £200,001	0	0	0	0	**0**	**0**	0	0	0	0
Total	**1**	**14,667**	**0**	**0**	1	**14,667**	**0**	**0**	1	26,689

	M1 to M3 2022-23		2021-22	
	Other Agreed Departures		Other Agreed Departures	
	Number	£s	Number	£s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	0	0

These tables report the number and value of exit packages agreed in the reporting period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Parliamentary accountability and audit report

NHS Northamptonshire 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, which starts at page 149 and audit certificate and report is also included in this Annual Report at page 194.

Annual accounts

This chapter sets out the annual budget for the CCG and a breakdown of how it was spent.

Toby Sanders

Chief Executive (Accountable Officer)

18 June 2023

M1 to M3
2022-23
NHS
Northamptonshire
CCG
Accounts

Statement of Comprehensive Net Expenditure
Period Ending 30 June 2022

	Note	M1 - M3 2022-23 £'000	2021-22 £'000
Income from Sale of Goods and Services	2	(3,297)	(14,782)
Other Operating Income	2	(157)	(4,366)
Total Operating Income		**(3,454)**	(19,148)
Staff Costs	4	3,344	10,469
Purchase of Goods and Services	5	338,954	1,365,683
Depreciation and Impairment Charges	5	79	0
Other Operating Expenditure	5	45	143
Total Operating Expenditure		**342,422**	1,376,295
Net Operating Expenditure		**338,968**	1,357,147
Financing	7	7	0
Other Comprehensive Expenditure		0	0
Comprehensive Net Expenditure for the Period Ending 30 June 2022		**338,974**	1,357,147

Statement of Financial Position
Period Ending 31 March 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-Current Assets			
Property, plant & equipment	8	0	0
Right-of-use assets	9	2,775	0
Total Non-Current Assets		**2,775**	0
Current Assets			
Trade & other receivables	10	4,852	8,510
Cash & cash equivalents	11	0	0
Total Current Assets		**4,852**	8,510
Total Assets		**7,627**	8,510
Current Liabilities			
Trade & other payables	12	(63,763)	(64,468)
Lease liabilities	9	(306)	0
Borrowings	13	(2,681)	(575)
Total Current Liabilities		**(66,750)**	(65,042)
Total Assets less Current Liabilities		**(59,123)**	(56,532)
Non-Current Liabilities			
Trade & other payables	12	0	0
Lease liabilities	9	(2,472)	0
Borrowings	13	0	0
Total Non-Current Liabilities		**(2,472)**	0
Total Assets Employed		**(61,596)**	(56,532)
Financed by Taxpayers' Equity			
General fund		(61,596)	(56,532)
Revaluation reserve		0	0
Other reserves		0	0
Total Taxpayers' Equity		**(61,596)**	(56,532)

The notes on pages 155 to 193 form part of this statement.

The financial statements on pages 151 to 154 were approved on 22 June 2023 by the Governing Body and signed on its behalf by:

Toby Sanders
Chief Executive

Statement of Changes in Taxpayers' Equity
Period Ending 30 June 2022

M1 to M3 2022-23	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total £'000
Balance at 1 April 2022	**(56,532)**	**0**	**0**	**(56,532)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted Balance at 1 April 2022	**(56,532)**	**0**	**0**	**(56,532)**
Changes in Taxpayers' Equity for 2022-23				
Total Net Expenditure for the Reporting Period	(338,974)		0	**(338,974)**
Net Recognised Expenditure for the Reporting Period	**(338,974)**	**0**	**0**	**(338,974)**
Net parliamentary funding	333,911	0	0	**333,911**
Balance at 30 June 2022	**(61,596)**	**0**	**0**	**(61,596)**

2021-22	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total £'000
Balance at 1 April 2021	(89,695)	0	0	(89,695)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted Balance at 1 April 2021	(89,695)	0	0	(89,695)
Changes in Taxpayers' Equity for 2021-22				
Net operating costs for the financial year	(1,357,147)			(1,357,147)
Net Recognised Expenditure for the Financial Year	(1,357,147)	0	0	(1,357,147)
Net parliamentary funding	1,390,310	0	0	1,390,310
Balance at 31 March 2022	(56,532)	0	0	(56,532)

Statement of Cash Flows
Period Ending 30 June 2022

	Note	M1 to M3 2022-23 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating costs for the reporting period		(338,974)	(1,357,147)
Depreciation and amortisation		79	0
(Increase)/decrease in trade & other receivables		3,658	3,257
Increase/(decrease) in trade & other payables		(705)	(33,156)
Net Cash Outflow from Operating Activities		**(335,941)**	(1,387,047)
Cash Flows from Investing Activities			
Interest paid/received		7	0
Net Cash Outflow from Investing Activities		**7**	0
Net Cash Outflow before Financing		**(335,934)**	(1,387,047)
Cash Flows from Financing Activities			
Net parliamentary funding received		333,911	1,390,310
Repayment of lease liabilities		(83)	0
Net Cash Inflow from Financing Activities		**333,828**	1,390,310
Net Increase/(Decrease) in Cash and Cash Equivalents		**(2,106)**	3,264
Cash and Cash Equivalents at the Beginning of the Reporting Period		(575)	(3,838)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash and Cash Equivalents at the End of the Reporting Period	11	**(2,681)**	(575)

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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the 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 the items considered material in relation to the accounts.

1.1. Going Concern

These accounts have been prepared on the going concern basis.

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

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.

NHS Northamptonshire CCG was dissolved on 30 June 2022 and its closing assets and liabilities transferred to NHS

Northamptonshire ICB on 1 July 2022. This followed the signing of the ICB establishment order on 27 June 2022 by the NHS England Chief Executive.

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

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the NHS 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. Details of the Pooled Budgets entered into by NHS Northamptonshire CCG are disclosed in Note 18.

1.4. Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1. Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see 1.4.2) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Accounting Treatment of Pooled Budgets

NHS Northamptonshire CCG and North Northamptonshire Council & West Northamptonshire Council have entered into agreements under section 75 of the NHS Act 2006, which were overseen by the local Health and Wellbeing Boards. These agreements established pooled budgets to further the integration of health and social care commissioned services across Northamptonshire.

The pooled budget arrangements, including the Better Care Fund, have all been judged, by the CCG, under IFRS 11 to be joint operations i.e. they involve the contractually agreed sharing of control but not through a separate vehicle. The contractual arrangements (Section 75 agreements) establish the parties' rights to the assets, and obligations for the liabilities relating to the arrangement, and the parties' rights to the corresponding revenues and obligations to the corresponding expenses. Note 17 sets out the rights and obligations of the CCG in relation to the pooled arrangements.

1.4.2. Key Sources of Estimation Uncertainty

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the CCG's accounts. Estimations have been made in respect of a number of accruals. Accruals for Prescribing have been calculated based on the best available information and on historic experience. Smaller accruals have been taken for the expected liability of goods or services that were received on or before 30 June 2022.

1.5. Revenue and Funding

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less;
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;

The main source of funding for the clinical commissioning group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

1.6. Employee Benefits

1.6.1. Short-Term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, 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.

1.6.2. Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. The 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 assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.7. Operating Expenditure

Operating expenditure, including expenditure on healthcare services with NHS and Non NHS organisations, is 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.

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8. Property, Plant & Equipment

1.8.1. 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 cost 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,

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2. Measurement

All property, plant and equipment are 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. All assets are measured subsequently at valuation.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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 should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3. Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9. Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.
At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible 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.

1.10. Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 Leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the Standard have been employed. These are as follows;

- The CCG has applied the practical expedient offered in the Standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease and not to those that were identified as not containing a lease under previous leasing standards.
- On initial application the CCG has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

- No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the Standard.
- The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
- Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.
- Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
- The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.
- The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The CCG is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the CCG has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.10.1. As Lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The CCG employs a revaluation model for the subsequent measurement of its right of

use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure. Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16. Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the CCG.

1.11. Cash & Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management. Cash, bank and overdraft balances are recorded at current values.

1.12. 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.

1.13. Non-Clinical Risk Pooling

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

1.14. 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 initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through the profit or loss. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

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.

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.

1.15. Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or expired.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.16. Value Added Tax

Most of the activities of the 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.

1.17. 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).

1.18. Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure, gains and losses, assets, liabilities and cash flows.

1.19. Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group. NHS Northamptonshire CCG consider there is only one segment, the commissioning healthcare services.

1.20. Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be

applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

Note 2: Other Operating Revenue

	M1 to M3 2022-23 £'000	2021-22 £'000
Income from Sale of Goods and Services (Contracts)		
Non-patient care services to other bodies	3,171	13,664
Other contract income	126	1,118
Total Income from Sale of Goods & Services	**3,297**	14,782
Other Operating Income		
Other non contract revenue	157	4,366
Total Other Operating Income	**157**	4,366
Total	**3,454**	19,148

Note 3: Contract Income Recognition

3.1 Disaggregation of Income - Income from Sale of Goods and Services (Contracts)

	M1 to M3 2022-23		2021-22	
	Non-Patient Care Services to Other Bodies £'000	**Other Contract Income £'000**	Non-Patient Care Services to Other Bodies £'000	Other Contract Income £'000
Source of Revenue				
NHS	0	126	1,292	682
Non NHS	3,171	0	12,372	436
Total	**3,171**	**126**	13,664	1,118
Timing of Revenue				
Point in Time	3,171	126	13,664	1,118
Over Time	0	0	0	0
Total	**3,171**	**126**	13,664	1,118

3.2 Transaction Price to Remaining Contract Performance Obligations

NHS Northamptonshire CCG did not have any balances to declare under this note for 2021-22 or for M1 to M3 2022-23.

Note 4: Employee Benefits & Staff Numbers

4.1.1 Employee Benefits Expenditure

	M1 to M3 2022-23 Total			2021-22 Total		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	2,244	94	**2,338**	7,531	689	8,219
Social security costs	271	11	**282**	840	49	889
Employer contributions to the NHS Pensions Scheme	383	4	**387**	1,275	30	1,305
Other pension costs	2	0	**2**	6	0	6
Apprenticeship levy	8	0	**8**	23	0	23
Termination benefits	328	0	**328**	27	0	27
Gross employee benefits expenditure	**3,235**	**109**	**3,344**	9,701	768	10,469
Less: recoveries in respect of employee benefits	0	0	**0**	0	0	0
Net employee benefits expenditure including capitalised costs	**3,235**	**109**	**3,344**	9,701	768	10,469
Less: employee costs capitalised	0	0	**0**	0	0	0
Net employee benefits expenditure excluding capitalised costs	**3,235**	**109**	**3,344**	9,701	768	10,469

4.2 Average Number of People Employed

	M1 to M3 2021-22			2021-22		
	Employees Number	**Other Number**	**Total Number**	Employees Number	Other Number	Total Number
Total	161	5	**166**	137	8	145
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	**0**	0	0	0

4.3 Staff Annual Leave Accrual Balances

	M1 to M3 2022-23			2021-22		
	Permanent Staff £'000	**Other £'000**	**Total £'000**	Permanent Staff £'000	Other £'000	Total £'000
Employee accrued benefits liability at end of reporting period	(113)	0	**(113)**	(113)	0	(113)

Note 4: Employee Benefits & Staff Numbers (continued)

4.4 Exit Packages Agreed in the Financial Year

	M1 to M3 2022-23								2021-22	
	Compulsory Redundancies		**Other Agreed Departures**		**Total**		**Departures where Special Payments have been made**		Total	
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**	**£s**	Number	£s
Less than £10,000	0	0	0	0	**0**	**0**	0	0	0	0
£10,001 to £25,000	1	14,667	0	0	**1**	**14,667**	0	0	0	0
£25,001 to £50,000	0	0	0	0	**0**	**0**	0	0	1	26,689
£50,001 to £100,000	0	0	0	0	**0**	**0**	0	0	0	0
£100,001 to £150,000	0	0	0	0	**0**	**0**	0	0	0	0
£150,001 to £200,000	0	0	0	0	**0**	**0**	0	0	0	0
Over £200,001	0	0	0	0	**0**	**0**	0	0	0	0
Total	**1**	**14,667**	**0**	**0**	**1**	**14,667**	**0**	**0**	1	26,689

	M1 to M3 2022-23 Other Agreed		2021-22 Other Agreed	
	Number	**£s**	Number	£s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	0	0

These tables report the number and value of exit packages agreed in the reporting period. The expense associated with these departures may have been recognised in part or in full in a previous period.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Note 4: Employee Benefits & Staff Numbers (continued)

4.5 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.5.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as at 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Note 4: Employee Benefits & Staff Numbers (continued)

4.5.2 Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to uncertainty around member benefits caused by the discrimination ruling to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions is required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 5: Operating Expenditure

	M1 to M3 2022-23 £'000	2021-22 £'000
Purchase of Goods and Services		
Services from other CCGs and NHS England	1,496	7,510
Services from Foundation Trusts	130,506	522,294
Services from Other NHS Trusts	99,139	402,652
Services from Other WGA Bodies	0	1
Purchase of Healthcare from Non-NHS Bodies	44,124	165,323
Purchase of Social Care	(277)	(408)
Prescribing costs	27,854	112,332
Pharmaceutical services	0	136
General ophthalmic services	36	171
GPMS/APMS and PCTMS	34,070	137,485
Supplies and services - clinical	454	1,737
Supplies and services - general	992	11,852
Consultancy services	(315)	299
Establishment	317	2,580
Transport	0	1
Premises	486	1,139
Audit fees	25	83
Other auditor's remuneration		
● Other services	0	18
Other professional fees ex audit	11	108
Legal fees	23	(163)
Education and training	13	534
Total Purchase of Goods and Services	**338,954**	1,365,683
Depreciation and Impairment Charges		
Depreciation	79	0
Total Depreciation and Impairment Charges	**79**	0
Other Operating Expenditure		
Chair & Non-Executive Members	37	136
Expected credit loss on receivables	8	8
Total Other Operating Expenditure	**45**	143
Total Operating Expenditure	**339,078**	1,365,827

The CCG Statutory Audit Fee for 2022-23 is £55,000 plus £11,000 VAT. This was agreed after the closure of the CCG's accounts. The amount disclosed in the line Audit Fees above was an estimate of the likely fees at the point the CCG's accounts were closed resulting in the difference between the am ount included above and the final agreed value.

Note 5: Operating Expenditure (continued)

Other Auditor's Remuneration - Other Services is audit-related assurance services provided by the external auditor on the assessment of the achievement of the Mental Health Investment Standard.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the CCG must disclose the principal terms of the limitation of the auditors liability. This is detailed as follows:
For all defaults resulting in direct loss or damage to the property of the other party - £2m limit.
In respect of all other defaults, claims, losses or damages arising from breach of contract, misrepresentation, tort, breach of statutory duty or otherwise - not exceed the greater of the sum of £2m or a sum equivalent to 125% of the contract charges paid or payable to the supplier in the relevant year of the contract.

Note 6: Better Payment Practice Code

6.1 Measure of Compliance

	M1 to M3 2022-23		2021-22	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the reporting period	7,087	44,176	27,742	186,716
Total Non-NHS trade invoices paid within target	6,942	42,737	27,237	182,638
Percentage of Non NHS trade invoices paid within target	**97.95%**	**96.74%**	98.18%	97.82%
NHS Payables				
Total NHS trade invoices paid in the reporting period	110	4,545	676	81,395
Total NHS trade invoices paid within target	103	4,213	666	80,486
Percentage of NHS trade invoices paid within target	**93.64%**	**92.70%**	98.52%	98.88%

The Better Payment Practice Code requires NHS Northamptonshire CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Note 7: Finance Costs

	30 June 2022 £'000	31 March 2022 £'000
Interest		
Interest on loans and overdrafts	0	0
Interest on lease liabilities	7	0
Total Interest	**7**	0
Other finance costs	0	0
Provisions: unwinding of discount	0	0
Total Finance Costs	**7**	0

7.1 Finance Income

NHS Northamptonshire CCG did not have any balances to declare under this note for 2021-22 or for M1 to M3 2022-23.

Note 8: Property, Plant & Equipment

M1 to M3 2022-23	**Plant & Machinery £'000**	**Information Technology £'000**	**Fixture & Fittings £'000**	**Total £'000**
Cost or Valuation at 1 April 2022	82	200	230	**512**
Disposals other than by sale	0	(98)	0	**(98)**
Cost of valuation at 30 June 2022	**82**	**101**	**230**	**413**
Depreciation at 1 April 2022	82	200	230	**512**
Disposals other than by sale	0	(98)	0	**(98)**
Depreciation at 30 June 2022	**82**	**101**	**230**	**413**
Net Book Value at 30 June 2022	**0**	**0**	**0**	**0**

2021-22	Plant & Machinery £'000	Information Technology £'000	Fixture & Fittings £'000	Total £'000
Cost or Valuation at 1 April 2021	82	200	230	512
Cost of valuation at 31 March 2022	82	200	230	512
Depreciation at 1 April 2021	82	200	230	512
Depreciation at 31 March 2022	82	200	230	512
Net Book Value at 31 March 2022	0	0	0	0

Note 8: Property, Plant & Equipment (continued)

NHS Northamptonshire CCG did not hold any balances or incur any expenditure under the following categories during 2021-22 or for M1 to M3 2022-23:

- Revaluation Reserve for Property, Plant & Equipment,
- Additions to Assets Under Construction,
- Donated Assets,
- Government Granted Assets,
- Property Revaluation,
- Compensation to Third Parties,
- Write Down to Recoverable Amount,
- Temporarily Idle Assets,

8.1 Economic Lives

	Minimum Life Years	**Maximum Life Years**
Plant & machinery	10	10
Information technology	2	2
Furniture & fittings	10	10

8.2 Cost or Valuation of Fully Depreciated Assets

	30 June 2022 £'000	31 March 2022 £'000
Plant & machinery	82	82
Information technology	101	200
Furniture & fittings	230	230
Total	**413**	512

Note 9: Leases

IFRS 16 - Leases accounting standard was adopted by the NHS from 1 April 2022 and replaces the previous accounting standards for operating leases. As part of the adoption, there is no requirement to restate prior year comparators.

Note 9.1: Right-of-Use Assets

M1 to M3 2022-23	Land £'000	Buildings excluding Dwellings £'000	Total £'000
Cost or Valuation at 1 April 2022	0	0	**0**
IFRS 16 transition adjustment	336	2,519	**2,854**
Cost of valuation at 30 June 2022	**336**	**2,519**	**2,854**
Depreciation at 1 April 2022	0	0	**0**
Charged during the reporting period	9	70	**79**
Depreciation at 30 June 2022	**9**	**70**	**79**
Net Book Value at 30 June 2022	**326**	**2,449**	**2,775**

Note 9.2: Lease Liabilities

	30 June 2022 £'000
Lease Liabilities at 1 April 2022	0
IFRS 16 transition adjustment	2,854
Interest expense relating to lease liabilities	7
Repayment of lease liabilities (capital and interest)	(83)
Lease Liabilities at 30 June 2022	**2,778**

Note 9.3: Maturity Analysis of Undiscounted Future Lease Payments

	30 June 2022 £'000
Within one year	(330)
Between one and five years	(1,322)
After five years	(1,239)
Total Future Lease Payments	**(2,891)**
Effect of Discounting	**113**
Included in:	
Current lease liabilities	(306)
Non-current lease liabilities	(2,472)
Total	**(2,778)**

Note 9.4: Amount Recognised in Statement of Comprehensive Net Expenditure

	30 June 2022 £'000
Depreciation expense on right-of-use asset	79
Interest expense on lease liabilities	7
Total	**86**

Note 9.5: Amount Recognised in Cashflow

	30 June 2022 £'000
Total cash outflow on leases under IFRS16	(83)
Total cash outflow for lease payments not included within the measurement of lease liabilities	0
Total cash inflows from sale and lease back transactions	0
Total	**(83)**

Note 10: Trade & Other Receivables

	Current 30 June 2022 £'000	**Non-Current 30 June 2022 £'000**	Current 31 March 2022 £'000	Non-Current 31 March 2022 £'000
NHS receivables: revenue	918	0	5,307	0
NHS prepayments	7	0	0	0
NHS accrued income	173	0	938	0
Non-NHS and Other WGA receivables: revenue	1,438	0	1,494	0
Non-NHS and Other WGA prepayments	1,637	0	22	0
Non-NHS and Other WGA accrued income	100	0	101	0
Expected credit loss allowance-receivables	(124)	0	(116)	0
VAT	703	0	764	0
Total	**4,852**	**0**	8,510	0
Total Current and Non-Current	**4,852**		8,510	
Included in NHS receivables are pre-paid pension contributions	**0**		0	

10.1 Receivables Past Their Due Date But Not Impaired

	30 June 2022 Bodies £'000	**30 June 2022 Bodies £'000**	31 March 2022 DHSC Group Bodies £'000	31 March 2022 Bodies £'000
By up to three months	394	51	271	159
By three to six months	0	29	0	48
By more than six months	152	238	164	190
Total	**546**	**318**	435	397

NHS Northamptonshire CCG did not hold any collateral against receivables outstanding at 31 March 2022 or 30 June 2022.

Note 10: Trade & Other Receivables (continued)

10.2 Loss Allowance on Asset Classes

	M1 to M3 2022-23 Trade & Other Receivables - Non DHSC Group Bodies £'000	2021-22 Trade & Other Receivables - Non DHSC Group Bodies £'000
Allowance for credit losses at 1 April	(116)	(110)
Lifetime expected credit loss on trade and other receivables - Stage 2	(8)	(8)
Amounts written off	0	2
Allowance for credit losses at end of reporting period	**(124)**	(116)

10.3 Provision Matrix on Lifetime Credit Loss

	Lifetime Expected Credit Loss Rate %	**30 June 2022 Gross Carrying Amount £'000**	**Lifetime Expected Credit Loss £'000**	31 March 2022 Lifetime Expected Credit Loss £'000
Up to 90 days	0%	51	0	0
Between 90 & 360 days	15%	151	23	20
Between 360 & 720 days	50%	8	4	1
Over 720 days	90%	107	97	95
Total Expected Credit Loss		**318**	**124**	116

Note 11: Cash & Cash Equivalents

	M1 to M3 2022-23 £'000	2021-22 £'000
Balance at 1 April	(575)	(3,838)
Net Change during the reporting period	(2,106)	3,264
Balance at end of reporting period	**(2,681)**	(575)

	30 June 2022 £'000	31 March 2022 £'000
Made up of:		
Cash with the Government Banking Service	0	0
Cash with Commercial Banks	0	0
Cash in Hand	0	0
Current Investments	0	0
Cash and Cash Equivalents as in SoFP	**0**	0
Bank Overdraft: Government Banking Service	(2,681)	(575)
Bank Overdraft: Commercial Banks	0	0
Balance at 31 March	**(2,681)**	(575)
Patients' money held by NHS Northamptonshire CCG not included above	**0**	0

NHS England require CCGs to manage the cleared bank account balance at the end of the month to a target of 1.25% of that month's drawdown. Where CCGs are required to make payments by BACs at the end of the month to meet contractual commitments, the payment will be included in the CCG's cashbook and financial ledger but will not clear the bank account until the following month as it takes 3 working days for the payments to clear the bank account. Where this occurs, NHS England has confirmed that this is acceptable as it only reflects a timing difference in the cash drawdown process and cash being made available by the bank.

Note 12: Trade & Other Payables

	Current 30 June 2022 £'000	**Non-Current 30 June 2022 £'000**	Current 31 March 2022 £'000	Non-Current 31 March 2022 £'000
NHS payables: revenue	3,689	0	3,937	0
NHS accruals	8,354	0	800	0
Non-NHS & Other WGA payables: revenue	9,672	0	12,801	0
Non-NHS & Other WGA accruals	40,923	0	45,995	0
Social security costs	158	0	127	0
Tax	129	0	107	0
Other payables	838	0	701	0
Total	**63,763**	**0**	64,468	0
Total Current and Non-Current	**63,763**		64,468	

There are no liabilities included above that are due in future years under the arrangements to buy out the liability for early retirement over 5 years as at 31 March 2022 or 30 June 2022. Other Payables includes £1,016,000 of outstanding pension contributions at 30 June 2022 (31 March 2022: £794,000).

Note 13: Borrowings

	Current 30 June 2022 £'000	**Non-Current 30 June 2022 £'000**	Current 31 March 2022 £'000	Non-Current 31 March 2022 £'000
Bank overdrafts:				
● Government Banking Service	2,681	0	575	0
● Commercial banks	0	0	0	0
Total	**2,681**	**0**	575	0
Total Current and Non-Current	**2,681**		575	

Note 13: Borrowings (continued)

13.1: Repayment of Principal Falling Due

	30 June 2022		31 March 2022	
	Department of Health & Social Care £'000	**Other £'000**	Department of Health & Social Care £'000	Other £'000
Within one year	0	2,681	0	575
Between one and two years	0	0	0	0
Between two and five years	0	0	0	0
After five years	0	0	0	0
Total	**0**	**2,681**	0	575

Note 14: Provisions

NHS Northamptonshire CCG did not have any provisions to disclose as at 31 March 2022 or 30 June 2022.

Note 15: Contingencies

NHS Northamptonshire CCG did not have any contingent assets or liabilities to disclose as at 31 March 2022 or 30 June 2022.

Note 16: Financial Instruments

16.1 Financial Risk Management

International Financial Reporting Standard 7: Financial Instrument: Disclosure requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Northamptonshire CCG is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. NHS Northamptonshire CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing NHS Northamptonshire CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within NHS Northamptonshire CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by NHS Northamptonshire CCG's internal auditors.

16.1.1 Currency Risk

NHS Northamptonshire CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS Northamptonshire CCG has no overseas operations. NHS Northamptonshire CCG therefore has low exposure to currency rate fluctuations.

16.1.2 Interest Rate Risk

NHS Northamptonshire CCG borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. NHS Northamptonshire CCG therefore has low exposure to interest rate fluctuations.

16.1.3 Credit Risk

Because the majority of NHS Northamptonshire CCG's revenue comes from parliamentary funding, NHS Northamptonshire CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity Risk

NHS Northamptonshire CCG is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. NHS Northamptonshire CCG draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. NHS Northamptonshire CCG is not, therefore, exposed to significant liquidity risks.

16.2 Financial Assets

	Financial Assets Measured at Amortised Cost 30 June 2022 £'000	Financial Assets Measured at Amortised Cost 31 March 2022 £'000
Trade and other receivables with NHSE bodies	927	6,097
Trade and other receivables with other DHSC group bodies	263	261
Trade and other receivables with other external bodies	1,438	1,482
Total at end of reporting period	**2,629**	7,840

Note 16: Financial Instruments (continued)

16.3 Financial Liabilities

	Financial Liabilities Measured at Amortised Cost 30 June 2022 £'000	Financial Liabilities Measured at Amortised Cost 31 March 2022 £'000
Loans with external bodies	2,681	575
Trade and other payables with NHSE bodies	2,048	1,595
Trade and other payables with other DHSC group bodies	13,655	6,079
Trade and other payables with other external bodies	50,551	56,560
Total at end of reporting period	**68,935**	64,809

16.4 Maturity of Financial Liabilities

	Payable to DHSC Group 30 June 2022 £'000	**Payable to Other Bodies 30 June 2022 £'000**	**Total Payable 30 June 2022 £'000**	Total Payable 31 March 2021 £'000
In one year or less	15,703	53,232	**68,935**	64,809
In more than one year but not more than two years	0	0	**0**	0
In more than two years but not more than five years	0	0	**0**	0
In more than five years	0	0	**0**	0
Total at end of reporting period	**15,703**	**53,232**	**68,935**	64,809

Note 17: Operating Segments

NHS Northamptonshire CCG consider there is only one segment: commissioning healthcare services.

Note 18: Pooled Budgets

Note 1.3 *Pooled Budgets,* Note 1.4.1 *Critical Judgements in Applying Accounting Policies* and Note 1.18 *Joint Operations* of these accounts provide further information on Pooled Budgets.

18.1 Children and Adolescent Mental Health Pooled Budget

NHS Northamptonshire CCG is the host of a pooled budget for the commissioning of Children and Adolescent Mental Health Services across the county with NHS Cambridgeshire & Peterborough CCG and North Northamptonshire Council. Under the arrangement, funds are pooled under S75 of the NHS Act 2006 for Children and Adolescent Mental Health commissioning activities. The partners determine the nature of the programmes of work making up the Fund. The CCG's contribution to the Pool in 2022-23, was £1.991m which is included within Note 5 - Operating Expenditure.

18.2 Better Care Fund - North & East Northamptonshire

North Northamptonshire Council host the Better Care Fund (BCF) pooled budget for the North and East of the county. Under the arrangements, funds are pooled under S75 of the NHS Act 2006. NHS Northamptonshire CCG contribute to the pool for services to be delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. The CCG is a party to the Northamptonshire BCF pooled budget, established under Section 75 of the NHS Act 2006. The Fund has been established to further the integration of health and social care services in Northamptonshire. Other parties to the Section 75 agreement other than the hosts is NHS Cambridgeshire and Peterborough CCG. The partners determine the nature of the programmes of work making up the Fund. The CCG's contribution to the Fund in 2022-23, was £6.170m which is included within Note 5 - Operating Expenditure. Partners are solely liable for any overspends to services commissioned in exercise of their statutory functions.

18.3 Better Care Fund - West & South Northamptonshire

West Northamptonshire Council host the Better Care Fund (BCF) pooled budget for the West and the South of the county. Under the arrangements, funds are pooled under S75 of the NHS Act 2006. NHS Northamptonshire CCG contribute to the pool for services to be delivered as a provider of healthcare. Members to the BCF pool account for transactions and balances directly with providers. The CCG is a party to the Northamptonshire BCF pooled budget, established under Section 75 of the NHS Act 2006. The Fund has been established to further the integration of health and social care services in Northamptonshire. Other parties to the Section 75 agreement other than the hosts is NHS Cambridgeshire and Peterborough CCG. The partners determine the nature of the programmes of work making up the Fund. The CCG's contribution to the Fund in 2022-23, was £7.176m which is included within Note 5 - Operating Expenditure. Partners are solely liable for any overspends to services commissioned in exercise of their statutory functions.

Note 18: Pooled Budgets (continued)

NHS Northamptonshire CCG's shares of assets/liabilities and income/expenditure handled by the pooled budgets in the financial year were:

Name of Arrangement	Parties to the Arrangement	Description of Principal Activities	**Amounts Recognised in CCG's Accounts Only M1 to M3 2022-23**				Amounts Recognised in CCG's Accounts Only 2021-22			
			Assets £'000	**Liabilities £'000**	**Income £'000**	**Expenditure £'000**	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Children and Adolescent Mental Health	NHS Northamptonshire CCG, NHS Cambridgeshire & Peterborough CCG, North Northamptonshire Council	Provision of specialist mental health support for children within the community.	0	0	0	1,991	0	0	0	7,566
Better Care Fund - North & East Northamptonshire	NHS Northamptonshire CCG, NHS Cambridgeshire & Peterborough CCG and North Northamptonshire Council	Provision of services which are enablers to reduce non elective admissions, to reduce delayed transfers of care.	0	0	0	6,170	0	0	0	23,440
Better Care Fund- West & South Northamptonshire	NHS Northamptonshire CCG, NHS Cambridgeshire & Peterborough CCG and West Northamptonshire Council	Provision of services which are enablers to reduce non elective admissions, to reduce delayed transfers of care.	0	0	0	7,176	0	0	0	27,265

Note 19: Related Party Transactions

Senior Manager	Position	Related Party	Relationship to Related Party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts Owed to Related Party £'000	Amounts Due from Related Party £'000
Julie Curtis	Director of Primary & Community Integration	East Midlands Ambulance Services NHS Trust	Daughter employed as PDM	7,810	0	489	0
Chris Ellis	Locality Chair for Wellingborough & East Northants	Queensway Medical Centre	GP at practice	455	0	1	0
		3Sixty Care Ltd	GP Federation Member	641	0	115	(85)
Ammar Ghouri	Locality Chair for Kettering & Corby	Lakeside Healthcare	GP at practice	2,729	0	151	0
		DHU	Locum GP	2,980	0	0	0
Darin Seiger	Locality Chair for Northampton	Moulton Surgery	GP at practice	521	0	0	0
		General Practice Alliance	GP Federation Member	735	0	214	0
		MWEB PCN	Acting Clinical Director	1,470	0	8	0
Philip Stevens	Locality Chair for Daventry & South Northants	Washington House Surgery	GP at practice	72	0	0	0
		Brackley Medical Centre	GP at practice	829	0	88	0
		Principal Medical	Shareholder	1,570	(203)	75	0
Joanne Watt	GP Chair	Great Oakley Medical Centre	GP at practice	426	0	0	0
		Northamptonshire Healthcare NHS Foundation Trust	Independent contractor	48,556	(105)	3,710	(166)
		Kettering General Hospital NHS Foundation Trust	Spouse is consultant	71,564	0	3,545	0
		3Sixty Care Ltd	GP Federation Member	641	0	115	(85)

The Department of Health & Social Care is regarded as a related party. During the reporting period, NHS Northamptonshire CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England & NHS Improvement, NHS NEL CSU, NHS Arden & GEM CSU, NHS North of England CSU
- Kettering General Hospital NHS Foundation Trust, Northamptonshire Healthcare NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust
- Northampton General Hospital NHS Trust, University Hospitals of Leicester NHS Trust, University Hospitals Coventry & Warwickshire NHS Trust, East Midlands Ambulance Services NHS Trust
- NHS Resolution; and,
- NHS Business Service Authority.

In addition, NHS Northamptonshire CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with North Northamptonshire Council and West Northamptonshire Council.
NHS Northamptonshire CCG has not received any revenue or capital payments from charitable funds where members of the Governing Body are trustees of the Charitable Funds.

Note 20: Events After the Reporting Period

Under the Health and Care Act 2022, Clinical Commissioning Groups (CCGs) are to be abolished and be replaced by Integrated Care Boards (ICBs). ICBs will take on the commissioning functions of CCGs from 1 July 2022. NHS Northamptonshire CCG was dissolved on 30 June 2022 to establish NHS Northamptonshire ICB with effect from 1 July 2022.

The closure of CCGs and establishment of ICBs is regarded as a transfer of function. The DHSC Group Accounting Manual directs that such transactions should be accounted for as a transfer by absorption. NHS Northamptonshire ICB will recognise the assets and liabilities received as at the date of transfer (1 July 2022).

The financial effect of the transfer is set out in the table below:

	CCG Assets & Liabilities to Transfer by Absorption to ICB 30 June 2022 £'000
Property, Plant and Equipment	0
Right-of-Use Asset	2,775
Trade & Other Receivables (current and non current)	4,852
Trade & Other Payables (current and non current)	(63,763)
Lease Liabilities (current and non current)	(2,778)
Borrowings	(2,681)
General Fund	**(61,596)**

Note 21: Losses & Special Payments

	M1 to M3 2022-23		2021-22	
	Total Number of Cases Number	**Total Value of Cases £'000**	Total Number of Cases Number	Total Value of Cases £'000
Losses	0	0	1	2
Special Payments	0	0	0	0
Total	**0**	**0**	1	2

The Losses balance reported above in 2021-22 was an Administrative Write Off relating to legacy debt from the previous CCGs that was no longer deemed to be recoverable.

Note 22: Financial Performance Targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).

NHS Northamptonshire CCG's performance against those duties was as follows:

NHS Act Section	**Duty**	**Target £'000**	**M1 to M3 2022-23 Performance £'000**	**Duty Achieved**
223H (1)	Expenditure not to exceed income - Surplus/(Deficit)	342,429	342,429	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	338,975	338,974	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes
223J (3)	Revenue administration resource use does not exceed the amounts specified in Directions	3,375	3,375	Yes

NHS Act Section	**Duty**	Target £'000	2021-22 Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income - Surplus/(Deficit)	1,385,030	1,376,295	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	1,365,882	1,357,147	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes
223J (3)	Revenue administration resource use does not exceed the amounts specified in Directions	13,938	11,912	Yes

Note 1: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

Independent auditor's report to the members of the Governing Body of NHS Northamptonshire ICB in respect of NHS Northamptonshire CCG

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Northamptonshire (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Northamptonshire CCG transferred to NHS Northamptonshire ICB on 1 July 2022. When NHS Cannock CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Northamptonshire ICB.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to

the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

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

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

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

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; 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 make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 87 to 88, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, 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.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

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.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the audit committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Material manual year end journals and unusual manual journals
  - Reasonableness of year end accruals
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on material year end journals and unusual manual journals
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of year end accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to year end accruals.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

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

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer was 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 the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 were operating effectively during the three month period ended 30 June 2022..

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

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

Use of our report

This report is made solely to the members of the Governing Body of NHS Northamptonshire ICB, as a body, in respect of the CCG, 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 NHS Northamptonshire ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Northamptonshire ICB and the CCG and the members of the Governing Bodies of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Avtar Sohal

Avtar Sohal, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

29 June 2023