NHS
Northamptonshire
Clinical Commissioning Group

Northamptonshire CCG Annual Report 2022

1st April 2022 to 30th June 2022

Contents

Performance report **2**

Chair's introduction 3

Performance overview 7

Performance analysis 34

Improving quality 66

Engaging people and communities 71

Reducing health inequality 72

Accountability report **80**

Corporate governance report 81

Member's report 81

Statement of Accountable Officer's responsibilities 87

Governance statement 89

Remuneration and staff report 122

Remuneration report 122

Staff report 134

Parliamentary accountability and audit report 148

Annual accounts **149**

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
18 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:

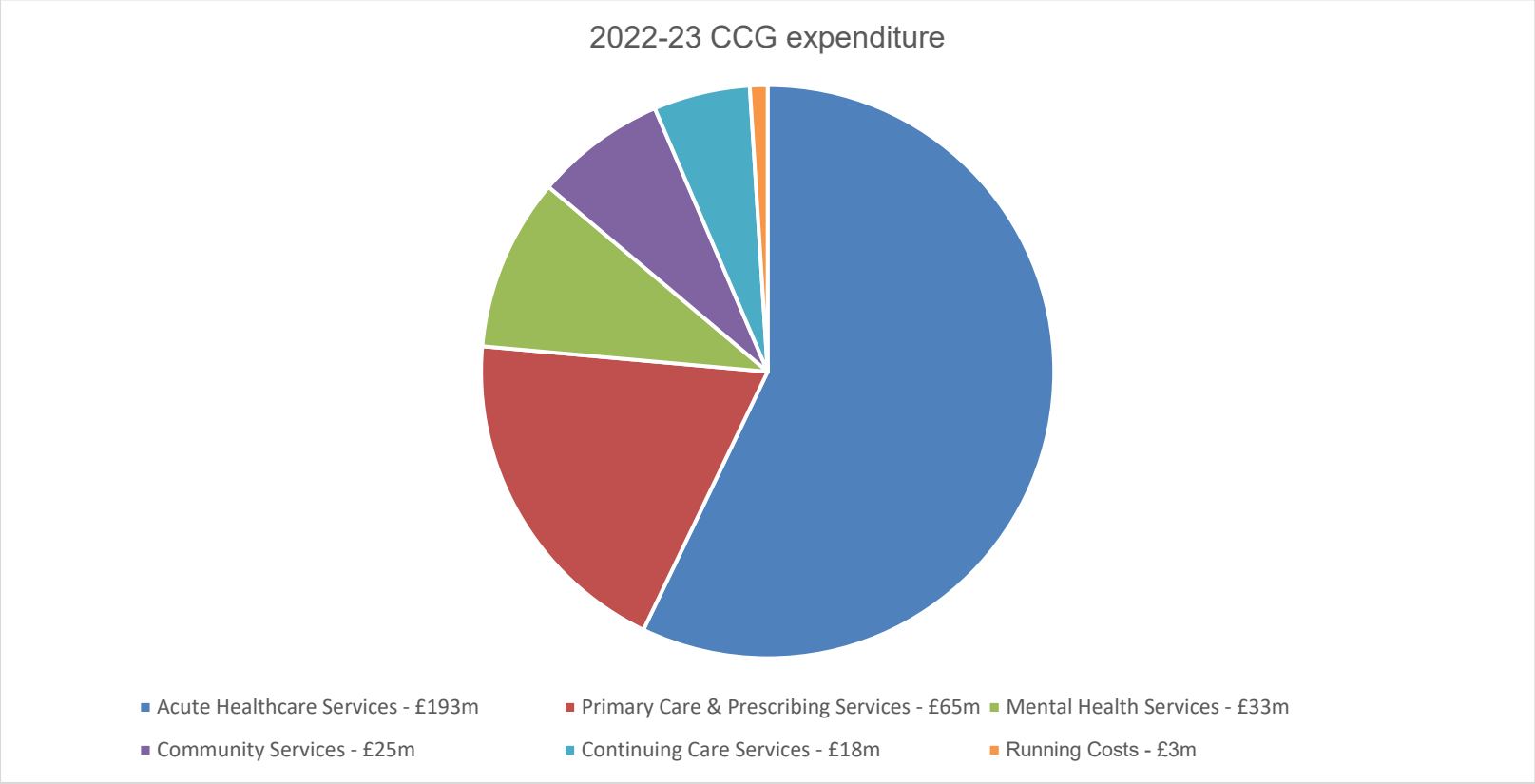
- ED four-hour performance at NGH (KGH does not report on this)
- Delivery of the Ambulance Response Programme waiting times
- 62-day waiting time standards at both of Northamptonshire's acute hospitals
- Meeting the 18-week Referral to Treatment time for planned care
- The number of 52+ week waits for 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.



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.

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.

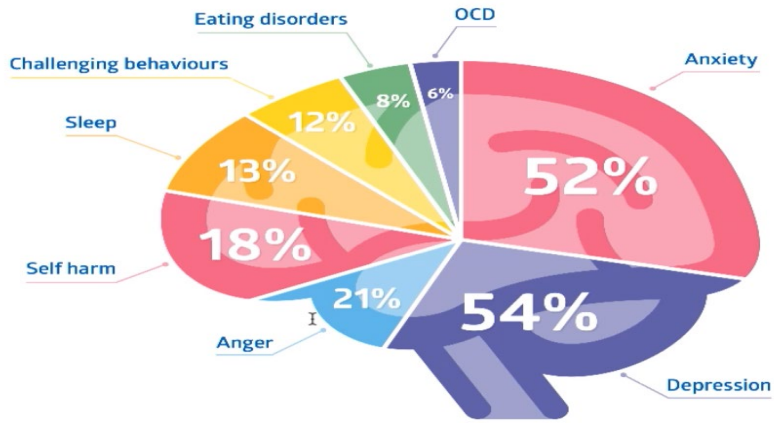
Engagement

- 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.

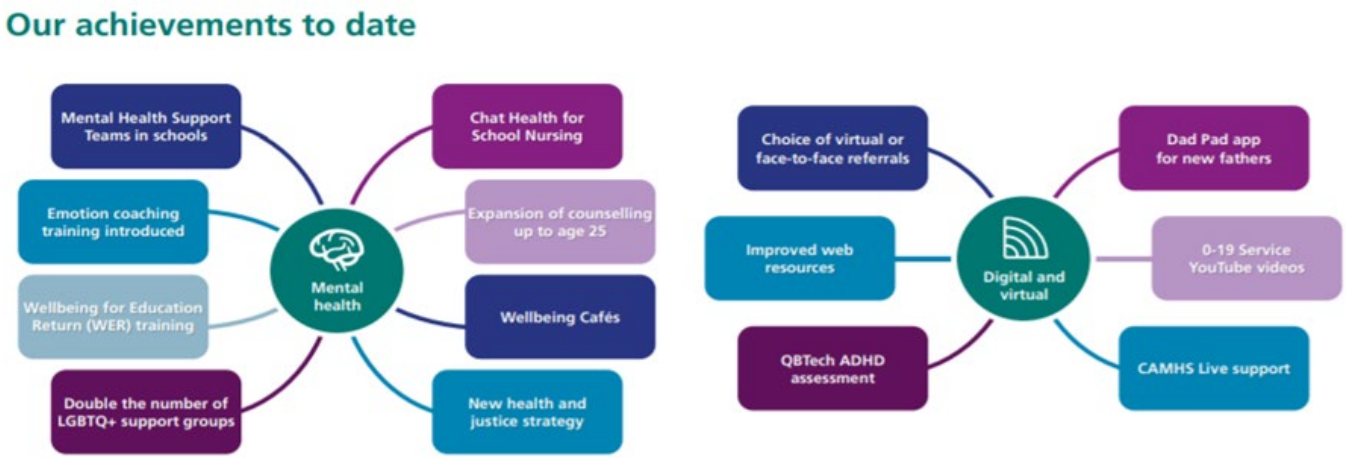
Mental health and wellbeing (young people)

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:

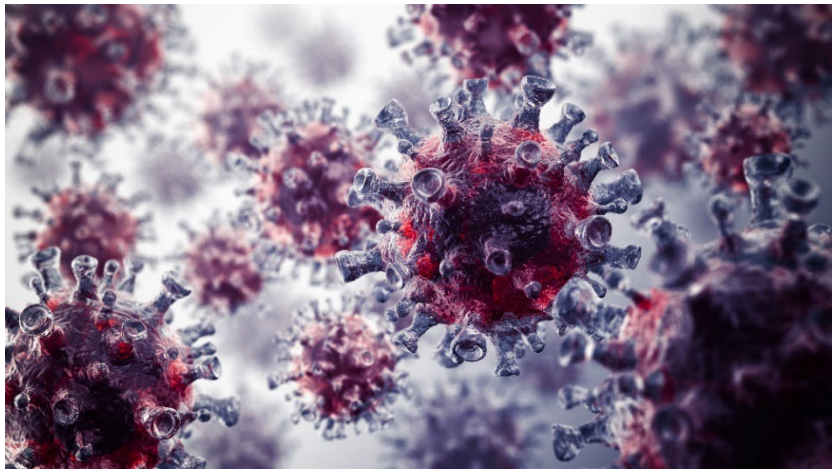
- Heart failure
- Coronary heart disease
- Atrial fibrillation

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:

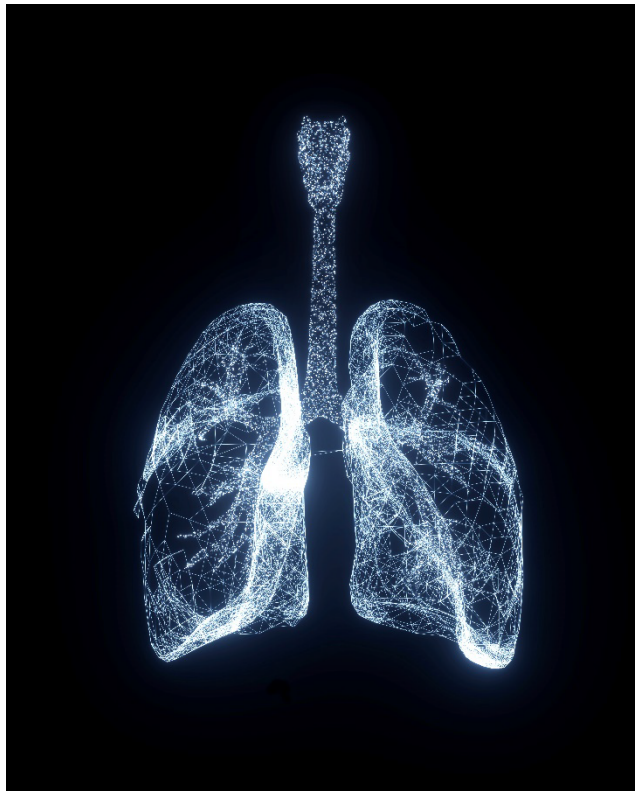
- Development of a GP resource pack supporting implementation of the Network contract Direct Enhanced Service (DES) in Primary Care
- Continuation of Corby Targeted Lung Health checks, on track for completion of baseline low dose CT scans by end Quarter 2 2022/23
- Participation in the national NHS Galleri 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.

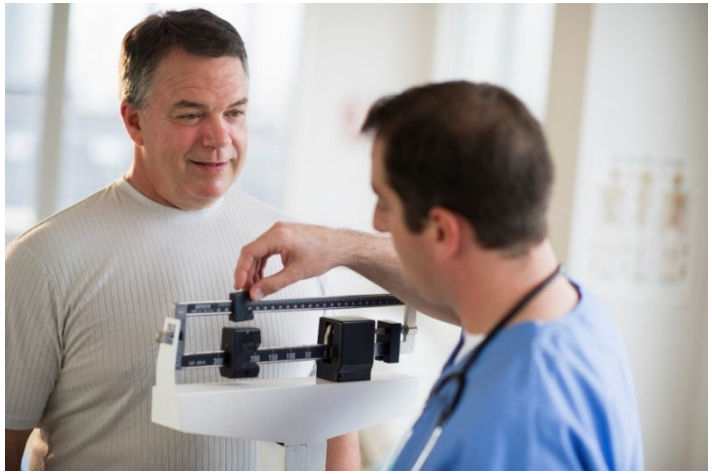
System discussions have been focused on building resilience, capacity and managing risk. In May, the system signed up to a trajectory and a plan to eliminate ambulance handover delays and commenced discussion on a number of transformational integrated health and social care projects to support the forthcoming 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.

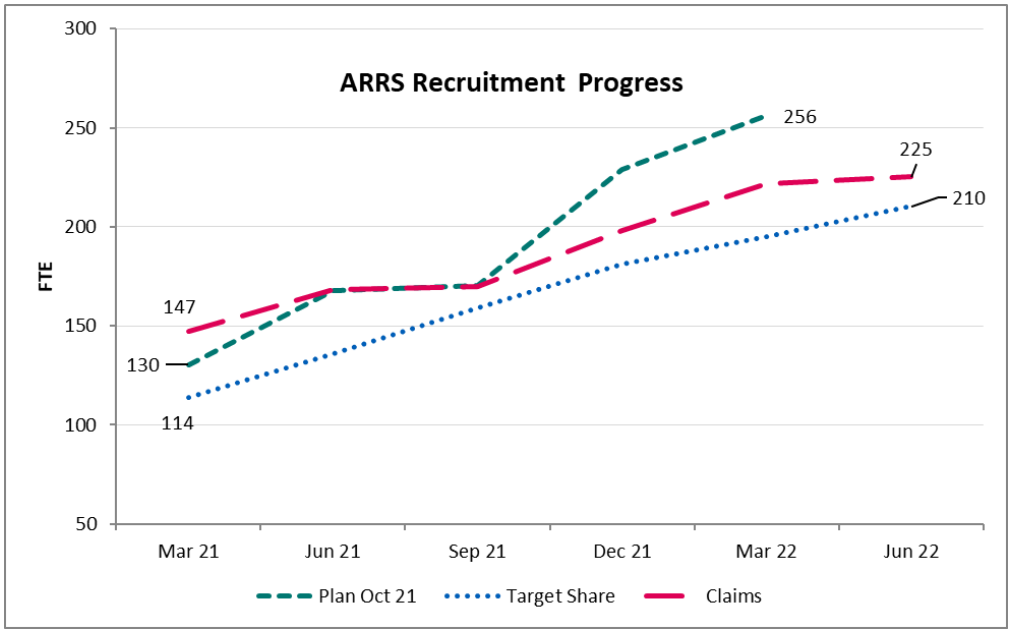
Direct patient care staff in primary care have increased by 19% since 2019. However, when combined with the direct patient staff employed by Primary Care Networks via the Additional Roles Reimbursement Scheme (ARRS) the increase rises to 158.25%. ARRS recruitment in Northamptonshire is tracking above 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.

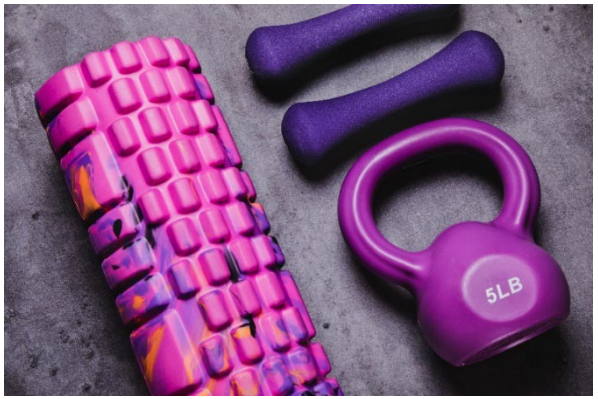
The NHS health check programme targets people who are at high risk of having a heart attack or stroke in the next 10 years. It is currently offered across the county in GP practices. It can help to tackle health inequalities, as the burden of early death from cardiovascular disease is higher in the most 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.

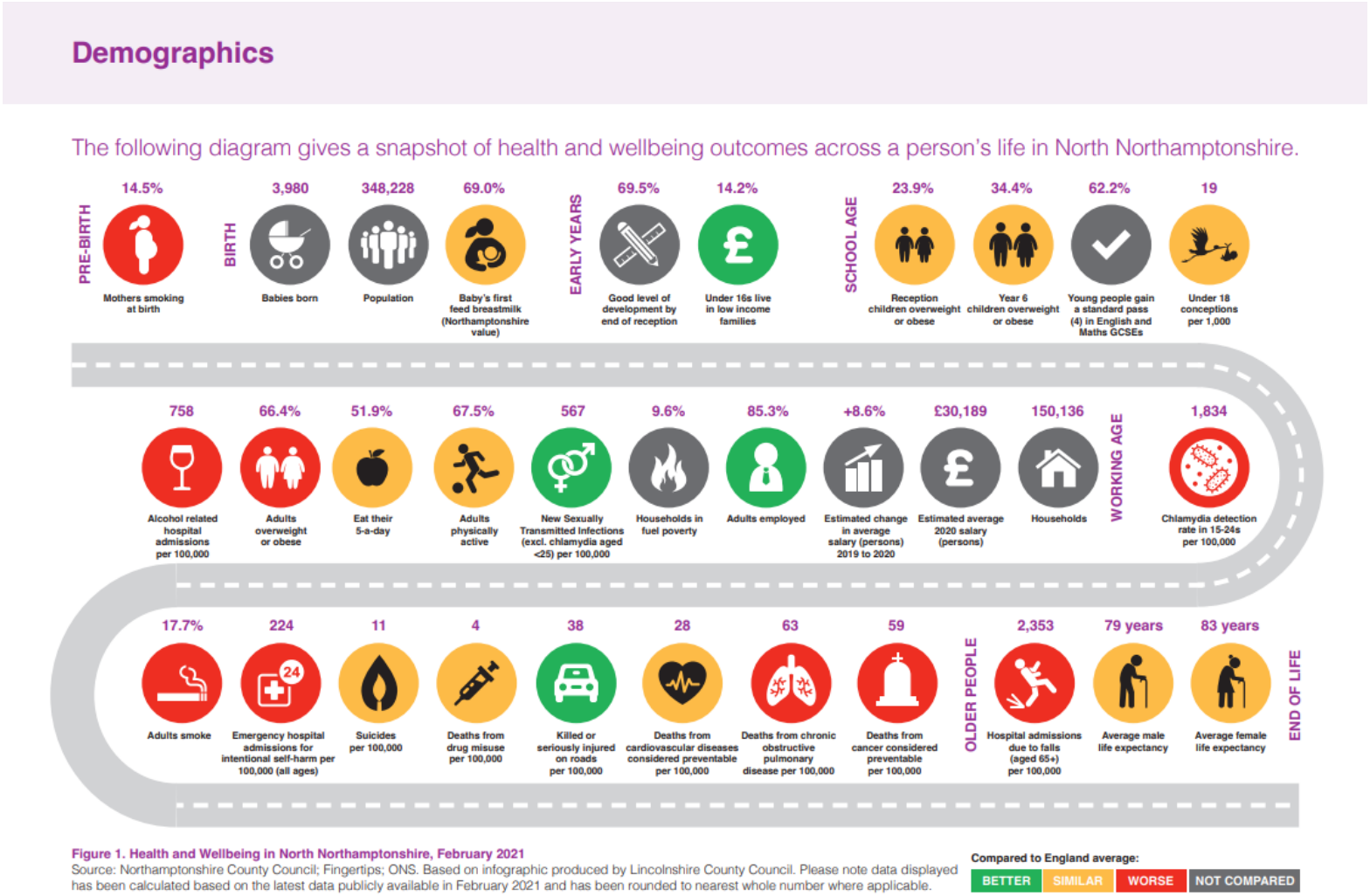


Figure 1. Health and Wellbeing in North Northamptonshire, February 2021
Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and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

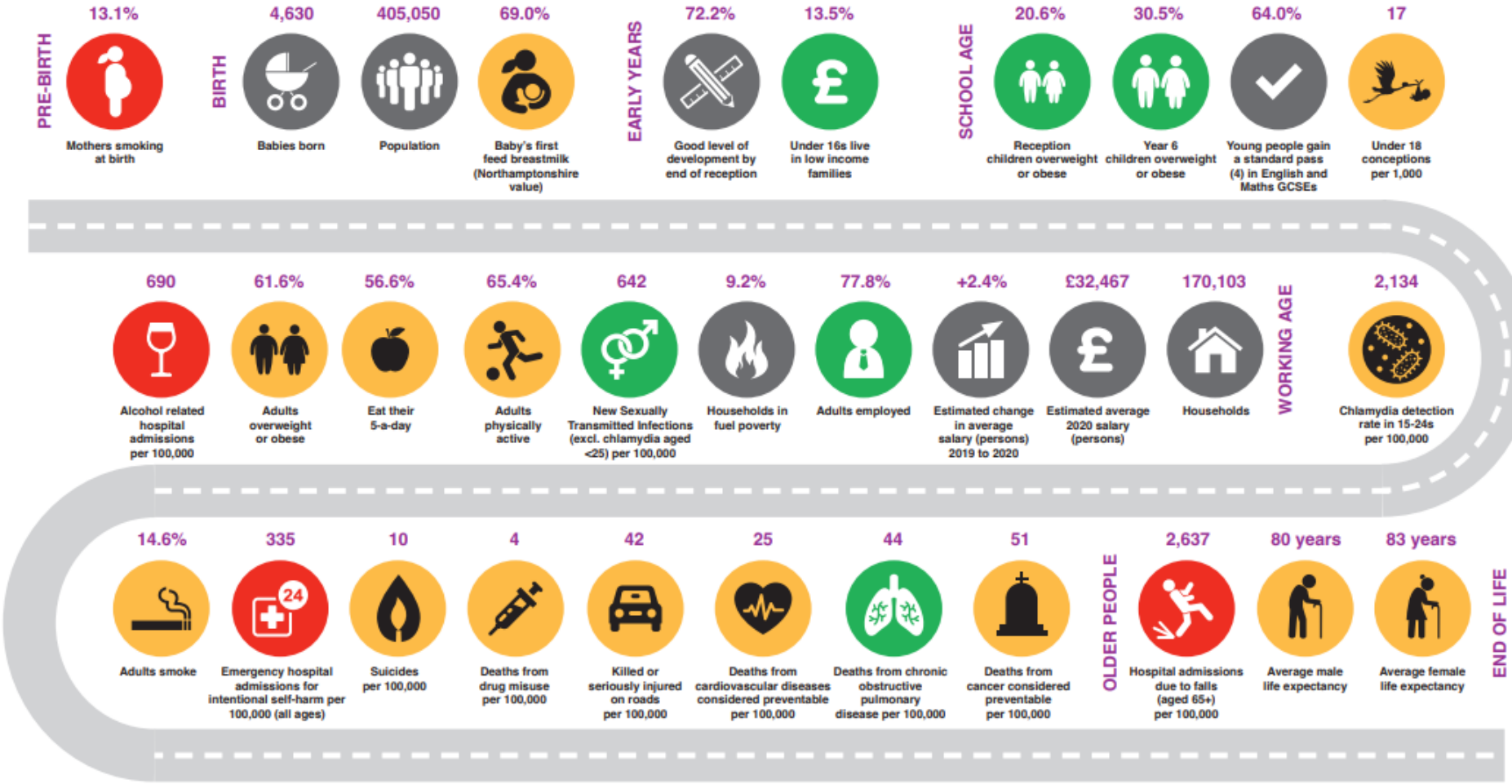


Figure 2. Health and Wellbeing in West Northamptonshire, February 2021

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.

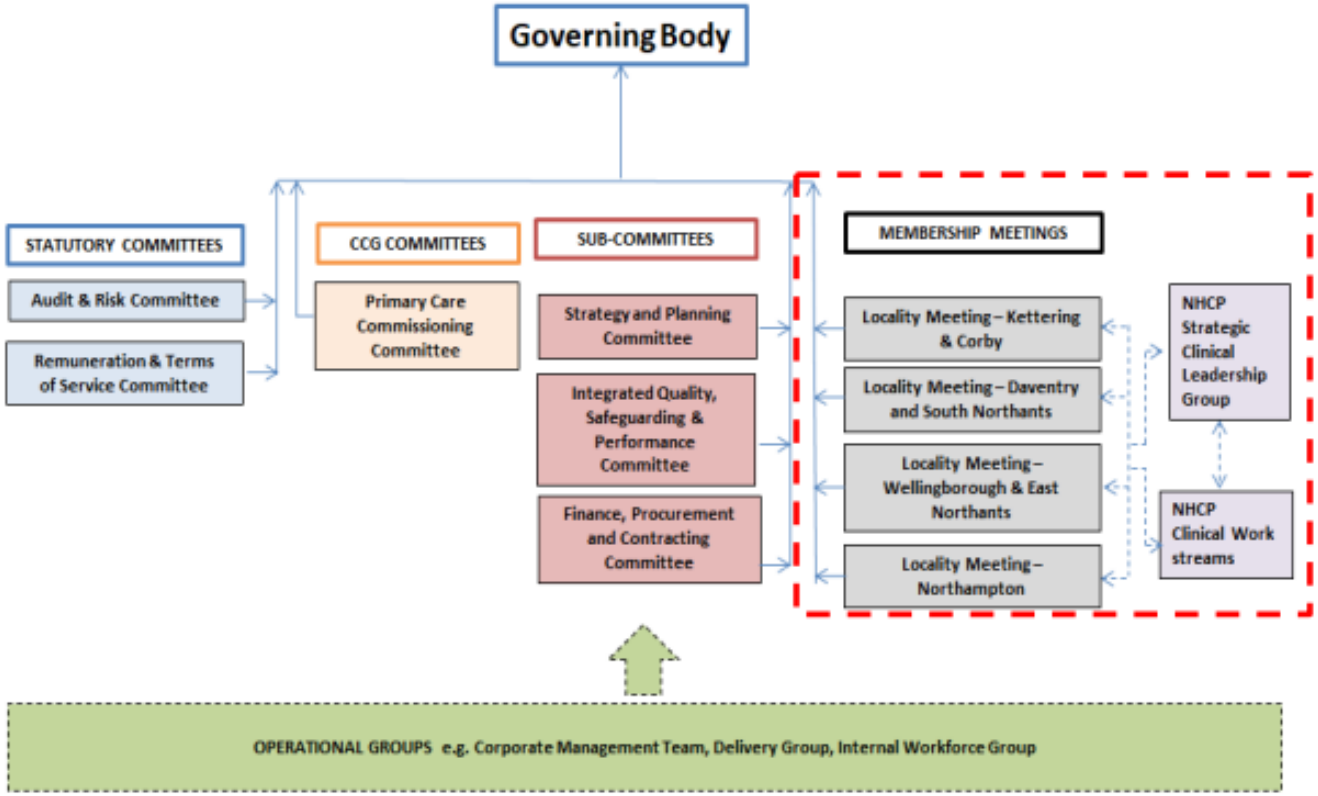


Diagram 1: NHS Northamptonshire CCG governance structure

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

- 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.

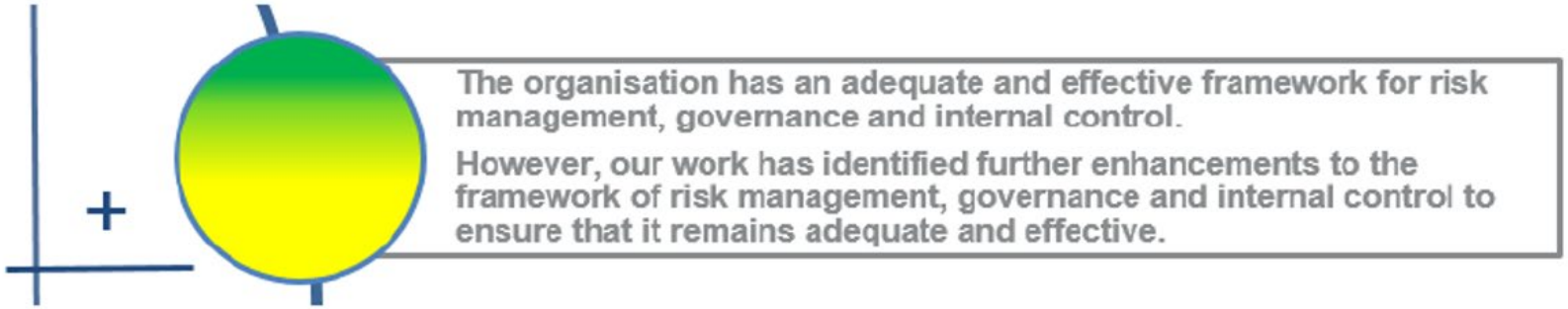
The chair of the committee draws the Governing Body's attention to any issues that require disclosure or executive action as required.

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.

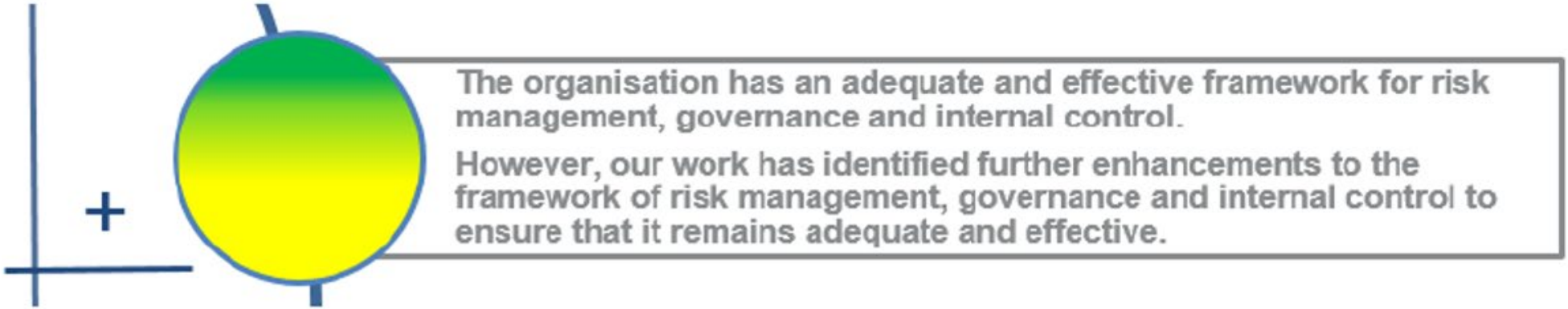
The Audit and Risk committee receives regular progress updates on the delivery of the counter fraud work plan and an annual report which summarises activity undertaken during the period. The CCG also completes an annual counter fraud functional standard return (CFFSR) which is a self-assessment against 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

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.

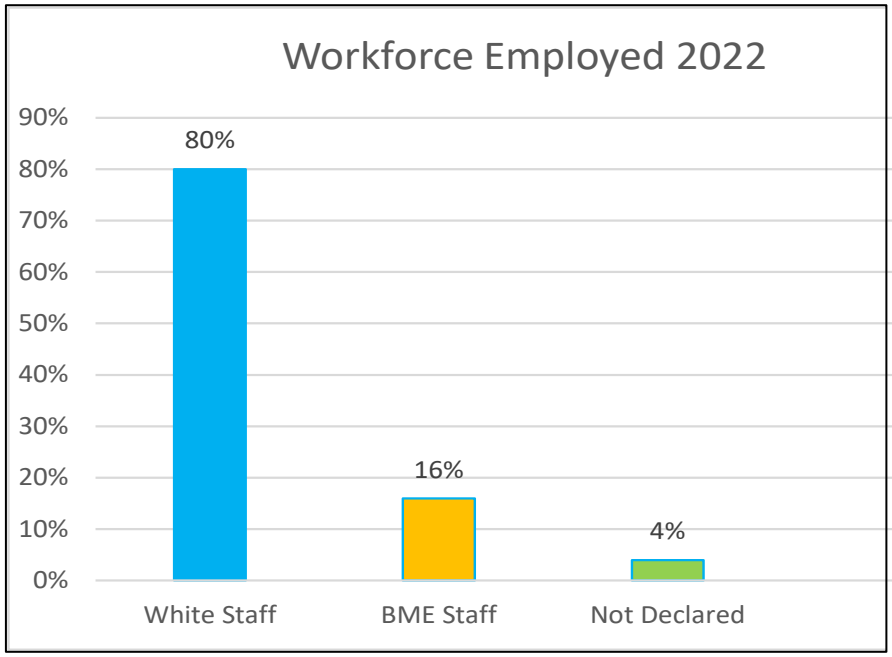
Positive about disability in the workplace

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