NHS
Sunderland
Clinical Commissioning Group

Annual report and accounts

2018/19

Better health for Sunderland

Contents

PERFORMANCE REPORT

David Gallagher
Chief Officer (Accountable Officer)
21 May 2019

Performance Overview

Our vision is for *Better Health for Sunderland* and is delivered through our three key strategic objectives:

- **Transforming out of hospital care** (through joining up health and social care and enabling seven day working);
- **Transforming in hospital care**, specifically urgent and emergency care (and enabling seven day working);
- **Enabling self-care and sustainability** to ensure the NHS can survive and thrive in the future.

In this, our performance overview, we have set out our main areas of work and achievements towards this vision during 2018/19, as well as outlining our business model, organisational structure and an overview of our local population.

Statement from the Clinical Chair and Chief Officer

Welcome to the NHS Sunderland Clinical Commissioning Group's sixth annual report covering the financial year 2018/19.

The past 12 months have seen significant achievements in NHS services across Sunderland as we work towards the Five Year Forward View vision through a range of initiatives and understand how our plans need to reflect the NHS Long Term Plan that was published in January 2019.

In 2018/19 we have made further progress by building upon community services integration and making a significant improvement to services through this work, which has involved radical cultural change and working closely with our partners and stakeholders in the way care is delivered in Sunderland. We have implemented a health-based multi-speciality provider model with our partners across the City in order to secure the out of hospital model of care for the future.

As a result, more patients are now able to receive the treatment they need outside a hospital environment where this is appropriate.

We undertook an in-depth review of our urgent care services, gathering views from our staff, partners, stakeholders and the public before entering into an extensive and robust formal public consultation period on new models of care which aim to improve delivery and provide a simpler system for patients to access.

We have continued to develop new and innovative ways to address the nationally recognised shortage of GPs and primary care staff. We know this is a challenge for our member practices, and we have taken a series of steps to manage these issues and

encourage more GPs and primary care staff to start and/or build their careers in Sunderland.

We have continued to work closely with City Hospitals Sunderland NHS Foundation Trust, NHS South Tyneside CCG and South Tyneside NHS Foundation Trust, (combined into South Tyneside and Sunderland NHS FT from 1 April 2019) to review and plan hospital services through a strategic transformation programme (the reform of services) known as the Path to Excellence.

This programme has been set up to secure the future of local NHS hospital services in Sunderland and South Tyneside and to identify new and innovative ways of delivering high quality, joined up, safe and sustainable care. Local people are now starting to see the benefits of this with stroke patients in both Sunderland and South Tyneside seeing significant positive improvements to their care as a result of changes implemented from Phase 1 of this work. We are now embarking on Phase 2.

We will continue to work towards this shared vision for the transformation of healthcare services and ensure we continue to have safe, high quality services for our local residents in the future.

Dr Ian Pattison
Clinical Chair

David Gallagher
Chief Officer (Accountable Officer)

Statement of Purpose

This section outlines our business model and environment, organisational structure, objectives and strategies.

About NHS Sunderland Clinical Commissioning Group

NHS Sunderland CCG (the CCG) is the statutory body responsible for planning, purchasing and monitoring the delivery and quality of most local healthcare and health services for the people of Sunderland. It is made up of doctors, nurses and other health professionals with management support.

All 40 GP practices in Sunderland are members of the CCG and together they elect six GPs to lead the CCG on their behalf, as part of a governing body which also includes a local authority representative, lay members, senior managers, a secondary care clinician and a senior nurse.

The Governing Body and its formal committees are responsible for setting the strategy for health improvement in the city and ensuring the CCG delivers the improvements set out in the strategy whilst maintaining and adhering to good governance principles.

The Governing Body works closely with a range of partners, as part of Sunderland's Health and Wellbeing Board, to improve the overall wellbeing of local people.

Our vision

Our vision is to achieve *Better Health for Sunderland* and we use the following seven core values to support the delivery of our vision:

These seven core values were informed through local engagement with member practices, patients and local people and they shape everything we do to deliver our vision.

System principles

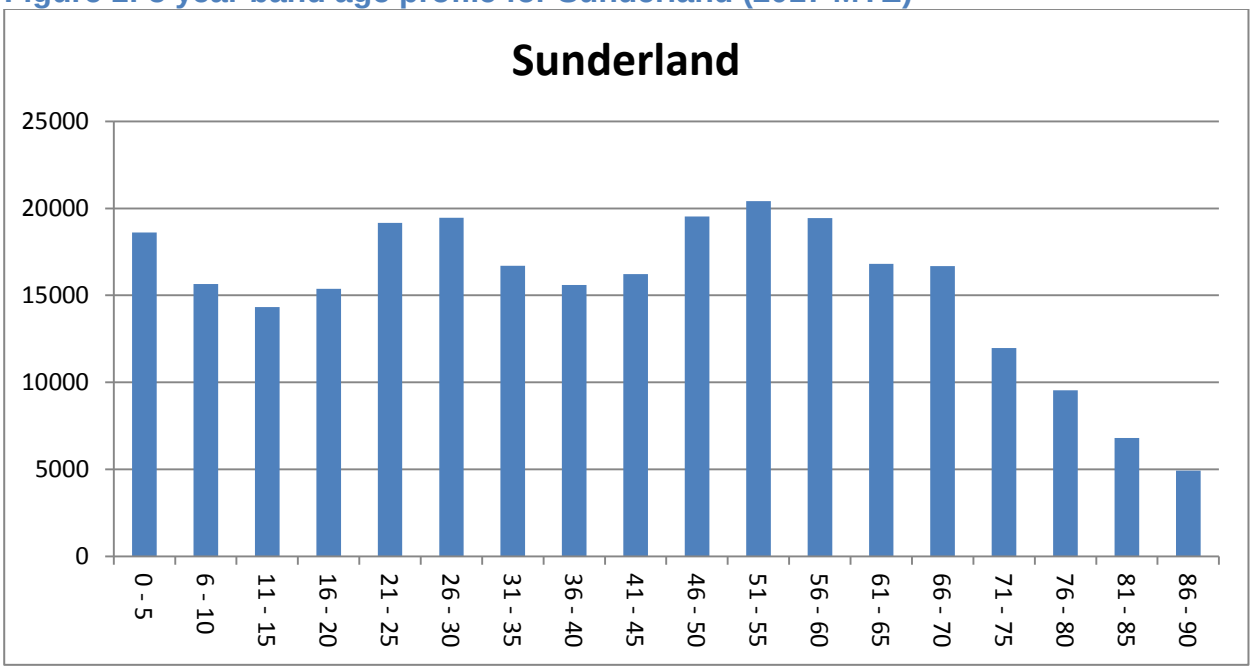
The following system-wide principles underpin the delivery of all our transformational change programmes:

- Evidence-based
- Effective, safe care and positive patient experience
- Prevention-focused
- Mental and physical health are of equal importance
- 7-day services
- One system for health and social care across Sunderland

Overview of Sunderland

The current population of Sunderland is 277,249 (2017 MYE).

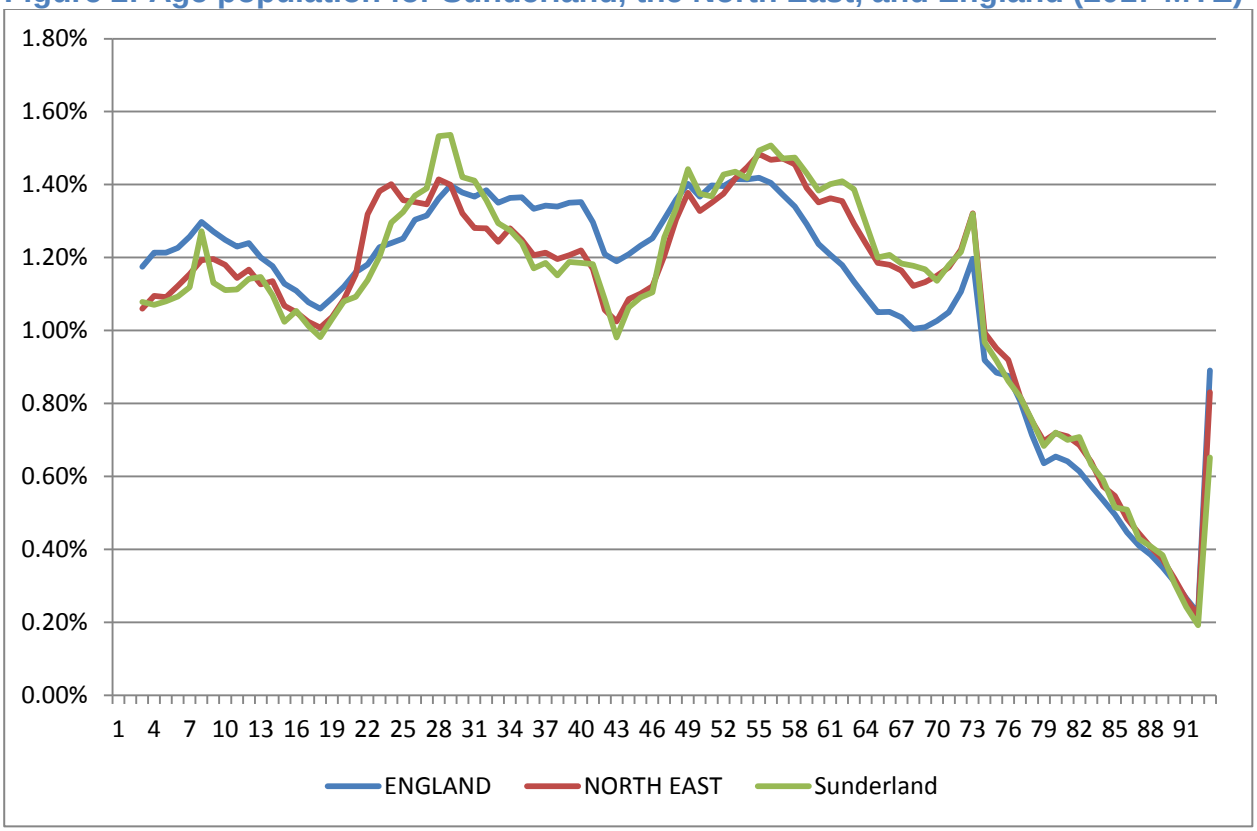
Figure 1: 5 year band age profile for Sunderland (2017 MYE)



Over the past 20 years, the population of Sunderland has been falling. However, this decline has recently levelled off and the population is forecast to rise over the next 20 years.

Compared to England, the population of Sunderland has a higher proportion of older people but less than the North East average. Older people use health and social care services more intensively than any other age group, which Sunderland CCG takes into consideration whilst planning services.

Figure 2: Age population for Sunderland, the North East, and England (2017 MYE)

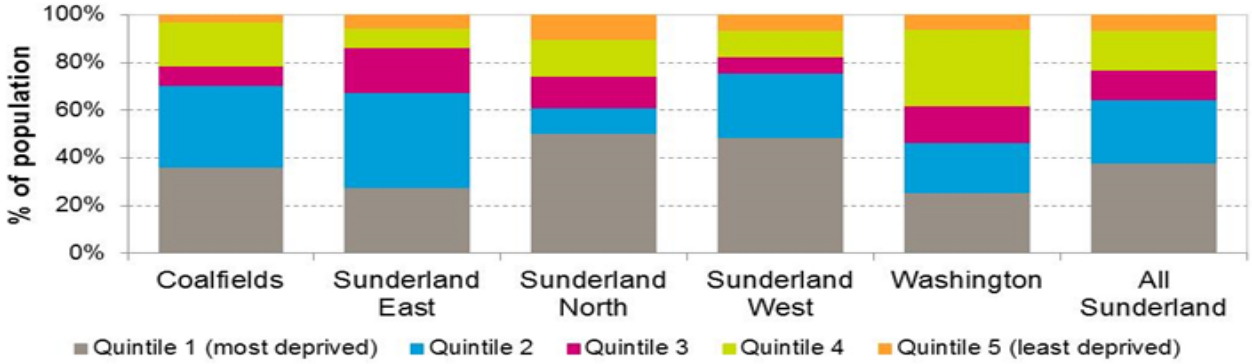


Culture and ethnicity may influence health beliefs and behaviours, and impact on health and wellbeing. In 2011, people from black and minority ethnic (BME) groups represented 4.1% of the Sunderland population, compared with 4.7% in the North East and 14.7% across England (2011 Census).

The age distribution of people from black and minority ethnic groups is generally younger than the rest of the population; there were lower proportions of all age groups from the 40-44 age group upwards. Population forecasts over the next three years suggests that Sunderland will have annual inward migration of around 6,700 persons from elsewhere in the United Kingdom and around 1,500 from the rest of the world, which is likely to continue to increase ethnic diversity but not rapidly increase the population size.

The Sunderland population experiences a higher level of social and economic disadvantage than the England average. Sunderland is the 31st most deprived upper tier local authority in England (based on IMD 2015 Average Score). Seventy one of Sunderland's 185 Lower Super Output Areas (LSOAs) are among the most disadvantaged fifth of all areas across England, and 38% of the Sunderland population lives within these super output areas. Sunderland North has the highest proportion of people living in both the most and least disadvantaged areas. The other areas have decreasing levels of disadvantage.

Figure 3: LSOA, depravation, and localities

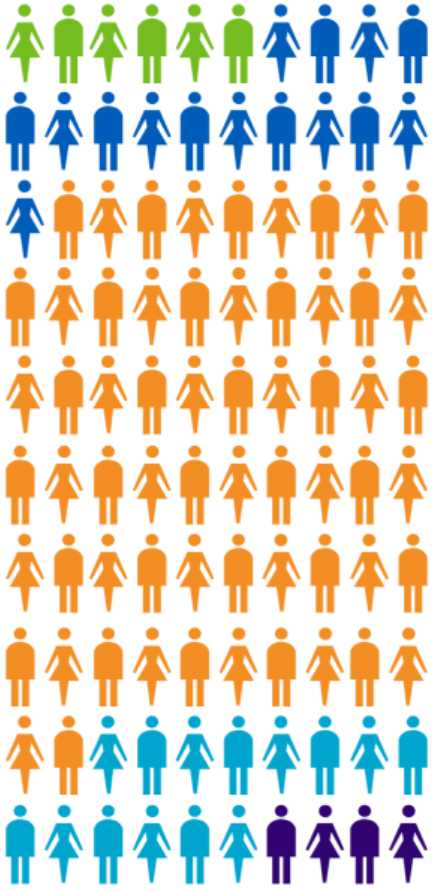


42% of older people live in areas which are in the 20% most disadvantaged by older people living in poverty across England. Sunderland East, West and North have higher levels of older people living in poverty.

According to Public Health England's local authority health profile for Sunderland, the health of people in Sunderland is generally worse than the England average. Sunderland is one of the 20% most deprived districts/unitary authorities in England and about 23% (11,100) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.5 years lower for men and 8.7 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

POPULATION

If Sunderland was a village of 100 people



Actual population: 277,249

- 6 x Diabetes
- 5 x Heart Disease
- 17 x Raised Blood Pressure
- 3 x Cancer
- 1 x Dementia
- 1 x Severe Mental Illness
- 6 x Asthma
- 2 x Had a Stroke
- 23 x Long-term illness
- 38 x Living in 'Most Deprived' quintile

Key challenges

The Five Year Forward View identified three key challenges for the NHS:

- **To improve health and wellbeing**: Health is determined by a complex interaction between individual characteristics, lifestyle, and the physical, social and economic environment. People in Sunderland are living longer but are at risk of spending their extended years in poor health as a result of high levels of poverty, deprivation and lack of opportunity which influence behaviours such as poor diet, lack of exercise, smoking and excessive alcohol use. Without greater focus on prevention and the wider determinants of health, these inequalities will widen.
- **Improve care and quality**: The quality of general practice is very good, but pressures are increasing and workforce recruitment and retention in Sunderland and the wider North East has historically been challenging. There are a number of challenges facing our two local hospital providers, City Hospitals NHS Foundation Trust and South Tyneside NHS Foundation Trust as they merge to become South Tyneside and Sunderland NHS FT. To ensure safe, sustainable high-quality services in the future, it is important that the issue of duplication in service provision is addressed.
- **Ensure sustainability**: In terms of funding and efficiency, 2018/19 has been financially challenging for the CCG and we expect this challenge to continue and become more difficult in future years. Rapid delivery of financial and associated efficiencies, alongside increased productivity, will be needed in order to remain within the available allocations.

High-level health challenges

The high-level health challenges in Sunderland include:

- Responding to changes in the population structure, including fewer children and younger working age adults, an increasing elderly population and greater ethnic diversity. 8.3% of our population is aged 75 and over, compared to the England average of 8.1% (based on 2014 mid-year population estimates).
- Tackling poverty through increasing employment, educational attainment and skills to give every child the best start in life. In Sunderland, the prevalence of childhood poverty is 23.6% against the England average of 18.6% (based on the 2013 snapshot from HMRC). In Sunderland 25.3% of the population aged 16-64 are qualified to NVQ level 4 or equivalent or above (higher education) compared to 36.7% for England (based on 2015 data from the Annual Population Survey).
- Tackling the big four lifestyle risk factors – smoking, excessive alcohol use, poor diet, and low levels of physical activity. The prevalence of smoking in adults aged 18 years and over is 22.8% in Sunderland compared to the England average of 18.0% (based on 2014 data from the Integrated Household Survey).
- Preventing early deaths from cancer, cardiovascular disease and respiratory disease. People in Sunderland on average live shorter lives than the England average. Life expectancy at birth is 77.3 years for males and 80.8 years for females,

compared to 79.5 for males and 83.2 for females in England (based on data for 2012-2014).

- Managing the likely increase in the level of long-term conditions, including increasing proportions of people with multiple long term conditions.
- Delivering better integrated care for individuals and reducing the over-reliance on hospital services, through promotion and support for self-care.
- Tackling poor mental health through prevention and building individual and community resilience.
- Addressing teenage pregnancy, smoking during pregnancy, breastfeeding and child obesity.

Working as part of the Sunderland Health and Wellbeing Board, we started focusing efforts with partners on three key areas across the city:

- Smoking (officer lead DPH)
- Alcohol misuse (officer lead CCG CO)
- Healthy Economy Integration / Joint working (officer lead FT CEO)

Strategic objectives

In order to achieve our vision of *Better Health for Sunderland* our three key strategic objectives and their areas of focus are:

1. **Transforming out of hospital care:**

- Patient-centred
- Right care, right place, right time
- System-wide approach with one common vision
- Multi-disciplinary teams in localities working together with older people, adults and children with long term conditions / complex needs to improve their lives / meet their needs
- Improved overall quality of care for the elderly
- Reduced variation in primary care
- A system which is simple to navigate
- Reduced emergency admissions to hospital as people are cared for effectively in the community

2. **Transforming in- hospital care, specifically urgent and emergency care:**

- Equality of access across the city to urgent care
- 24/7 hub
- More seamless transition between services

- Reduction in emergency admissions

3. **Enabling Self Care and Sustainability:**

- Local people influence and understand the system
- A city that actively supports / enables people to be and stay healthy, well and happy
- Improved public health outcomes
- Managing demand and utilising community assets
- A single Transformation Board to oversee this work
- Working closely with partners in neighbouring CCGs where our patients use services in those areas or where the level of transformation required is on a larger footprint than Sunderland.

Statement of Activities

Below we outline our main areas of work and some of our achievements during the past year. More detailed information about the projects and activities we have undertaken in 2018/19 are detailed in NHS Sunderland Annual Involvement and Engagement Report 2018/19 (https://www.sunderlandccg.nhs.uk/get-involved/involving-the-public-in-governance/annual-engagement-and-involvement-report/)

Transforming out of hospital care

All Together Better Sunderland

As part of NHS England's (NHSE) new models of care programme, All Together Better (ATB) has played a key role in making services more integrated, person-centred and efficient.

In 2015 Sunderland was awarded national 'vanguard status' which provided additional funding to deliver the Sunderland vision – to transform care out of hospital through increased integration of services and more person-centred care. The ATB Sunderland vanguard programme ran between 2015 and December 2017.

Between November and December 2017, building on our vanguard work engagement activity took place focused on gathering feedback from the public, patients, carers, and stakeholders representing the public on plans presented in the prospectus for a multispecialty community provider (MCP).More information about this engagement, can be found at: https://www.sunderlandccg.nhs.uk/get-involved/multi-specialty-community-provider-mcp-model/engagement-activity/

In February 2018, the CCG formally decided to secure an MCP collaboration business model via an alliance approach. This was initially supported through a compact for collaboration and subsequently through the establishment of an Alliance Executive Group

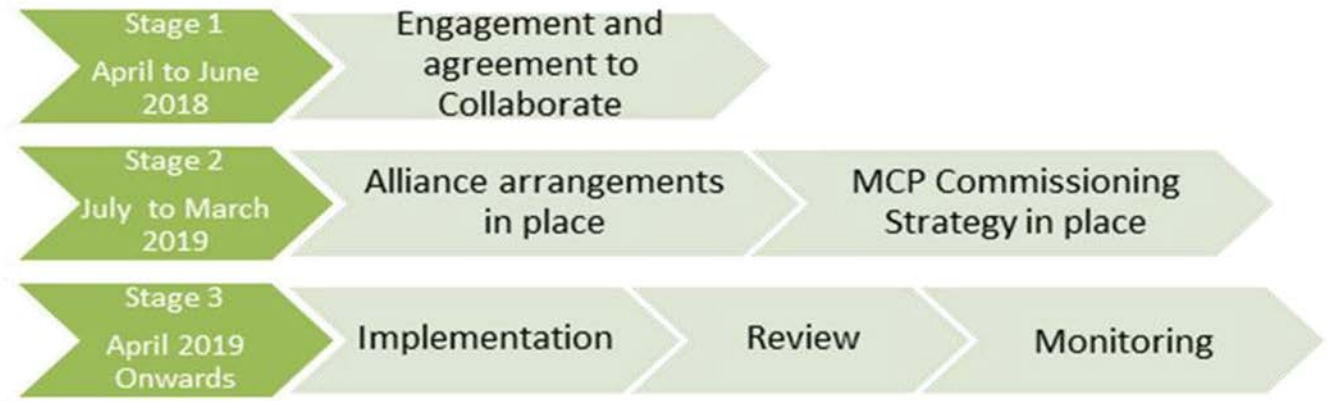
with alliance principles being incorporated into each contract commissioned by the CCG. The aim of the Alliance Executive Group is to achieve the outcomes in the CCG's prospectus (https://www.sunderlandccg.nhs.uk/wp-content/uploads/2018/03/Final-Prospectus-23.2.18-2.pdf) which was published in final form on 23 February 2018.

It is intended that the alliance approach will focus on “person centred proactive and coordinated care which will support appropriate use of health and care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life”.

The Alliance Executive Group is made up of the founding partners of ATB and has provided the input and ideas on the development of the alliance model for Sunderland. The membership includes representation from the CCG, Sunderland City Council, City Hospitals Sunderland Foundation Trust, South Tyneside Foundation Trust, Northumberland Tyne and Wear Foundation Trust, and the Sunderland General Practice Alliance.

Since March 2018, the ATBA Executive Group has been overseeing the development of the alliance approach, whilst undertaking engagement with wider stakeholders throughout the process. The Group has proposed that the alliance be formally known as the All Together Better Alliance (ATBA).

The development and implementation of the ATBA arrangements is taking a phased approach over three key stages:



In support of the proposals, the CCG has undertaken significant engagement work with the marketplace, including with contracted and non-contracted providers in order to gain opinion on the proposals. The views received were overwhelmingly supportive of the approach, influencing and shaping the proposed governance of the ATBA. Current providers have now signed a ‘compact for collaboration’ which is in addition to their existing contracts.

Following an engagement event in June 2018 the Alliance Executive Group members developed outline proposals for the ATBA. The proposals commit providers into the

alliance way of working, supporting collaboration between all stakeholders, not just those on the executive group, to ensure clinical leadership at all levels, with quality and safety at the heart of transformation, whilst delivering sustainability.

The outline proposals were accepted by the CCG Governing Body on 24 July 2018, including recommendations to:

- Develop the alliance arrangements including the programme approach
- Implement new executive group structure, including new system roles for a GP chair and managing director
- Develop a scheme of delegation
- Develop a local assurance process

The scope of services included within the remit of the alliance can be summarised as all out of hospital services including mental health, learning disabilities, autism, urgent care, intermediate care, urgent care, enhanced primary and community care and general practice.

In the alliance arrangements the CCG retains all its statutory accountability including its key statutory responsibility to commission health services for Sunderland. In order to describe how those services within the scope of the alliance will be commissioned, the CCG is developing an ATBA commissioning strategy. Stakeholders have been supportive of the draft proposals which describe alignment of the scope to a programme approach.

To find out more about All Together Better, visit www.atbsunderland.org.uk.

Transforming in-hospital care

Path to Excellence – transforming hospital services in South Tyneside and Sunderland

The CCG has continued its partnership with NHS South Tyneside CCG, South Tyneside Hospital NHS Foundation Trust, and City Hospitals Sunderland NHS Foundation Trust on the Path to Excellence programme, a five-year transformation of hospital healthcare provision across South Tyneside and Sunderland.

In February 2018, at a joint meeting of their governing bodies, the two CCGs decided their approach to the three key vulnerable hospital services that were the focus of a public consultation over summer 2017.

The decisions were:

- All acute strokes to be directed to Sunderland Royal Hospital, with the consolidation of all inpatient stroke care at Sunderland (this arrangement had been running temporarily since December 2016 due to service vulnerability)

- To develop a free-standing midwifery-led unit, known as a birthing centre, at South Tyneside District Hospital
- To base a medically-led obstetric unit at Sunderland Royal Hospital
- Gynaecology care requiring an overnight hospital stay to be carried out at Sunderland Royal Hospital
- Care for minor gynaecology conditions, including day case surgery and outpatient clinics, to continue at South Tyneside District Hospital
- To develop a nurse-led paediatric minor injury and illness facility at South Tyneside District Hospital – open 8am to 10pm – and 24/7 paediatric emergency department at Sunderland Royal as the most sustainable long-term model (option 2)*

* As it will take a period of time to develop a nurse-led paediatric minor injury and illness facility, implementation in the short-term includes the development of a daytime paediatric emergency department at South Tyneside District Hospital and 24/7 paediatric emergency department at Sunderland Royal Hospital.

NHS partners are mindful of their statutory duties to engage with health overview and scrutiny committees and elected members. South Tyneside and Sunderland NHS partners therefore began a formal discussion in April 2016 with the two health overview and scrutiny committees around the partnership's formation and the developing Path to Excellence phase one programme. A South Tyneside and Sunderland Joint Health Overview and Scrutiny Committee (JHOSC) was formed in September 2016.

Over the pre-consultation, consultation, and post consultation periods, NHS partners in the Path to Excellence attended eleven JHOSC meetings, providing information and evidence on the issues around the case for change. On 1 May 2018, the JHOSC referred these decisions (on behalf of both South Tyneside Council and Sunderland City Council) to the Secretary of State for Health and Social Care, citing referral grounds as follows:

- Adequacy of the content of consultation
- That the proposals would not be in the interests of the health service in the area

The Secretary of State sought advice from the Independent Reconfiguration Panel and wrote back to the CCGs, JHOSC and other interested stakeholders on 30 August 2018. The Secretary of State accepted advice from the Panel that said:

1. While the three options are being implemented, there needed to be further engagement, with a view to developing a better understanding about the bigger picture for healthcare in the area
2. All inpatient stroke services should be consolidated at Sunderland Royal Hospital
3. All obstetrics, inpatient gynaecology and special care for babies should be consolidated at Sunderland Royal Hospital with a free-standing midwife-led unit at South Tyneside Hospital

4. Further work is required on long term options for paediatric emergency care as part of considering the future of the whole urgent and emergency care system for the area. In the meantime, emergency paediatric care overnight should be consolidated at Sunderland Royal Hospital.

The local NHS and the JHOSC gave a joint response to the Secretary of State at the end of October 2018, outlining the implementation of the IRP recommendations. Joint sessions with the JHOSC continue to take place with a focus on phase one and assurances that elected members wish to have around phase one implementation.

Judicial review

In August 2018, the 'Save South Tyneside Hospital Campaign Group' was given permission for a judicial review around these decisions after citing that the public consultation process was unlawful. This culminated in a three-day hearing starting on Friday 21 December at the High Court of Justice, Leeds, under His Honour Judge Raeside QC. The judgement was that the CCGs had acted lawfully and that changes to services could now go ahead.

Phase one mobilisation

Changes to services were prepared as much as possible pending the outcome of the Independent Reconfiguration Panel review and Judicial Review processes but certain aspects could not be progressed until the judicial review process was complete.

The clinical teams are working as quickly as possible toward implementation, with maternity (and gynaecology) and paediatrics needing to change at the same time due to clinical interdependencies. More detailed conversations with the North East Ambulance Service (NEAS) around individual clinical pathways are underway and the priority is to make sure that the changes are managed robustly, with clear public awareness and communication.

Stroke

Acute stroke care for both Sunderland and South Tyneside has been consolidated at Sunderland Royal Hospital since December 2016. This was initially a temporary measure, as a result of service vulnerability.

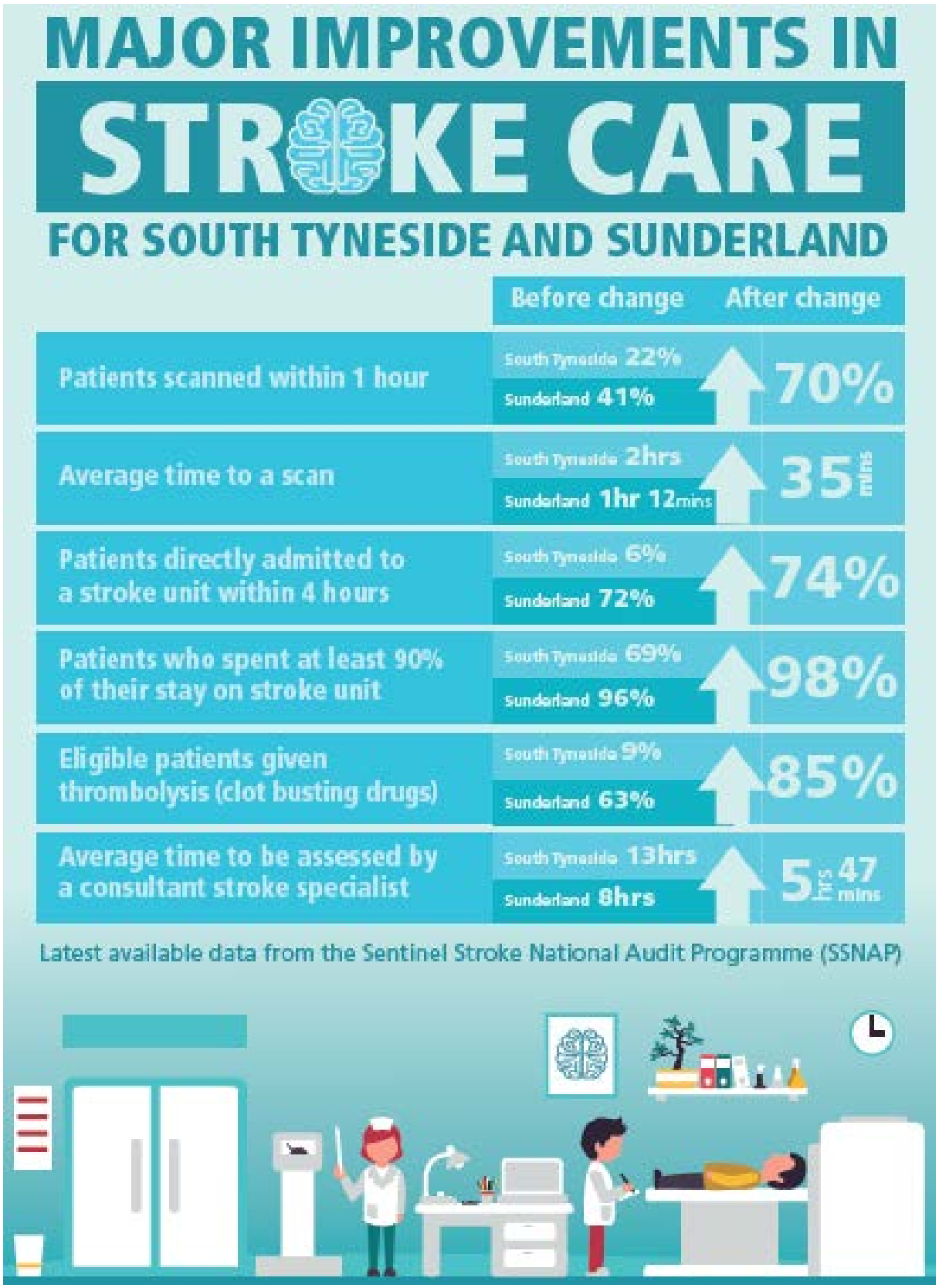
Consolidation of stroke consultants and therapy specialists into a single acute stroke unit has led to life-changing benefits for patients, saving lives for some, and preventing serious long-term disabilities in others, giving them the very best chance of returning to as normal as possible after their stroke.

The service's overall quality score has improved significantly from 66 to 80 under the Sentinel Stroke National Audit Programme (SSNAP), which is the single source of stroke data in England, Wales and Northern Ireland. This means the service has moved from SSNAP level D to level B (data published in January 2019), and is within one point of achieving level A.

The figures show that for stroke:

- 70% of patients are now receiving a CT scan within 1 hour, compared to just 41% of Sunderland patients prior to the changes
- 85% of eligible patients are now receiving thrombolysis (clot busting drugs), compared to 63% of Sunderland patients prior to the changes
- The average time taken for Sunderland patients to receive a CT scan has reduced from just over an hour to 35 minutes
- The average time taken for Sunderland patients to be assessed by a specialist has reduced from 8 hours to 5 hours and 47 minutes.

The overall improvements for all patients are illustrated below.



Maternity and women's healthcare
For maternity and women's healthcare the focus has been on getting a new service right from the start, with a new birthing centre and community hub. This includes using an evidence-based approach, involving staff and women.

Over summer 2018, workshops took place with women from both trusts to look at key areas of practice for development. Staff also went to visit centres of excellence at the Friarage in North Yorkshire, Huddersfield, Pontefract and Edgware in London.

Northumbria University School of Nursing, Midwifery and Health will conduct an independent review of the clinical evidence base, assess developments to date and provide an objective view, working with the local health system to co-produce the birthing centre with local women through targeted engagement activities, building on the significant engagement activity that has already taken place.

Travel and transport
People who took part in the phase one public consultation told us their concerns about having to travel further as a result of changes to key vulnerable services being delivered from Sunderland Royal Hospital, rather than South Tyneside Hospital.

Examples included concern around the ability of the North East Ambulance Service to deal with additional patients needing emergency transport, the impact on visitors using public transport and the capacity for car parking.

After the public consultation and before the decisions were made, the clinical commissioning groups sought assurance from North East Ambulance Service that all three service changes were deliverable from their perspective, as the provider responsible for emergency 999 response. We have continued to work with the ambulance service to ensure arrangements will be in place to take patients to the right place at the right time when changes start.

In addition, the North East CCGs agreed £6.5 million extra investment over the next four years, meaning the ambulance service can recruit another 100 paramedics, and improve the ambulance fleet. This all helps support the service to ensure a high level of performance and response. Sunderland's share of this investment is £676k.

As a result of the public consultation, a travel and transport stakeholder working group was formed, with a wide membership of transport providers, NEXUS, elected members, local authorities, Trusts and the Tyne and Wear Public Transport User Group.

The group meets quarterly, with a sub-group of transport providers, trusts, councils and CCGs progressing work to make improvements to travel and transport issues highlighted by public feedback from the phase one consultation.

Its work is focusing on improvement to travel planning and joining up services and information across the NHS, transport providers, local authorities for the benefit of patients, families, visitors and staff.

One initiative is looking at improving access to the hospital sites by bus operators, NEXUS and councils, including new publicity and information summarising bus and metro links serving each hospital site, including walking routes into sites and increasing the visibility of public transport stops.

NEXUS is working with the hospitals to develop personalised journey planning for patients, so it can be automatically included in patient correspondence.

The councils are supporting the work and are carrying out 'last mile of journey' audits looking at things like distances, signage, pathways and crossing facilities to inform plans for improvements.

Path to Excellence phase two

Phase two is the final part of the Path to Excellence programme, and will involve the following key areas of hospital-based care:

- Emergency care and acute medicine
- Emergency surgery
- Planned care (including surgery and outpatients)

NHS partners continue to work together to plan for the future, to identify new and innovative ways of delivering high quality, joined-up, sustainable hospital services that will further improve the quality of care and patient outcomes.

The engagement phase ran until May 2019. The two main methods for this patient engagement research and insight phase included surveys, either by direct mailing with a freepost return, or face-to-face questionnaires carried out on hospital wards and clinics by Trusts' patient insight staff and volunteers. In order to ensure good practice, surveys and questions were benchmarked against national surveys conducted by the NHS or special interest groups.

The general public perception is that hospitals provide the majority of NHS care, but the reality is that the majority of NHS care takes place in local communities, and this is something we want to expand further. We also know that more needs to be done to improve the health and wellbeing of the population, with a focus on preventing people becoming unwell in the first place (our "Enabling Self-Care and Sustainability" strategic objective).

Merger of the two hospitals

In December 2018, the individual boards of South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust approved a full business case which was submitted to the trust regulator “NHS Improvement” for approval of the proposed merger of the two organisations.

The business case was approved by NHS Improvement, and this was taken forward by the individual Trust Boards and respective Councils of Governors in March 2019. From 1 April 2019, the newly merged South Tyneside and Sunderland NHS Foundation Trust came into operation and detailed work will continue to bring the two organisations together as one. Individual hospitals and local healthcare facilities have retained their existing names, which staff and patients are familiar with.

The CCG has supported this merger which is about changes to organisational form rather than clinical services for patients. The Path to Excellence programme of clinical transformation is an entirely separate process, and any future significant changes to hospital services as part of Phase Two will be subject to full formal public consultation planned for summer 2019.

The new Trust and the CCG agreed that a formal merger was in the best interests of the population in both South Tyneside and Sunderland and will allow further improvements in the quality of patient care by cementing relationships for the long-term and giving staff much-needed stability for the future.

The North East and North Cumbria Integrated Care System and Integrated Care Partnerships

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

The North East and north Cumbria (NENC) ICS aims to bring together local organisations to redesign care and improve population health, creating shared leadership and action, integrating primary and specialist care, physical and mental health services, and health with social care.

NHS Sunderland Clinical Commissioning Group (CCG) is one of the NHS partners in the NENC ICS who have agreed to work together at scale where it makes most sense to do so, while protecting and emphasising the importance of ‘place’ - local accountability to local populations and the ability to respond to local needs.

The NENC ICS will not be a new organisation but a new way of working, drawing several existing strands of work together into a single system leadership and governance framework that will allow us to harness their collective resources and expertise to make

faster progress on improving health outcomes and deliver better value across the population.

The NENC ICS ambition is to significantly improve health outcomes for people in the North East and north Cumbria by working with, and through, communities, partner organisations and our staff. We are focused on creating a common purpose and joint ambition to drive improvements in health, wealth and wellbeing.

Our ICS aims to streamline its commissioning arrangements to enable decision-making at system level where appropriate. There is an expectation that CCGs will become more strategic supporting providers to partner with local government and other community organisations on population health and service redesign.

Our agreed joint priorities – regardless of organisation or service provider – are focused on improving people's health and wellbeing and ensuring safe and sustainability services. By holding regular 'health and care summits', involving local authorities, members of the public and voluntary sector, we will continue to check our priorities and direction of travel.

The value of contributing towards a single ICS is understood by partners, however the majority of services will continue to be commissioned, planned and delivered locally. We will be working across three different levels of scale:

- Place – populations of circa 150,000 to 500,000 people, in boroughs, cities and counties, will be the main focus for partnership working between the NHS and local authorities. In these areas, primary care networks (providing services to populations of circa 30,000-50,000 people) will support collaboration between GP practices, social care, other community based care providers and voluntary sector organisations.
- Integrated care partnerships – populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features), focused on collaboration across NHS hospital trusts, to ensure safe and sustainable services.
- Integrated care system – a population of circa 3.1 million people, focussed on 'at scale' activity that achieves efficiencies.

In County Durham, South Tyneside and Sunderland, NHS organisations are coming together, working with the local authorities, to lead and plan care for their population in a coordinated way as the Central Integrated Care Partnership (Central ICP).

North East and North Cumbria Urgent and Emergency Care Network

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

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

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

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

The new NHS 111 Online service went live in July 2018 and provides a digital option for patients accessing urgent care in the North East and North Cumbria. Patients are able to receive self-care advice via their smart phone, tablet or computer, be signposted to pharmacy and optician services, be referred to GP services and receive telephone call-backs from clinicians when appropriate.

Winter funding for 2018/19 allocated by NHS England for schemes to deliver against the UECN strategy were agreed for a small number of priority regional schemes as agreed by local A&E delivery boards:

- Consultant connect – based on a system in place in Sunderland offering phone advice and guidance allowing GPs to contact local physical and mental health specialists directly and immediately
- Point of care testing for norovirus and flu – to enable point of care testing for flu and norovirus in emergency departments following successful use the previous year in Sunderland hospitals
- Regional communications campaign – regional messages aimed at educating patients about NHS services, helping people to self-care and to use the most appropriate NHS service for their needs. Locally this was supplemented through the Sunderland A&E Delivery Board.

The UEC-RAIDR App

This App shows where providers across the system are experiencing pressure, offering real-time information on Operational Pressure Escalation Levels (OPEL) ratings, ambulance activity, patients present, bed availability and emergency department waiting times.

Digital care

Thousands of patients are benefiting from better, safer care, thanks to a new system supported by the network. In the past, different parts of the NHS have had their own paper records and exchanged information using letters, telephone and fax. As a result, important

information held by GPs, such as medications prescribed and recent test results – was not easily available to other healthcare professionals at the point of care.

Now 100% of practices in the North East have agreed to share patient records with emergency doctors, nurses and paramedics, using the Medical Interoperability Gateway (MIG) system. The MIG offers secure, real-time access to a summary of GP-held records, so clinical decisions are made using the most up-to-date information, such as diagnoses, medications, details of hospitals admissions and treatments.

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

Rolling out the MIG was an important first step towards the long-term vision for a Great North Care Record.

Direct GP bookings

All GP surgeries in the North East are committed to accepting appointments through NHS 111, putting the region in the forefront of change within the NHS nationally.

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

Results from last year's survey, completed by three-quarters of the region's practices, helped streamline and inform further improvements to the service.

The technology developed for in-hours direct booking has also been used to provide electronic extended access appointments outside core GP hours, to the out-of-hours GPs, extended access hubs in Sunderland and urgent treatment centres. Direct booking of appointments is available to 100% of out of hours services across the North East and North Cumbria.

In Sunderland, all GPs are committed to accepting appointments through NHS111.
Only 4 out of 40 practices are not yet live with direct booking and they are currently being tested in readiness for activation.

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

NHS Child Health App
This app helps parents who may be unsure or need guidance on how best to deal with common childhood illnesses as well as reducing the pressure on services. Children account for a high proportion of A&E attendances in the North East, but around 60% of under-fives are discharged with no treatment.

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

Urgent and emergency care regional campaign
The campaign aimed to raise awareness in the most effective way to influence people's decisions about the best use of health services, and significantly change the use of urgent care services across the North East. It ran for 12 months, mapped against peak surge activity at key times of the year. It was integrated with national campaigns by NHS England and Public Health England to deliver planned locally tailored communications activities.

This last winter, the CCG supported a region-wide campaign aimed at helping people to stay well this winter, by providing lots of useful advice on how to prevent and manage the most common winter ailments.

The campaign featured additional family members of 'plasticine people', who will help the region's NHS through the challenges of winter, by helping people to make the best use of NHS services.

Other local activities included the use of digital, media advertising and out of home activity. The campaign will continue to support our approach to surge management, using recent behavioural analysis research, which provided in-depth insight into people's views, motivations and behaviours in using urgent and emergency care.

Recognising the importance of a strong public information campaign to help local people make better choices, Sunderland CCG funded additional local activity to complement the regional campaign. Backed by local partners including Sunderland AFC, this included bespoke advertising and artwork.

The campaign evaluation showed that:

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

creating or updating a first aid kit, finding out about GP and pharmacy opening times or arranging an evening or weekend GP appointment.

Enabling self-care and sustainability

Northern CCG Forum and Northern CCG Joint Committee

In common with all CCGs in the region, the CCG played an active role in the Northern Clinical Commissioning Group Forum which operated until May 2018. The Forum provided leadership to the North East and North Cumbria health system, addressed national and regional policy issues and carried out business on a joint basis where this achieved the best outcome. This included areas like winter pressures, Commissioning for Quality and Innovation (CQUIN), implementation of new services and avoidance of inequitable treatment through 'postcode prescribing'. At its meeting in May 2018, the Forum agreed that it should be stood down and its business would be transferred to the Northern CCGs' Joint Committee.

The CCG is a member of this joint committee which makes decisions on subjects recommended to it. These are confined to issues that pertain to all CCG areas in Cumbria and the North East initially the commissioning of specialist acute services and 'NHS111' services.

During 2018/19 the Joint Committee also considered the following:

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

Meetings are open to members of the public to attend to observe the Joint Committee at work.

Urgent care

The Sunderland urgent care consultation concluded with the decision to have an urgent treatment centre located at Pallion Health Centre with five Sunderland Extended Access Services located throughout the city.

Changes were made to the initial clinical model following concerns voiced by members of the public, meaning minor injuries services will also be available at the Sunderland

Extended Access Services at Houghton Primary Care Centre and Washington Primary Care Centre as well as at the urgent treatment centre in Pallion.

The CCG decided the future of urgent care services following a 16-week consultation period in which people were invited to consider a range of different ways in which urgent care services could be arranged in the future. From 9 May until 2 September 2018, the CCG engaged with over 2,500 people through surveys, public events, focus groups, emails and over the phone on the proposals for a new system of urgent care in Sunderland.

The Governing Body reviewed and considered of all the clinical evidence and feedback from a process of public consultation at its meeting on 29 January 2019.

Following this, the CCG decided that from April 2019 patients only need to call their own GP practice or 111 to access urgent healthcare. Services that will be available include:

- An integrated urgent care service (111) which has been available since October 2018.
- A Recovery at Home service which supports vulnerable patients with complex needs to remain at home. This team (which includes a GP) responds quickly to provide intensive support to those who need more help while they are getting back to normal after a short term illness or injury in their own home, a care home or on discharge from hospital.
- 45,000 GP appointments per year (including an additional 14,000 from April 2019) through the Sunderland Extended Access Service. You will need to book an appointment through your GP practice and this service is available from 6pm-8.30pm, Monday to Friday, 9am-5.30pm weekends and 10am-2pm on bank holidays. From April 2019 this will be at five locations in Sunderland (Pallion Health Centre, Bunny Hill Primary Care Centre, Houghton Primary Care Centre, Riverview Health Centre, Washington Primary Care Centre).
- Minor injury services will be accessed at the urgent treatment centre at Pallion Health Centre (open 10am to 10pm, Monday to Friday and 8am-10pm weekends and bank holidays) and via appointment at the Sunderland Extended Access Service in Houghton Primary Care Centre and Washington Primary Care Centre.

The changes are planned from the summer of 2019 and any changes will only take place when robust plans are in place to ensure that patient care is not adversely affected.

More information about the Sunderland urgent care consultation can be found by going to: https://www.sunderlandccg.nhs.uk/get-involved/urgent-care-services/

Information on the decision making report for Sunderland urgent care can be found by going to: https://www.sunderlandccg.nhs.uk/get-involved/decision-making-on-the-urgent-care-consultation/

Optimising the use of over the counter medicines

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

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

The savings could be used to fund other NHS services for example £22.8 million on constipation – enough to fund around 900 community nurses; £3 million on athlete's foot and other fungal infections – enough to fund 810 hip operations; £2.8 million on diarrhoea – enough to fund 2912 cataract operations

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

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

During a 12-month period, the campaign made savings of over £1 million across the region helping redirect money to other healthcare needs.

In March 2018 NHS England released the findings from a national consultation and recommendations on the conditions for which over the counter items should not be routinely prescribed in primary care. The findings mirrored the local evidence and research showing that the North East and North Cumbria areas were ahead of the curve and had already made significant savings prior to the recommendations being released.

CCGs win landmark high court victory over pharmacy companies

The CCG supported an important programme which won a landmark court case against two multinational drug companies, saving millions of pounds in the treatment of the wet age-related macular degeneration (wet AMD).

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

Avastin is equally effective and much less expensive, with approximate savings of around £13.5 million per year for the 12 CCGs involved (the equivalent of extra 270 nurses or 266 heart transplants each year for example) which can be put back into caring for patients.

Drug companies Novartis and Bayer took legal action to try to stop the CCGs from offering Avastin to patients, despite it being found by NICE to be just as clinically effective and safe. As a well-known cancer drug, Avastin is widely used around the world, including the EU and private practice in the UK, to treat wet AMD.

In the ruling, the judge dismissed the appeal by the companies on all four grounds and ordered the claimants to pay the CCGs' legal costs. The ruling provided vital clarity for the NHS in the region and nationally and reassured clinicians that the use of Avastin for wet AMD is lawful, safe and effective.

My COPD

The CCG supported a campaign to highlight a new app about chronic obstructive pulmonary disease (COPD) that encourages patients to self-manage their condition. COPD is a serious long term condition which can impact the quality of life for those have been diagnosed.

The app includes information and advice on managing the condition including:

- inhaler technique videos
- education from experts
- a six-week pulmonary rehabilitation program
- prescription assessment
- self-management plan
- symptom and assessment tracking
- weather and air pollution forecasting

Patients can sign up for the app at their GP surgery. It's easy to use and can be downloaded onto any internet device such as a smart phone, tablet or computer.

Red bag scheme

A new scheme, designed to improve communication and experience for care home residents who need hospital treatment was launched.

The Red Bag Scheme is a joint project between City Hospitals Sunderland NHS Foundation Trust, Sunderland CCG, Sunderland City Council, North East Ambulance

Service NHS Foundation Trust and care homes across Sunderland to make sure that residents can be easily identified when they are brought into hospital by having all their health-related paperwork and personal belongings in the dedicated red bag.

The bag stays with the care home resident from the moment they leave in an ambulance and will stay with them throughout their assessment in the Emergency Department, stay on a ward and through their discharge back to the care home. The bag contains vital information about the general health of the patient, any medication they are taking as well as personal items, such as dentures and hearing aids and day clothes for discharge.

The Red Bag Scheme is part of a wider initiative that has recently introduced to help more patients get back to their own bed quickly and safely. #TheresNoBedLikeHome uses the red and green days concept to identify any delays in the patient's care and encourage a joined-up approach between health professionals to work together to make a plan to get the patient back to the comfort of their own home.

Investors in People

Following our Investors in People Platinum Award in December 2017, the CCG was a finalist for the international Investors in People Best Platinum Employer of the Year in November 2018.

Key Issues and Risks

The CCG identified the following key risks to the delivery of its strategic objectives in 2018/19:

- Sustainability of IT, workforce and infrastructure within the CCG and general practice
- Financial overspend on CCG programme and running cost budgets
- Changes in NHS Property Services billing policies, impacting both on the CCG and member practices
- Delivery of all cancer standards within City Hospitals Sunderland NHS Foundation Trust under the NHS Constitution
- Delivery of ambulance response targets by North East Ambulance Service NHS Foundation Trust
- Providers ability to meet the A&E 95% four hour target
- Delivery of a multi-specialist community provider model
- Overspend on the delivery of the Better Care Fund
- Quality within primary care
- Transforming Care financial impact
- Delivery of productivity plans for 2018/19 and 2019/20
- Delivery of an urgent care strategy

Performance analysis

Performance summary

We measure performance to ensure the services we commission are delivered to a quality standard and provide value for money. The CCG has internal processes in place to manage performance against a range of indicators including a mechanism to work with internal and external colleagues to identify and mitigate areas of risk. The CCG Improvement and Assessment Framework (IAF) sets out the key performance requirements for CCGs.

Throughout the year, reports are provided to the Governing Body setting out performance against the agreed local and national measures. When undertaken in conjunction with other CCG services, such as quality monitoring and financial management, monitoring of performance enables us to understand the effectiveness of services better. In 2016/17 and 2017/18, the CCG received an IAF rating of outstanding due to its commitment and focus on the delivery of quality and performance standards.

Throughout the year, the CCG has been working hard to achieve our targets as set out by the NHS Constitution and CCG Improvement and Assessment Framework.

The next few pages highlight performance in 2018/19 against the following key pressure areas:

- Accident and emergency waiting times
- Cancer waiting times
- Referral to treatment (RTT) including waiting list volumes
- Mental health standards and expectations
- Ambulance response times
- Clinical priority areas as part of the IAF

Accident and emergency (A&E) waiting times (four hour wait standard)

Delivery of the four hour wait A&E standard remains a pressure in Sunderland due to increased demand at the emergency department (ED) at Sunderland Royal Hospital. This demand increased as a result of more patients self-presenting and attending via ambulance. The four GP led urgent care centres (UCC) continued to deliver performance above the 95% standard and the CCG and its partners continue to focus on delivery of improvements across the urgent care system in 2018/19. The Sunderland health economy did not deliver the 95% standard in 2017/18 with performance of 91.3% and as 2018/19 closes, performance was 91%.

The local multi agency A&E Delivery Board (A&E DB) oversees the achievement of the standard and the delivery of an improvement plan.

The CCG continued to work with stakeholders to deliver the improvement plan which covers:

- Implementation of streaming to appropriate services in and out of hospital e.g. ambulatory/same day emergency day
- Implementation of the CCG's Urgent Care Strategy which includes:
    - Implementation of an Urgent Treatment Centre (UTC)
    - Full roll out of extended access services across the city in five locality hubs, one of which is co-located with the UTC in Pallion Health Centre
    - Relocation of the GP out of hours Service into ED providing additional resource into ED for streaming
    - Implementation of the new national Integrated Urgent Care (IUC) service (111)
- Whole systems approach to surge and resilience throughout winter and throughout the year
- Paramedic pathfinder project to support reduction of ambulance conveyance to hospital
- Working with City Hospitals Sunderland NHSFT(CHSFT) and other stakeholders to develop the ED interface which focuses on streaming to alternative settings. This was as a consequence of the recommendations made by the Emergency Care Improvement Programme (ECIP) and the outcome of the Sunderland system transformation plan.

This work continues into 2019/20, along with targeted engagement with the public around the use of the ED and the ongoing implementation of the urgent care strategy which was agreed by the Governing Body in January 2019.

Referral to Treatment (RTT) and waiting lists

The CCG continued to deliver the 92% standard for RTT pathways in 2018/19, whilst working to resolve some pressurised specialties locally.

Areas of specialty pressure are predominantly within orthopaedics, rheumatology and dermatology with work ongoing to reduce demand upon these services. Due to the ongoing and sustained pressures in orthopaedics, the CCG's Executive Committee agreed to implement a single point of access (SPoA) for orthopaedic referrals, using SIMS (Sunderland's Intermediate Musculoskeletal Service) which aims to reduce inappropriate demand into secondary care and allow secondary care to focus treating those patients that need consultant based care. This system change was planned to "go-live" from the 1st April 2019.

Rheumatology remains a key pressure in Sunderland and across the Integrated Care Partnership (ICP) and as such, a programme of work to address workforce and demand

pressures across the central and south ICPs in 2019/20. The CCG will continue to work with STSFT to improve performance as the ICP work is developed.

The CCG had one over 52 week waiter in 2018/19, which related to an out of area provider (London). Unfortunately, the CCG were not sighted on this patient due to an issue in the provider's data submissions. Once aware, the CCG instigated an action plan with the lead commissioner for the provider and the patient was treated swiftly thereafter. The CCG confirmed with the provider that no quality or safety concerns had arisen as a result of the excessive wait.

As part of national policy, a new requirement was introduced during 2018/19, with the expectation that commissioners maintain or reduce the March 2018 waiting list position. Due to increased demand and a reduction in capacity, the CCG saw an increase in the waiting list position throughout 2018/19. As a result of the increase, the CCG commissioned additional capacity in a number of key areas, which has seen incremental improvement in the number of patients waiting.

Ambulance Response Times (Ambulance Response Programme)

Ambulance trusts were required to report against the new ambulance standards which were implemented in October 2017. The Ambulance Response Programme (ARP) replaced the previous ambulances standards with a focus on making sure the best, high quality, most appropriate response is provided for each patient first time.

Throughout 2018/19, reporting was in place nationally for all ambulance trusts and North East Ambulance Service (NEAS) continue to be a good performer nationally for all standards and in particular category 2 (life threatening illnesses and injuries). Despite NEAS being a good performer nationally, locally in Sunderland, response times remain one of the lowest in the region which remains a concern. As part of contract negotiations in 2018/19, CCGs across the North East agreed an additional investment profile for three years, based upon recommendations made in the jointly commissioned Operational Research in Health Limited (ORH) report. This investment will support the delivery of the following requirements, all of which should have a positive impact on delivery of the ARP standards:

- Changes in the configuration of ambulance fleet vehicles
- Rostering changes of shifts to focus the workforce at the time of greatest need
- Changes in front line skill mix to 60:40 paramedics to emergency care assistants

Alongside the comparable poorer performance in response times in Sunderland, the CCG saw increased ambulance arrivals into hospital and increased handover delays which takes crews off the road and unable to respond to critical calls. The CCG continues to work with NEAS to reduce the number of patients conveyed to hospital where alternative dispositions exist. Due to increased conveyances to hospital, the CCG are working with partners across the health economy to understand the reasons for increased conveyances

which will lead to the development and implementation of key actions to reduce conveyance into hospital throughout 2019/20.

As this remains a significant concern for the CCG, discussions have taken place at A&E Delivery Board to understand why Sunderland is an outlier in this area. The outcome of those discussions is a planned live audit ("the perfect system") which will be a multi-agency audit into arrivals into ED to understand the reasons patients end up in ED rather than alternative dispositions.

Alongside the development of an improvement plan from the "perfect system", the CCG also commissioned as part of a regional procurement, the Integrated Urgent Care (IUC) service (currently the 111 service) which was mobilised in October 2018. This enhanced service, when fully operational, will provide additional clinical resource into the 111 service (24/7) to ensure patients access the most appropriate urgent and emergency care services for their needs. Part of this includes additional clinical input into those calls where an ambulance is dispatched or the disposition is to attend the emergency department. The ultimate aim is to ensure these patients access the most appropriate setting.

Additional funding has also been provided to NEAS in 2019/20 to work with commissioners to reduce the number of conveyances to hospital.

Cancer Standards

The CCG continued to deliver all cancer standards in 2018/19, despite continued pressures in some tumour groups (e.g. lung and urological). Workforce pressures remain an issue in 2019/20 with STSFT actively recruiting and focusing on pathway improvements such as improved access to diagnostics and additional capacity in the Durham Treatment Centre (DTC) which is a new facility opened in 2018.

As part of the CCG's operational plan, the CCG continues to implement the national cancer strategy requirements and cancer remains a CCG priority in 2019/20. Our local cancer plan sets out how we aim to improve cancer outcomes by implementing 28 local priorities across six areas: prevention, early diagnosis, waiting times, patient experience, living with and beyond cancer, investment and commissioning. This will be taken forward with partners including the Cancer Alliance.

Mental health standards

The CCG continued to perform well against national mental health standards and expectations. The Mental Health Fiver Year Forward View set an ambitious vision to transform mental health services.

Performance against the key mental health requirements is outlined below.

Improving access to psychological therapies (IAPT)

The CCG continues to deliver the national requirements relating to IAPT, delivering an improved access rate to IAPT services in 2018/19 and maintaining a recovery rate of 50%. Sustaining an annual increased access rate remains a challenge with the CCG on course to meet the national requirement of 19% access by the end of 2018/19. 2019/20 remains a significant challenge with expectations that the CCG increase access rates again by March 2020 to 22%.

The CCG has worked with Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and voluntary sector providers to expand the IAPT service into people with long term conditions with additional recurrent funding for workforce.

Access to Children and young people's services (CYPS)

The CCG is currently on track to deliver the national expectation of 33% of children accessing CYPS services with performance of 46%. CYPS remains a key priority and specific deliverables for 2019/20 have been agreed to maintain current performance and improve outcomes for children.

Learning disabilities (LD)

The CCG continues to work within the Transforming Care programme (collaboration between CCGs, local authorities and NHS specialised commissioning) to move away from inappropriate outmoded inpatient facilities and build up community capacity to reduce reliance on inpatient beds, which remains a challenge I Sunderland and plans have been agreed going into 2019/20 to reduce the number of patients in an inpatient bed.

The CCG also commissioned additional support to general practices around care planning for LD patients and the CCG has delivered a significant increase in the number of patients with an annual care plan review.

Clinical priority areas

As part of the Improvement Assessment Framework (IAF), national clinical priority areas have been set which includes a formal annual rating process. 2018/19 ratings will not be known until mid-2019/20 but in 2018/19, a number of annual ratings were released for Sunderland CCG for 2017/18 as follows:

- Dementia – rated as good
- Learning disabilities – rated as good
- Mental health – rated as good
- Maternity – rated as requires improvement
- Diabetes – rated as requires improvement
- Cancer – rated as requires improvement

Delivery of improvements in a number of the clinical priority areas remains a focus into 2019/20, particularly in maternity, diabetes and cancer.

Performance measures

Improvement and assessment framework (IAF) indicator snapshot

Key performance measures and a summary position against the IAF framework are shown in the tables below and on the following pages:

Table 1: A&E four hour waits for the Sunderland Health Community

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
A&E waits							
% patients spending 4 hours or less in A&E or minor injury unit - City Hospitals Sunderland	92.97%	91.25%	Jan-19 - YTD	89.43%	95.0%	92.2%	
% patients spending 4 hours or less in A&E or minor injury unit - Northern Doctors Urgent Care	98.76%	96.74%	Jan-19 - YTD	97.25%	95.0%	96.7%	
No waits from decision to admit to admission (trolley waits) over 12 hours	0	0	Jan-19 - YTD	0	0	0	

Table 2: Ambulance response times

NHS Constitution Measures	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Risk to Year End
Ambulance Response Times					
Ambulance: Mean Response time - Category 1 (7 minutes) - NEAS Overall	0:06	Jan-19	0:06	0:07	
Ambulance: 90th centile Response time - Category 1(15 minutes) - NEAS Overall	0:11	Jan-19	0:10	0:15	
Ambulance: Mean Response time - Category 2 (18 minutes) - NEAS Overall	0:22	Jan-19	0:26	0:18	
Ambulance: 90th centile Response time - Category 2 (40 minutes) - NEAS Overall	0:47	Jan-19	0:56	0:40	
Ambulance: 90th centile Response time - Category 3 (2 hours) - NEAS Overall	3:27	Jan-19	4:02	2:00	
Ambulance: 90th centile Response time - Category 4 (3 hours) - NEAS Overall	2:55	Jan-19	3:45	3:00	
Ambulance: Mean Response time - Category 1 (7 minutes) - SCCG	0.06	Jan-19	0:05	0:07	
Ambulance: 90th centile Response time - Category 1(15 minutes) - SCCG	0:10	Jan-19	0:09	0:15	
Ambulance: Mean Response time - Category 2 (18 minutes) - SCCG	0:24	Jan-19	0:31	0:18	
Ambulance: 90th centile Response time - Category 2 (40 minutes) - SCCG	0:52	Jan-19	1:06	0:40	
Ambulance: 90th centile Response time - Category 3 (2 hours) - SCCG	4:29	Jan-19	4:36	2:00	
Ambulance: 90th centile Response time - Category 4 (3 hours) -SCCG	3:16	Jan-19	5:36	3:00	

Table 3: Cancer waiting times - two week waits

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
Cancer waits - 2 week							
% patients seen within 2 weeks of urgent referral for suspected cancer	96.14%	96.59%	Dec-18 - YTD	95.79%	93.0%	96.92%	
% patients seen within 2 weeks of urgent referral for breast symptoms	96.35%	94.71%	Dec-18 - YTD	95.14%	93.0%	94.35%	

Table 4: Cancer waiting times - 31 day waits

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
Cancer waits - 31 days							
% patients treated within 31 days of cancer diagnosis	98.74%	97.84%	Dec-18 - YTD	99.06%	96.0%	97.88%	
Cancer diagnosis to treatment waiting times (31 day subsequent treatment surgery)	97.22%	96.57%	Dec-18 - YTD	95.95%	94.0%	96.58%	
Cancer diagnosis to treatment waiting times (31 day subsequent treatment drugs)	99.77%	99.88%	Dec-18 - YTD	99.68%	98.0%	100.00%	
Cancer diagnosis to treatment waiting times (31 day subsequent treatment radiotherapy)	99.24%	99.45%	Dec-18 - YTD	99.78%	94.0%	99.50%	

Table 5: Cancer waiting times - 62 day waits

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
Cancer waits - 62 days							
% patients treated within 62 days of urgent referral for suspected cancer	86.24%	86.95%	Dec-18 - YTD	87.97%	85.0%	86.32%	
% patients treated within 62 days of urgent referral from NHS Cancer Screening Programmes	95.54%	95.54%	Dec-18 - YTD	90.80%	90.0%	95.65%	
62 day wait for first treatment for cancer following a consultants decision to upgrade the patient priority	*81.19%*	*72.07%*	*Dec-18 - YTD*	*77.46%*	*85.0%*	*71.3%*	

Table 6: Diagnostic waiting times

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
Diagnostic test waiting times							
Patients waiting more than 6 weeks for 15 key diagnostic tests	1.74%	1.24%	Dec-18 - YTD	0.70%	1.0%	1.48%	

(Note this is the year to date position at the time of publication of this report)

Table 7: Referral to treatment - 18 weeks

NHS Constitution Measures	2016/17 Outturn	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year	Risk to Year End
Referral to treatment waiting times for non-urgent consultant-led treatment							
18 Week Referral to Treatment Waiting Times - Admitted (adjusted) pathways	*85.27%*	*83.61%*	*Dec-18 - YTD*	*83.07%*	*90.0%*	84.52%	
18 Week Referral to Treatment Waiting Times - Non-admitted pathways	*95.60%*	*95.88%*	*Dec-18 - YTD*	*94.66%*	*95.0%*	95.98%	
18 Week Referral to Treatment Waiting Times - Incomplete Pathways	94.68%	94.54%	Dec-18 - YTD	93.56%	92.0%	94.8%	
52 Week Referral to Treatment Waiting Times - incomplete pathway	0	0	Dec-18 - YTD	3	0	0	

Other national requirements

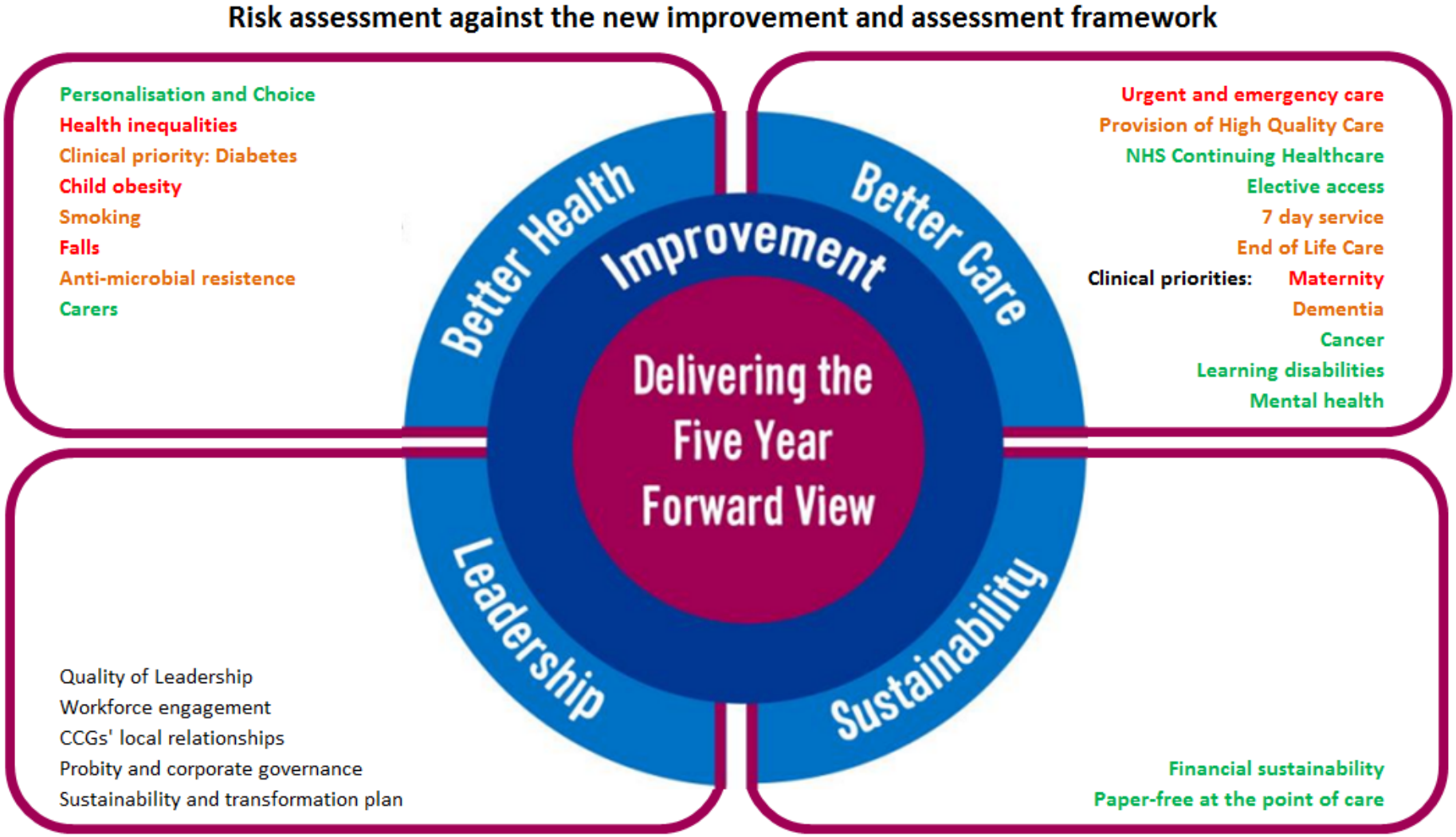
Table 8: Mental health

Other National Requirements	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year
Mental Health					
Proportion of people with depression and/or anxiety disorders with access to psychological therapies	16.2%	Jan-19 - YTD	15.6%	15.8%	14.32%
The number of people accessing IAPT who are moving to recovery	51.7%	Jan-19 - YTD	49.7%	50.0%	50.10%
Proportion of people that wait 6 weeks or less from referral to entering treatment	99.6%	Nov-18 - YTD	99.3%	75.0%	99.67%
Proportion of people that wait 18 weeks or less to start treatment compared to those finishing treatment	99.8%	Nov-18 - YTD	99.8%	95.0%	99.75%
People with a severe mental illness (SMI) receiving a full annual physical health check and follow-up interventions in primary care		Jan-19 - YTD	26.8%	50.0%	

Table 9: Dementia

Better Care	2017/18 Outturn	Latest Data	Actual To Date	Target To Date	Same Period Last Year
126a - Estimated diagnosis rate for people with dementia	86.1%	Jan-19 - YTD	72.70%	70.0%	74.60%
126b - Dementia care planning and post-diagnostic support	78.6%	Feb-19 - YTD	73.0%	79.5%	71.80%

Summary of the CCG's assessment against the 2018/19 IAF:



Sustainable Development

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. 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 rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Sunderland CCG has created a sustainable development management plan (SDMP).

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 by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020-21 using 2007-08 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Table 10: Sustainability in processes and procedures

Area	Is sustainability considered
Travel	Yes
Procurement (environmental)	No
Procurement (social impact)	Yes
Suppliers' impact	Yes

A procurement (environmental) policy will be implemented in 2019/20.

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. A refreshed SDMP will go to the Governing Body for approval in 2019/20.

We engage with suppliers to understand, record and track sustainability of services and adherence to related contract requirements via normal contract management mechanisms where contract requirements are monitored.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc.

The organisation has identified the need for the development of a governing body approved plan for future climate change risks affecting our area.

We do not currently use the Sustainable Development Assessment Tool (SDAT) tool; however this will be considered going forward.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Our organisation is clearly contributing to the following Sustainable Development Goals (SDGs).

The CCG has an annual Modern Slavery Act Statement as required under the legislation. The CCG monitors compliance via the safeguarding designated and named assurance group which includes asking providers to confirm they have an MDS statement in place and can provide copies for CCG assurance. In addition, NHS contracts require compliance with the relevant legislation.

Our statement on Public Services (Social Value) Act is: The CCG agreed that it would include scoring for social value in all its procurement evaluations for which it tenders. Processes are under development to monitor compliance.

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

For commissioned services the sustainability comparator for our main providers is outlined below which is published a year in arrears:

Table 11: Partner organisations

Organisation Name	On track for 34% reduction	SDAT	SD Reporting score
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	1. On track to meet target	n/a	Good
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	1. On track to meet target	51	Minimum
SOUTH TYNESIDE NHS FOUNDATION TRUST	1. On track to meet target	n/a	Minimum
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	1. On track to meet target	n/a	Good

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

Performance

Commissioned activity

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 by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions.

Table 12: Commissioned activity

Organisation Name	Building energy use	Building energy use per WTE	Water	Water use per WTE	Percent high cost waste	Waste cost increase
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	>10% decrease	3.3	>20% increase	57	<=75% high cost	0-20% increase
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	>10% decrease	2.3	0-20% decrease	26	<=75% high cost	>20% decrease
SOUTH TYNESIDE NHS FOUNDATION TRUST	>10% decrease	2.4	>20% decrease	39	<=75% high cost	>20% decrease
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	>10% decrease	0.9	>20% decrease	6	<=75% high cost	>20% decrease

Energy

NHS Sunderland CCG has spent £22,510 on energy in 2018-19, which is a 17.7% increase on energy spend from last year. We will be exploring with our landlord NHS Property Services the use of green renewable electricity going forward. The CCG actively encourages the use of electric motor vehicles, and this has led to an increase in electricity being consumed by the CCG (staff pay for this electricity usage).

Table 13: Energy used

Energy consumption in kWh	2015-16	2016-17	2017-18	2018-19
Electricity consumed	113,144	110,776	101,002	152,114
Gas consumed	141,073	93,685	175,887	266,099
Total	**254,217**	**204,461**	**276,889**	**418,213**

Figure 4: Energy - Carbon emissions resulting

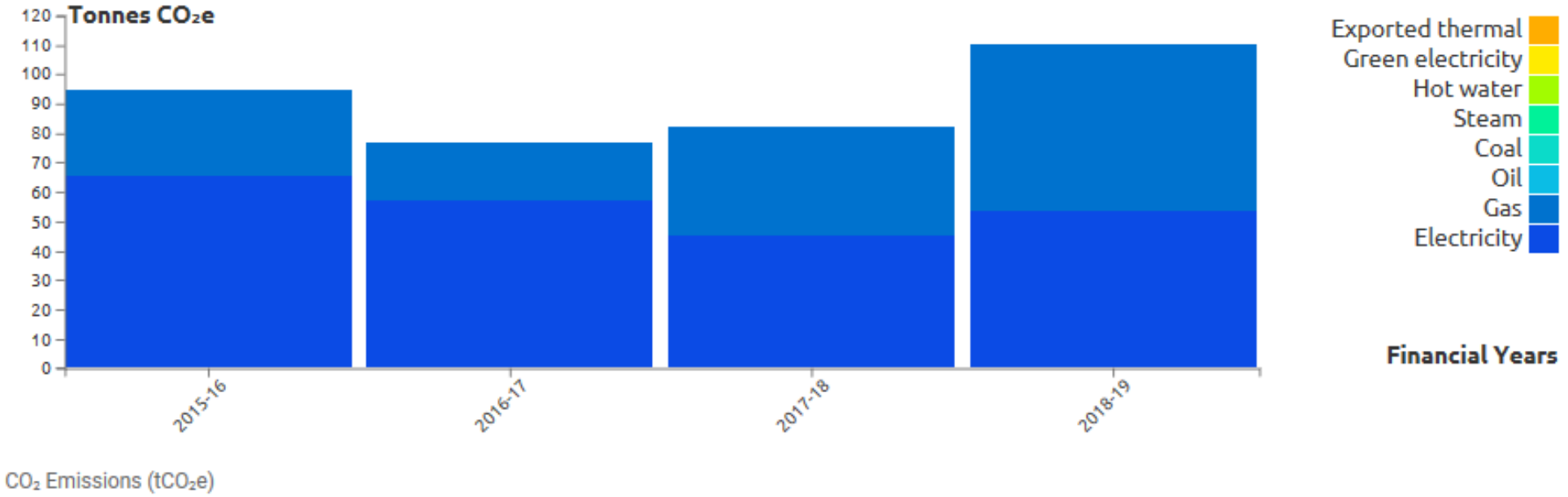


Table 14: CO_2 Emissions (tCO_2e)

	2015-16	2016-17	2017-18	2018-19
Electricity	65	57.2	45	53.7
Gas	29.5	19.6	37.3	56.5
Total	94.6	76.8	82.3	110

Paper

The movement to a paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security. The low spend on paper in 2017-18 is because the CCG bulk bought paper in previous years.

Table 15: Paper consumed

	2015-16	2016-17	2017-18	2018-19
Paper spend (£)	4,294	2,601	298	1,626

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport. The CCG actively encourages the use of electric vehicles by its staff, and has shower facilities to encourage cycling to work. There is also a salary sacrifice scheme for cycling equipment available to staff.

Table 16: Travel undertaken (miles)

	2015-16	2016-17	2017-18	2018-19
Patient and visitor travel	2,253	1,696	1,643	710
Business travel and fleet	42,101	27,123	26,392	31,802
Total	44,354	28,819	28,035	32,512

Table 17: Co2 Emissions (tCO2e)

	2015-16	2016-17	2017-18	2018-19
Business Mileage - Road	15.2	9.8	9.4	11.7

Water

Table 18: Finite resource use – water

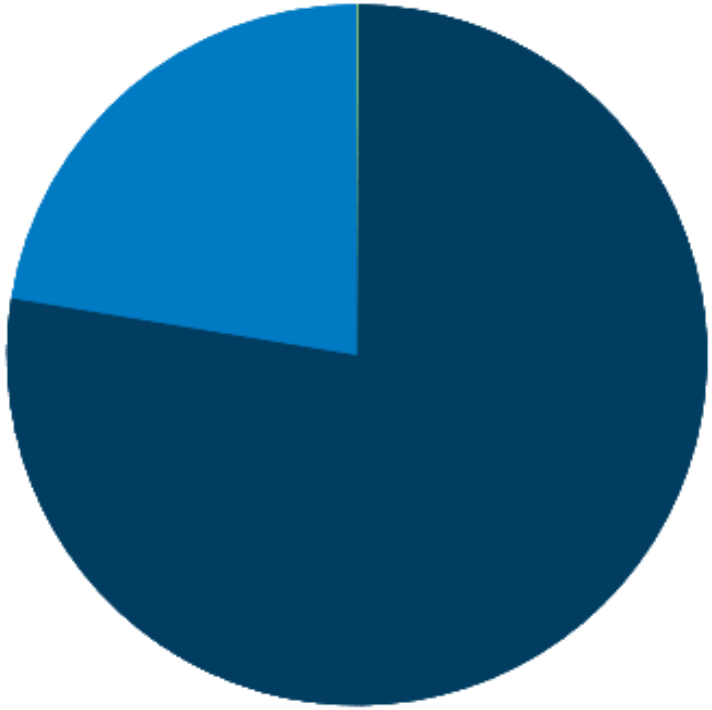
	2017-18	2018-19
Water volume (m^3)	1,222	993
Waste water volume (m^3)	978	794

Table 19: CO2 emissions

	2017-18	2018-19
Water related emissions	0.42	0.34
Waste treatment related emissions	0.69	0.56
Total	1.11	0.9

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our spend. We are aware of and committed to reducing our carbon footprint, and we need to do more work to understand how accurate the data and what it is telling us to inform any future actions. More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx.



The values in the table below are percentages.

	2018-19
Core emissions	0.0853
Commissioning	77.5
Procurement	22.4
Community	0
Total	100

Improve quality

Quality and patient safety are at the heart of everything we do in Sunderland. The CCG has regular quality review group meetings with providers where all information related to the quality of services is reviewed and triangulated i.e. safety, effectiveness (including performance) and patient experience.

Quality Strategy 2018-21

During 2017, we undertook a significant amount of work to refresh our quality strategy and, following consultation with colleagues across the CCG, we produced a new version which continues to reflect the CCG's commitment to assure the quality of the services we commission. The strategy highlights the seven steps to quality from the National Quality Board's *'Shared commitment to quality'* document and we used these to inform the new quality framework outlined within the strategy.

The strategy was approved by the Governing Body in January 2018 and work to implement the strategy is underway. We also created the 'strategy on a page' for ease of use as a reminder that quality and safety is everyone's business. A copy of the strategy can be found here: www.sunderlandccg.nhs.uk/?s=quality+strategy

Quality Impact Assessments

To ensure any decisions that the CCG makes regarding services we commission do not have a detrimental effect on quality, we have developed a quality impact assessment (QIA) policy and embedded a process across the CCG for staff to use. Project leads review proposed changes to services and assess whether there will be a positive, neutral or negative effect on safety, patient experience and effectiveness. This process is managed by the quality team, with the Medical Director and Director of Nursing, Quality and Safety reviewing and approving any completed QIAs.

Commissioning for Quality and Innovation

Commissioning for Quality and Innovation (CQUIN) is a scheme which supports providers to innovate care delivery resulting in improvements to the quality of care. The CQUIN framework enables commissioners to reward excellence by linking a proportion of a provider's income to the achievement of national and local quality improvement goals.

The CCG's CQUIN schemes for 2018/19 focused on:

- Developing and improving staff health and wellbeing initiatives
- Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
- Improving services for people with mental health needs who present to A&E
- Advice and guidance
- NHS e-Referrals

- Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness
- Transitions out of Children and Young people's Service (Mental Health)

The schemes are outcome based and monitored quarterly against agreed targets. They can only include national indicators and are in place for two years covering 2017-19. The schemes are also in line with the CCG's commissioning priorities.

Learning from Serious Incidents

The CCG is responsible for gaining assurance that when serious incidents occur - either within providers or within the CCG – there are measures in place which safeguard patients. Incident investigations to determine the root cause are undertaken to ensure that lessons learned are shared and embedded in improvements to practice.

The incident investigations and outcomes are reviewed by the CCG. We have robust governance processes in place which monitor the serious incidents through a combined Serious Incident Panel with NHS South Tyneside CCG. This panel is led by the CCGs' Directors of Nursing, Quality and Safety who ensure sufficient rigor has been applied to the investigations and that learning has been elicited and embedded into practice.

Serious incident reports and action plans are reviewed and signed off during these panels once appropriate assurances have been gained by the CCG(s). The CCG(s) also monitor serious incident themes and trends across the year and work with providers to manage and respond to any emerging themes. These are subject to debate and scrutiny both during the serious incident panel and quality review group meetings.

Healthcare Associated Infections

The Healthcare Associated Infections (HCAI) Improvement Group has been in operation throughout the year across Sunderland and South Tyneside, with representation from both CCGs and provider organisations.

The group provides leadership and ensures a consistent whole systems approach to preventing and controlling healthcare associated infections. The group has robust reporting mechanisms and receives regular assurance reports and updates on key metrics. These highlight any quality or patient safety issues as well as any key risks that require further action or may require escalating to the CCG's risk register.

There have been some areas that required a detailed focus to ensure work was being undertaken to implement specific requirements and also address areas of concern relating infection prevention and control. These have included:

- A focus on reducing the number of Clostridium Difficile (C.difficile),Methicillin-resistant Staphylococcus aureus (MRSA) infections and Gram Negative Blood

Stream Infections within providers and Sunderland and South Tyneside communities

- The development of a whole systems HCAI joint action plan for both Sunderland South Tyneside, with progress reported at each HCAI Improvement Group meeting
- The development of an HCAI Root Cause Analysis Peer Review Panel as a sub group of the HCAI Improvement Group. The purpose of this group is to review all root cause analyses for C.difficile and MRSA bacteraemia. The panel meets on a bi-monthly basis to review the patient's journey, ensure lessons learnt are discussed and establish whether the case was avoidable or unavoidable.

Many challenges remain across health and social care in relation to infection prevention and control and the CCG has remained focused throughout the year to ensure this is part of patient safety wherever care is delivered.

Quality in Primary Care

The CCG has delegated responsibility from NHS England for the commissioning of general medical services. We support NHS England in relation to our duty to improve the quality of primary medical services through agreements and processes with our member practices regarding quality and safety. We have a well-established Local Quality Review Group, with NHS England and the Care Quality Commission (CQC), to monitor the quality of care within general practice, review practices' achievement against a range of national and local quality indicators, share soft intelligence and consider the outcome reports following any CQC inspections of general practices.

Research and Development

In order to fulfil our statutory mandate to carry out research for benefit of the population we serve, we are committed to ensuring that research activity is undertaken rigorously and ethically under the governance framework established by our Research and Evidence Group. The findings of our research will be used as evidence to inform commissioning decisions. Additionally, the findings will be presented to the Executive and Governing Body and written up for publication in healthcare journals, lay summaries produced and disseminated to the public and patients to ensure transparency and understanding of research activities.

In 2018/19 the CCG designed and actively recruited to a study on the National Institute of Health Research (NIHR) portfolio. Entitled PROACT, the aim of the study is to implement an educational package to raise awareness of the signs and symptoms of pressure ulcers in health and social settings including care homes and domiciliary care, and those who care for others in informal settings. The intervention has been carried out using the recognised React to Red and SSKIN bundle tools, to minimise variation in working practices, evaluate the knowledge and impact of the intervention on practice. Concurrently, we have engaged with the voluntary sector to deliver a separate series of information sessions targeted at those who care for others in more informal care settings.

A steering group of partners across the NHS, academia and health and social care was formed to support PROACT, bringing together a wide and unique range of perspectives of care across Sunderland. Regular steering group meetings have allowed the development of close working relationships in an open forum, sharing of ideas, a greater understanding of the strengths and areas for development within health and social care across Sunderland, thereby maximising both expertise and resources. This steering group is currently identifying and developing future research projects to support and extend the CCG's increasing research activity, including delivery of objectives set out in the NHS Long Term Plan.

Local Accident and Emergency Delivery Board

The CCG Chief Officer chairs Sunderland's Local Accident and Emergency Delivery Board, which brings together senior personnel from health and social care across Sunderland who commission or provide urgent and emergency care services. The purpose of the Board is to take a whole system approach to improve urgent and emergency care standards, including the four hour target.

Patient Experience and Feedback

This is a key feature within all of our quality assurance processes. Information is gathered from quality review group meetings with providers of commissioned services, as well as other various sources such as Healthwatch, NHS Choices, the friends and family test and via our communication and engagement activities.

A patient story is a regular feature of our Governing Body meetings. This helps provide the Governing Body with an insight in to how services are operating from a patient's perspective.

Safeguarding

Executive leadership for safeguarding is provided via the Director of Nursing, Quality and Safety. Other statutory lead roles are delivered by the Head of Safeguarding (including the role of Designated Nurse Safeguarding Children), the Designated Nurse Safeguarding Adults and the Designated Nurse Looked After Children. Additional safeguarding nursing capacity within the CCG is provided by a Safeguarding Children Lead Nurse and Safeguarding Nurse. The CCG Chief Officer is a member of Sunderland's adult and children's safeguarding board (vice chair of the children's board).

The CCG continues to maintain its statutory safeguarding responsibilities and is providing leadership and support in ensuring our multi-agency safeguarding arrangements and child death review processes comply with changes in legislation. As a key statutory partner we are committed to ensuring our most vulnerable groups are protected from abuse and neglect and, in collaboration with our providers and multi-agency partners, ensure learning

from a range of statutory reviews and other improvement in practice methodologies is implemented and embedded.

Our commitment to safeguarding includes the significant leadership commitment across Sunderland.

The CCG provides safeguarding leadership across the health economy via a Joint Designated and Named Assurance Group which meets on a six weekly basis, alternating between learning and improvement and provider assurance on a quarterly basis. We have implemented safeguarding dashboard reporting arrangements across the provider trusts and this incorporates safeguarding children, safeguarding adults, Mental Capacity Act and Prevent. A safeguarding dashboard for primary care has been developed and approved by the Local Quality in Primary Care Group.

Through our leadership, we ensured our providers complied with key areas including the Prevent duty (training target 85%), FGM (mandatory reporting and training competencies) and Modern Slavery Act (modern slavery statement).

Engaging people and communities

NHS Sunderland CCG are committed to collecting the views from a range of Sunderland residents, including patients, the public, and carers. This includes listening to the views from protected characteristic groups.

We do this in a number of ways supported by NHS North of England Commissioning Support who provide expertise and capacity to support engagement activities aligned with the CCGs strategic plans. This has increased our access to expert knowledge in relation to public participation, engagement and involvement to help ensure we meet our statutory requirements.

The CCG monitors this via the Involving People Project and Action Plan (IPPAP) which is reported to the Communications and Engagement Steering Group (CESG), the Quality and Safety Committee (QSC), and Governing Body (GB) meetings. The action plan sets out our commitment to working with the public, patients, carers and communities and their representatives, to ensure health and social care services are shaped around what people need. The report is structured around the following domains identified in NHS England publication, *Patient and public participation in commissioning health and care* (April 2017):

- Involve the public in governance;
- Explain public involvement in commissioning plans/business plans;
- Demonstrate public involvement in annual reports;
- Promote and publicise public involvement;
- Access, plan and take action to involve;
- Feedback and evaluate;

- Implement assurance and improvement systems;
- Advance equality and reduce health inequalities;
- Provide support for effective involvement;
- Hold providers to account.

Each project has a specific bespoke communications and engagement plan which sets out objectives, tactics and resources required.

We have a long-established communications and engagement steering group, which includes key partners across the local health economy, including Healthwatch. It is a formal sub-group of the CCG's Executive Committee and is chaired by the Director of Nursing, Quality and Safety.

We have a robust process in place to ensure that patients' views are taken into account when changes to services are being considered. This includes a toolkit for staff to use when undertaking service change and guidance on mechanisms and techniques that can be used to ensure patient views are captured.

We have taken significant steps to enhance the range of mechanisms available to support our engagement activities. Examples of involvement and engagement projects undertaken in 2018/19 are detailed in NHS Sunderland Annual Involvement and Engagement Report 2018/19 (https://www.sunderlandccg.nhs.uk/get-involved/involving-the-public-in-governance/annual-engagement-and-involvement-report/)

In addition, the CCG has a membership scheme called My NHS, which allows people to sign up to be contacted about healthcare issues that interest them.

The Annual Involvement and Engagement Report provides detail on the following ways it involved people during 2018/19:

Regional Involvement and Engagement Activities

- Integrated Care Systems (ICS)
- Patient and Public Involvement (PPI)/ Patient and Public Voice (PPV) Network
- Non-executive and lay member community network

Sunderland Activity Updates

- Improvement and Assessment framework (IAF)
- Website development
- Equality and Diversity Group
- Sunderland Health Forum
- Communications and Engagement Strategy

Sunderland Project updates

- The Path to Excellence
- Multi-speciality provider (MCP) Model
- The All Together Better Alliance
- Sunderland Urgent Care
- Community Beds
- Breast services
- Pressure Ulcer Research Project (PROACT)
- GP Engagement Activity
- Surge evaluation
- MyCOPD and World CODP day
- New consultation types

An updated communications and engagement strategy was produced in 2018, which combines the previously separate engagement and communication strategies into one document. The plan was signed off in March 2019, and can be found here: https://www.sunderlandccg.nhs.uk/wp-content/uploads/2019/04/Communications-and-engagment-strategy-2019-2020.pdf

This strategy ensures that Sunderland CCG has a clear plan in place to meet legal duties to engage and consult the public and pledges set out in the NHS constitution. In addition, the CCG develops specific consultation and engagement plans for individual projects it undertakes.

In addition to services from North of England Commissioning Support (NECS) specialist advice and external benchmarking is obtained from the national Consultation Institute.

This ensures that projects such as Path to Excellence and the urgent care review follow best engagement practice. This best practice was borne out in December, when His Honour Judge Raeside QC ruled that the CCGs' Path to Excellence phase one public consultation was a fair and lawful process, following judicial review.

Reducing health inequality

We are fully committed to equality and diversity in keeping with the principles of the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998, and also by the duties of the Health and Social Care Act 2012 (section 14T) to reduce health inequalities, promote patient involvement and involve and consult with the public.

We have demonstrated our commitment to taking Equality, Diversity and Human Rights (EDHR) in everything we do, whether that is commissioning services, employing people,

developing policies, communicating, consulting or involving people in our work as evidenced below.

Public Sector Equality Duty (PSED)

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

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

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

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

Governance

Equality, Diversity and Health Inequalities is governed by and reports into the Executive Committee. The Governing Body ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity, develops and delivers national and regional diversity-related initiatives within the CCG, provides a forum for sharing issues and opportunities, functions as a two-way conduit for information dissemination and escalation, monitors progress against the equality strategy and supports us in the achievement of key equality and diversity objectives.

A quarterly Governance Assurance Report is submitted to the Executive Committee outlining relevant updates in relation to Equality, Diversity and Health Inequalities.

Equality Strategy

Our Equality Strategy was refreshed in 2016 and aims to ensure that the CCG promotes equality of opportunity to all our patients, their families and carers, and our staff, and to proactively address discrimination of any kind.

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

The Equality Delivery System 2 - Our Equality Objectives

We have implemented the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve

our performance for the community, patients, carers and staff with protected characteristics that are outlined within the Equality Act 2010. Working through the EDS2 framework has provided an opportunity to raise equality in service commissioning and gain insight into the local population's diverse health needs.

We reviewed our action plan for 2018 and the Executive Committee approved plans detailing actions we will take to ensure that individuals, communities and staff are treated equitably.

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

- **Objective 1** – Continuously improve engagement, and ensure that services are commissioned and designed to meet the needs of patients from at least 9 protected groups.
- **Objective 2** – Ensure processes are in place to provide information in a variety of communication methods to meet the needs of patients, in particular those with a disability, impairment or sensory loss.
- **Objective 3** – Continuously monitor and review staff satisfaction to ensure they are engaged, supported and have the tools to carry out their roles effectively.
- **Objective 4** – Ensure that the CCG Governing Body actively leads and promotes Equality and Diversity throughout the organisation.

Our Staff - Encouraging Diversity

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

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

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

We have recently agreed a new policy for armed forces reservists' leave to support staff who are required to undertake training exercises as part of our commitment to armed forces, reservists, veterans and their families. The CCG has the silver award for the armed forces covenant employer recognition scheme and is aiming to reach gold level in 2019/20.

Workforce Race Equality Standard

In accordance with the Public Sector Equality Duty and the NHS Equality and Diversity Council's agreed measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES).

We have due regard to the standard by seeking assurance of compliance from trusts and aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Impact Assessments

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

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

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

The EIA is embedded into our governance process and sign off from the Executive is required for monitoring and completion.

Accessible Information Standard

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

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

The CCG has due regard to the standard by obtaining feedback from the Equality, Diversity and Inclusion Steering Group who review key documentation and engagement, advising how we can improve our communication methods to make them more accessible.

A standard process is in place for CCG engagement which includes BSL interpreters at events, especially if they are live streamed, subtitles on videos and the use of audio. Easy read documents are also created.

Further information on the standard can be found at:
https://www.england.nhs.uk/ourwork/accessibleinfo/

Health Inequalities

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

We understand our local population and local health needs, through the use of joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

Sunderland has a population of approximately 281,000 people in Coalfields, Sunderland East, Sunderland North, Sunderland West and Washington localities.

Large increases in the elderly population, and particularly the very elderly, have significant implications for healthcare over the next 5, 10 and 20 years.

Our community is also affected by lifestyle factors such as obesity, smoking and alcohol abuse which pose a major risk to health and wellbeing.

Major health challenges are consistent across our 5 localities. They include:

- A growing ageing population with escalating health needs
- Poor health compared to the rest of the UK
- Excess deaths, particularly from heart disease, cancer and respiratory problems
- An over-reliance on hospital care
- Health inequalities across the city

The health of people in Sunderland is varied compared with the England average. The Sunderland population experiences a higher level of social and economic disadvantage than the England average, and Sunderland is the 31st most deprived upper tier local authority in England (based on IMD 2015 Average Score).

Life expectancy for both men and women is lower than the England average with it being 11.5 years lower for men and 8.7 years lower for women in the most deprived areas of Sunderland than in the least deprived areas.

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

For our CCG area, only 2.0% of hospitalisation records have an unknown ethnic group compared to the national England average of 6.6%.

We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, our CCG's Equality, Diversity and Inclusion Group and Healthwatch.

A range of stakeholders are invited to the CCG's Equality, Diversity and Inclusion Group including providers and Healthwatch. It is this group which oversees all activity for communications and engagement and acts as a 'critical friend'.

When engaging or communicating about particular project areas, a robust plan is developed to ensure representation is sought from as many areas as possible and stakeholders are demographically mapped. Our efforts are displayed in campaigns the CCG has undertaken this year including 'Sunderland Urgent Care' and the 'Path to Excellence Programme.

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

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

More information can be found at: https://www.sunderlandccg.nhs.uk/corporate/equality-and-diversity/equality-diversity-and-health-inequalities-information/

This webpage also includes links to the:

- Health profiles: www.healthprofiles.info

- Public Health England – Local Health: http://www.localhealth.org.uk
- Joint Strategic Needs Assessment: https://www.sunderland.gov.uk/article/15183/Joint-Strategic-Needs-Assessment-JSNA-
- NHS England Right Care Pack – https://www.england.nhs.uk/wp-content/uploads/2018/12/ehircp-ney-sunderland-ccg-dec-18.pdf

Health and wellbeing strategy

http://www.sunderlandccg.nhs.uk/about-us/who-we-work-with/health-and-wellbeing-board/
The Sunderland Health and Wellbeing Board aims to reduce health inequalities and improve the health and wellbeing of local residents. Working together as partners, including the council and CCG, they are committed to prioritising areas of need and allocating health and social care resources.

By focusing on areas such as housing, environment, education, employment, criminal justice and planning, the Health and Wellbeing Board believe they can have a real impact on the community, reducing inequalities in health across the region, and improving the quality of health and social care services for the local population.

Over the past year the Health and Wellbeing Board has looked at a range of issues including the STP and CCG's work on out of hospital, integrated teams and recovery at home, Path to Excellence - the joint working between City Hospitals and South Tyneside foundation trusts, alcohol, smoking, obesity and exercise and pharmacy needs assessment. It has also held joint session with other strategic boards in the city considering workforce.

David Gallagher
Chief Officer (Accountable Officer)

21 May 2019

ACCOUNTABILITY REPORT

David Gallagher
Chief Officer (Accountable Officer)
21 May 2019

Corporate Governance Report

Members Report

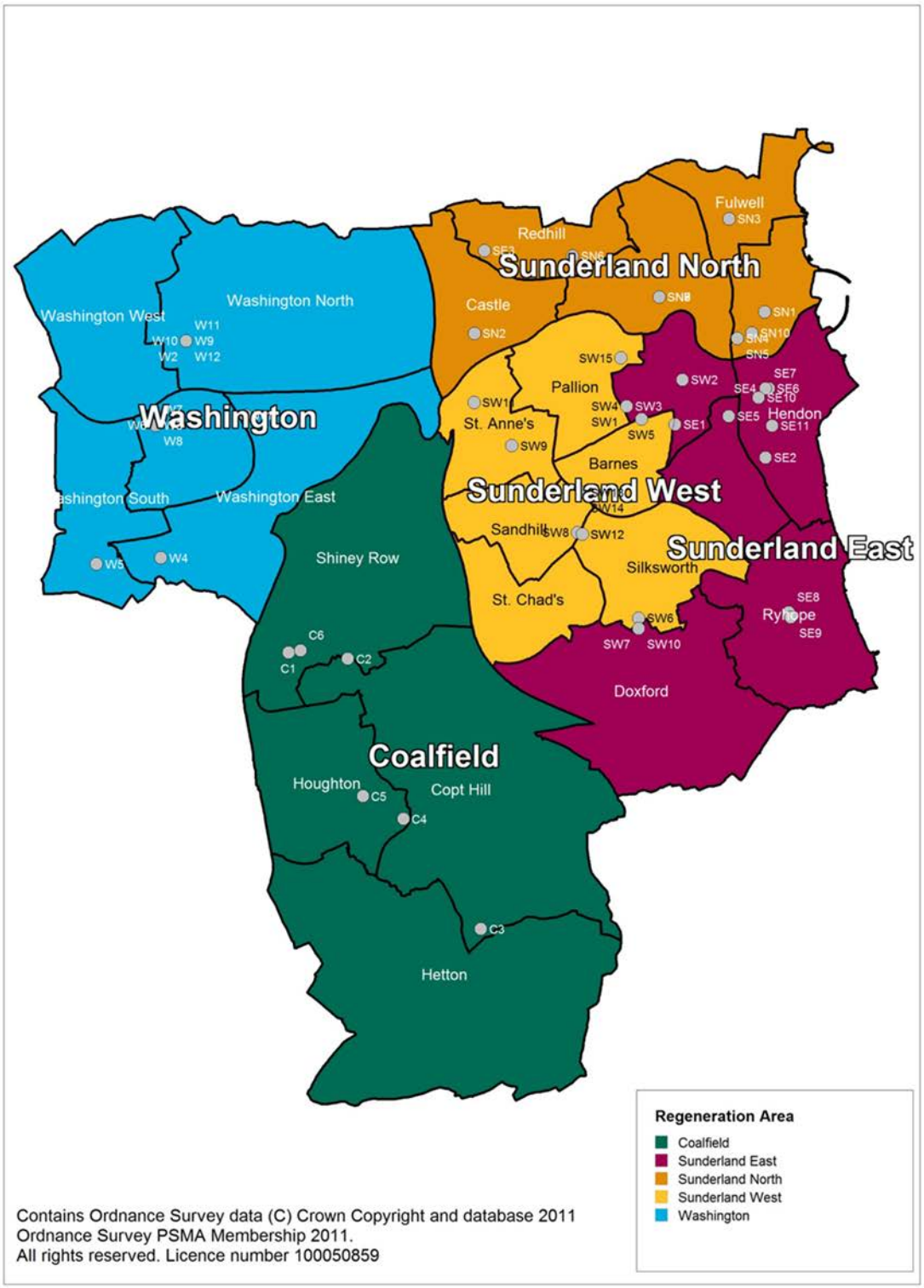
The CCG's Constitution sets out the terms by which we, through our appointed members, elected GP executives and governing body, implement all statutory obligations including the commissioning of secondary health care and other services for Sunderland. The Constitution contains the main governance rules of the CCG and Governing Body.

The Constitution was agreed and signed by all member practices in August 2012 as part of the CCG authorisation process and updated in November 2013. A further amendment was made in January 2015 to reflect the changes in relation to additional primary medical care commissioning responsibilities the CCG undertook from 1 April 2015. The CCG undertook further reviews of the Constitution in November 2016 and December 2017 and it remained fit for purpose.

Each member practice sits within one of five locality regeneration groups and has a lead GP elected by the GPs of Sunderland (who is also a member of the executive committee) as well as an assigned practice manager, practice nurse and a commissioning manager. The locality teams also work in close partnership with the local authority and local patients.

The CCG covers the whole of the city of Sunderland and details of our localities and member practices can be found on the following pages:

Sunderland CCG GP - Practice Location by Locality 2012



Member practices

Coalfields locality practices	
Hetton Group Practice	DH5 9EZ
Herrington Medical Centre	DH4 4LE
Kepier Medical Practice	DH4 5EQ
Houghton Medical Group	DH4 4DN
Grangewood Surgery	DH4 4RB
Westbourne Medical Group	DH4 4RW

Sunderland East locality practices	
Deerness Park Medical Group	SR2 8AD
The New City Medical Centre	SR1 2QB
Ashburn Medical Centre	SR2 8JG
Villette Surgery	SR2 8AX
Southlands Medical Group	SR2 0RX
Park Lane Practice	SR2 7BA
Dr Bhate and Dr El-Shakankery Practice	SR1 2HJ

Sunderland North locality practices	
Red House Medical Centre	SR5 5PS
Fulwell Medical Centre	SR6 8DZ
St.Bede Medical Centre	SR6 0QQ
Bridge View Medical Group (Southwick Health Centre)	SR5 2LT
Castletown Medical Centre	SR5 3EX
Dr Gellia and Balaraman - Monkwearmouth Health Centre	SR6 0AB
Dr Obonna (Southwick Health Centre)	SR5 2LT
Dr Weatherhead and Associates (Southwick Health Centre)	SR5 2LT

Washington locality practices	
The Health Centre, Victoria Road (Dr Stephenson & Partners)	NE37 2PU
The Galleries Health Centre (Dr Dixit and partner)	NE38 7NQ
Concord Medical Practice	NE37 2PU
Sunderland GP Alliance Medical Practice	NE38 7NQ
Rickleton Medical Centre	NE38 9EH
Harraton Surgery	NE38 9AB
New Washington Medical Group	NE37 2PU

Sunderland West locality practices	
Wearside Medical Practice	SR4 7XF
Pallion Family Practice	SR4 7XF
Village Surgery	SR3 2AN
The New Silksworth Medical Practice	SR3 2AN
Millfield Medical Group	SR4 7AF
Old Forger Surgery	SR4 6QE
The Broadway Medical Practice	SR3 4HG
Springwell Medical Group	SR3 4HG
Hylton Medical Group	SR4 7ZF
Happy House Surgery	SR3 4BY
South Hylton Surgery	SR4 0LS
Chester Surgery	SR4 7TU

Composition of Governing Body

The Governing Body is made up of the following members (voting):

- Executive GP chair (elected)
- Executive GP vice chair (elected)
- Executive GP x4 (elected)
- Chief Officer
- Deputy Chief Officer and Chief Finance Officer
- Director of Nursing, Quality and Safety
- Lay Member, Audit and Non-Clinical Vice chair
- Lay Member, Patient and Public Involvement
- Secondary Care Clinician

In addition to the above members, the following are regular non-voting attendees and participants in Governing Body meetings:

- Medical Director
- Director of Contracting and Informatics
- Executive Practice Manager
- Head of Corporate Affairs
- Lay member, Primary Care Commissioning
- Director of Public Health, Sunderland City Council
- Executive Director of People Services, Sunderland City Council

Governing Body Profiles

Dr Ian Pattison, Executive GP and Clinical Chair

Passionate about ensuring patients receive the best care available, Dr Pattison has been a GP at the Southland Medical Centre in Ryhope since 2001. With previous commissioning experience gained at Wearside Commissioning Group, Ian was elected to the CCG as chair in 2011. He is a member of the Governing Body, Executive Committee and Sunderland Health and Wellbeing Board.

Mr David Gallagher, Chief Officer (Accountable Officer)

With previous experience of working with CCGs in Newcastle, Gateshead, County Durham and Darlington, David has been involved with the NHS in both clinical and strategic roles as a commissioner and provider. He has lived locally all his life and has extensive management experience including in hospitals and commissioning. He started his career in 1982 at Sunderland Royal Infirmary and joined the CCG as chief officer in 2012. He chairs the Sunderland A&E Delivery Board and Sunderland's Children's Strategic Partnership, is vice chair of the Sunderland Safeguarding Children's Board and a member of the Health and Wellbeing Board and Sunderland Partnership. On a wider footprint he chairs the CNE Armed Forces Network and the Estates strategy group and is a member of the Workforce Strategy Group.

Mr David Chandler, Chief Finance Officer and Deputy Chief Officer

David Chandler is the Chief Finance Officer and Deputy Chief Officer for Sunderland CCG. He has worked in the NHS at a senior level for over 20 years and has experience in most sectors including acute care, community, mental health and commissioning within Gateshead, County Durham, Darlington and Sunderland. He is also the chair of the Northern Branch of the Healthcare Financial Management Association (HFMA) and the chair of the National HFMA Commissioning Forum.

Dr Claire Bradford, Medical Director (non-voting)

Originally from North London, Dr Bradford trained at Nottingham University and worked in Nottingham and Plymouth prior to moving (and staying) in the North East in 1989. She has worked in the NHS since 1984 as a haematologist after junior doctor posts. Since 1994 Claire has been a public health physician as DPH in Newcastle Primary Care Trust, Health Protection Agency, North East Public Health Observatory and NHS England. During her public health career, her achievements have included leading teams to develop the English health profiles, European health profiles and the National Library for Public Health.

Mrs Ann Fox, Director of Nursing, Quality and Safety

Ann is a registered nurse with a career in the NHS spanning over 34 years. Ann trained and has lived in Sunderland all of her life. Ann has always been an advocate for improving the quality of patient care, their safety and their overall experience. She has been instrumental in developing new services and clinical pathways in many areas including haematology/oncology and palliative care throughout her career and in her role as Nurse Director for the North of England Cancer Network. During this time Ann was a founder board member of the United Kingdom Oncology Nursing Society, (UKONS).

From 2009, Ann was Director of Clinical Care and Patient Safety (Executive Nurse) at the North East Ambulance Service NHS, a new role introduced to support the successful transition of the organisation to Foundation Trust status.

Ann has been the Executive Director of Nursing, Quality and Safety for the CCG since 2013 and is a visiting professor at the University of Sunderland in the department of nursing and health sciences.

Mr Scott Watson, Director of Contracting and Informatics (non-voting)

Scott was born and raised in Sunderland and has spent over twenty years working for local health and social care services in the city. He is currently the CCG's director lead on the development of the All Together Better Alliance and the transformation of local hospital services via the Path to Excellence programme.

Scott is a qualified health informatician, with postgraduate and masters qualifications in information management. He graduated the NHS Leadership Academy's Nye Bevan Programme in 2014 with an award in Executive Healthcare Leadership.

Dr Derek Cruickshank, Secondary Care Clinician

Derek qualified in Aberdeen in 1980 and has worked in Teesside since 1993 as a Consultant at South Tees, retiring from clinical practice in 2017. He was appointed the first Head of School for Obstetrics and Gynaecology in the Northern Deanery in 2008 and was the Royal College of Obstetrics and Gynaecology Regional College Advisor in the North East. Derek oversaw the reconfiguration to a standalone midwifery led unit at the Friarage Hospital and was appointed to the Northern England Senate Council from its inception in 2013. Derek was appointed as Secondary Care Clinician for Sunderland CCG in June 2017.

Dr Saira Malik, Coalfield locality Executive GP lead

Dr Malik has been a GP in Sunderland since 2013 and currently works with local GP practices providing clinical stability and support in transitioning practices.

She moved back home to the North East after graduating from Bart's and The London and has been working in the local NHS for over 12 years, bringing previous experience of national representative roles in the BMA. Other roles include working with the national GP health programme in supporting doctors in difficulty and setting up a local GP Balint group.

She was appointed as a Sunderland CCG GP executive body member in April 2018 and currently leads on respiratory, musculoskeletal and falls, and rehabilitation improvement areas for Sunderland CCG.

Dr Fadi Khalil, Sunderland East locality Executive GP lead and Clinical Vice-Chair

Dr Khalil has been a GP in Sunderland since 2010. He is a GP trainer and partner at The Broadway Medical Practice. He is also the lead GP at The New Silksworth Medical Practice.

He moved to the North East after graduating from Egypt in 2002. He has been part of the team leading on Sunderland's multi-speciality community provider Vanguard Programme and the development of the All Together Better Alliance. Dr Khalil is passionate about integrated care and providing high quality seamless proactive care to the people of Sunderland. He was appointed to the CCG's Governing Body in 2015, and subsequently elected in 2016, and is currently the Clinical Vice-Chair of Sunderland CCG.

Dr Karthik Gellia, Sunderland North locality Executive GP lead

After qualifying in medicine (MBBS 1997) and a gaining post-graduate degree (MD Dermatology 2003) in India, Dr Gellia came to the UK to work in the NHS. He became a qualified GP in 2010 and has since then worked in Sunderland. Since qualifying he has been involved in the development of General Practice services in the North Locality and has taken on the role of GP lead for the locality. He is a member of the Governing Body, Executive Committee and the executive GP lead on the newly set up South Tyneside and Sunderland Health care Group overseeing the in-hospital transformation programme.

Dr Tracey Lucas, Sunderland West locality Executive GP lead

Dr Lucas moved to the North East after graduating from Glasgow in 1999 to pursue a career in paediatric medicine. After gaining further qualifications in paediatric medicine, Dr Lucas trained and qualified as a GP in 2005. Dr Lucas is now a GP trainer and partner at Deerness Park Practice and she has been working as a Sunderland GP for 14 years. She has been an executive GP for the CCG for the past 5 years, and leads clinically on urgent and intermediate care for Sunderland. She is involved in the All Together Better Alliance as the senior responsible clinician for urgent care (programme four) and is the GP lead for the East locality.

Dr Raj Bethapudi, Washington locality Executive GP lead

Dr Bethapudi is a GP partner and appraiser and has over a decade of experience in the NHS. He is also an executive GP and member of the Governing Body. He is working on reforms in cardiovascular and cancer specialities to improve outcomes for patients and provide best value for tax payers' money. He is also an approved trainer for GP registrars.

Mrs Aileen Sullivan, Lay Member, Patient and Public Involvement;

After beginning her career as a nurse and midwife, Aileen moved into the education of health professionals. She became a principal lecturer at Northumbria University in 1995 and then the director of practice placements. Aileen was actively involved in research projects looking at the care older people received in nursing homes. After leaving Northumbria she became a non-Executive Director for Sunderland Teaching Primary Care Trust. Aileen retired from her role with Sunderland CCG in February 2019.

Mr Chris Macklin: Lay Member for Audit and Risk and Non-Clinical Vice Chair

Chris has worked in the NHS since 1975 and obtained his first finance director role at the Queen Elizabeth Hospital in Gateshead in 1996. He then became finance director for Sunderland PCT in 2003 before becoming director of finance for NHS South of Tyne and Wear in 2006. He is a governor of Gateshead College and chairs their Audit Committee. In 2009 he was awarded a fellowship by Healthcare Financial Management Association (HFMA) in recognition of his contribution to HFMA and the development of NHS Accounting Standards. Chris retired from his post as Chief Finance Officer at Sunderland CCG at the end of March 2015 and was appointed as Lay Member for Primary Care Commissioning with effect from 1 September 2015, becoming the Lay Member for Audit and risk and Non-Clinical Vice Chair from July 2017.

Mrs Pat Harle MBE, Lay Member Primary Care Commissioning (non-voting)

Pat has over 40 years NHS experience, the last 18 years at board level in NHS commissioning and provider services. Most recently she was a non-Executive Director at South Tyneside NHS Foundation Trust prior to joining the CCG in January 2018. Pat has held a number of national offices, including former president and chair of the British Association of Dental Nurses, training advisory board chair, (a national training accreditation organisation) and deputy chair of an examining board. Pat was awarded a 'Probe Lifetime achievement award 'and presented with a Medal of Distinction from the British Dental Association.

Mr Eric Harrison, Executive Practice Manager (non-voting)

Born in Durham 1961, Eric joined the forces in 1977 and saw active service in Falklands and Northern Ireland before becoming transport manager for Durham Constabulary. Eric joined Deerness Park Medical Group in 2002, and became a partner in September 2016. He has an MBA, first class honours degree in business and management, qualified accountant CIPFA and post graduate diploma in advanced NHS commissioning.

Ms Deborah Cornell, Head of Corporate Affairs (non-voting)

Deborah has over 20 years' experience of working in the public sector. She started her career in HM Prison Service in London in 1997, moving to the Home Office in 1999 and then back to the North East in 2001 to join the NHS. Deborah has held several senior level corporate governance roles within the NHS and has been the Head of Corporate Affairs in Sunderland CCG since 2013. She has also been an affiliated member of the Institute of Chartered Secretaries and Administrators since 2016.

(The non-voting members of the Governing Body below are paid by other organisations)

Mrs Fiona Brown, Executive Director of People services (non-voting)

Fiona has a number of years' experience in local government and health, especially in health and social care integration, events and designing new forms of service delivery vehicles. All of her career has been spent in the North east, working for a number of local authorities and acute health trusts. She is particularly known for her work on strategic commissioning and creating innovative community solutions for independent living. Fiona is an active member of a number of associations.

Mrs Gillian Gibson, Director of Public Health (non-voting)

Gillian has lived in Sunderland most of her life and worked for the NHS since 1984 until 2013 when responsibility for public health transferred to local government. She is a registered public health specialist and has been a consultant in public health in Sunderland since 2011, taking responsibility for the integration of public health services. She became acting Director of Public Health in April 2015 and was appointed substantially in January 2016.

Committee(s), including Audit and Risk Committee

Details of the CCG's committees can be found in the governance section of this annual report.

Register of Interests

The CCG's register of interests is available on our public website and can be found by using the following link:
http://www.sunderlandccg.nhs.uk/?s=register+of+interests

It is updated on an annual basis in line with current national guidance and reviewed by both the Audit and Risk Committee and Governing Body.

Personal data related incidents

The CCG has not had any serious incidents or serious information breaches during the year.

Principles of Remedy

The CCG complaints policy and procedure has been developed and updated in line with current legislation and statutory requirements and best practice. This includes adopting the principles as outlined in the Parliamentary and Health Service Ombudsman's principles of good complaints handling, principles of good administration and principles of remedy.

Emergency Preparedness, Resilience and Response

The CCG has a business continuity plan in place which is fully compliant with NHS England's Emergency Preparedness Framework 2015. The plan sets out the necessary process for staff to follow in the event of a business continuity incident and includes key contacts to support this. In addition, the CCG has completed business impact analysis for all its key functions and used these to prioritise which activities would need to be continued in the event of such an incident. The CCG is also a member of the Local Health Resilience Forum, however, as a category 2 responder, is not required to have a major incident plan.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Sunderland CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. The CCG is not formally required to produce an annual Slavery and Human Trafficking Statement as a supplier of goods and services as set out in the Modern Slavery Act 2015, but does produce an annual statement as a matter of best practice.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Sunderland 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 as contained in the Department of Health and Social Care Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual as contained in the Department of Health and Social Care Accounting 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, and subject to the disclosures set out below (e.g. directions issued, s30 letter issued by external auditors), 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.’

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

audit information and to establish that the CCG's auditors are aware of that information.

Governance Statement

Introduction and context

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

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

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

The CCG is a membership organisation and all GP practices in Sunderland are members. We are clinically led and the membership elected six GPs, one of which is the CCG chair, to lead the CCG on their behalf and work as part of the Governing Body. We also have a number of nurses and other clinical professionals working with us on key areas of improvement and development, as well as other professionals with management support and lay members.

The Governing Body and its formal committees are responsible for setting the strategy for health improvement for Sunderland and ensured the CCG delivered the improvements we set out in our commissioning plans. By doing this, we worked very closely with other partners across the city of Sunderland to improve the overall wellbeing of our local people.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 in my CCG Accountable Officer appointment letter.

I am responsible for ensuring that the CCG 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 CCG as set out in this governance statement.

Governance Arrangements and Effectiveness

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

The CCG's Constitution sets out the terms by which the CCG, through its appointed members, elected GP executives and Governing Body, implements all statutory obligations including the commissioning of secondary health care and other services in Sunderland. The Constitution contains the main governance rules of the CCG and Governing Body.

The CCG continues to take a locality approach across Sunderland and each member practice is in one of five localities (Coalfields, Sunderland East, Sunderland North, Sunderland West and Washington).

Each of the localities has a lead GP who is an elected executive and a member of the Governing Body and executive committee as well as an assigned practice manager and practice nurse. The locality teams also work in close partnership with the local authority and local patients.

The CCG has met regularly with all of its member practices as part of the 'time in time out' clinical educational sessions which are held on a regular basis. Through these sessions, we keep our members up to date on key developments both nationally and locally across the CCG, as well as obtaining their views and feedback on key issues, improvements and future developments.

We will hold our annual general meeting on 23 July 2019 to give us the opportunity to share our key achievements during the year and highlight our priorities for the coming year. We will also give an overview of the CCG's financial performance to demonstrate we have met our statutory duties in relation to these.

We use our governance framework to lead and manage the achievement of our vision for '*Better Health for Sunderland'.* We also use governance to lead and manage through our core values (and the public sector values of accountability, probity and openness) and our systems (such as governance structures and risk

management systems). Details of our strategic objectives and core values can be found in the performance report section of CCG's annual report.

We also use governance as the system of control, accountability and decision-making at the highest level of the organisation. The CCG governance framework comprises of the systems and processes and culture and values by which the CCG is directed and controlled. It enables us to monitor the achievement of our strategic objectives and ensure we deliver our vision of delivering appropriate, cost-effective services for the residents of Sunderland.

The CCG's system of internal control is a significant part of the governance framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure to achieve policies, aims and objectives and therefore can only provide reasonable and not absolute assurance of effectiveness.

Our system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of policies, aims and objectives
- Evaluate the likelihood of those risks materialising and the impact should they materialise,
- Manage risks efficiently, effectively and economically

The governance framework has been in place in the CCG for the whole of the year ending 31 March 2019 and up to the date of the approval of the statement of accounts.

To ensure effective governance arrangements are in place within the CCG, the Governing Body and its sub-committees operate in such a way as to ensure it discharges its functions appropriately and all of the functions are managed effectively. The Governing Body and committee agendas are structured to ensure key risks and issues were addressed and ensure delivery of our corporate objectives.

The Governing Body has an agreed assurance framework in place (described in more detail in the internal control framework section of this statement) which is supported by clear risk management processes to place for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

The Audit and Risk Committee has overseen the risk management function on behalf of the Governing Body since January 2018. This was formerly done by Quality, Safety and Risk Committee however following a review of the risk management arrangements in November 2017, the oversight function for risk

management was transferred to the Audit Committee (renamed the Audit and Risk Committee) as from 1 January 2018.

The Governing Body used its assurance framework to ensure delivery of the corporate objectives and has received regular updates on progress for assurance. The Audit and Risk Committee also supported this work and undertook regular reviews of the framework and process associated with it to ensure it remained robust throughout the year.

In 2018/19, the Governing Body met on twelve occasions, six of which were held in public. The other six occasions were used as more indepth sessions to continue focus developing the effectiveness of the Governing Body, both as individual members and as a board, and to review specific topics in more detail.

The Governing Body is made up of the following members:

- Executive GP chair (elected)
- Executive GP vice chair (elected)
- Executive GP x 4 (elected)
- Chief Officer
- Chief Finance Officer and Deputy Chief Officer
- Director of Nursing, Quality and Safety
- Lay Member, Audit and Non-Clinical Vice Chair
- Lay Member, Patient and Public Involvement
- Secondary Care Clinician

In addition, the following are regular non-voting attendees and participants to the Governing Body meeting:

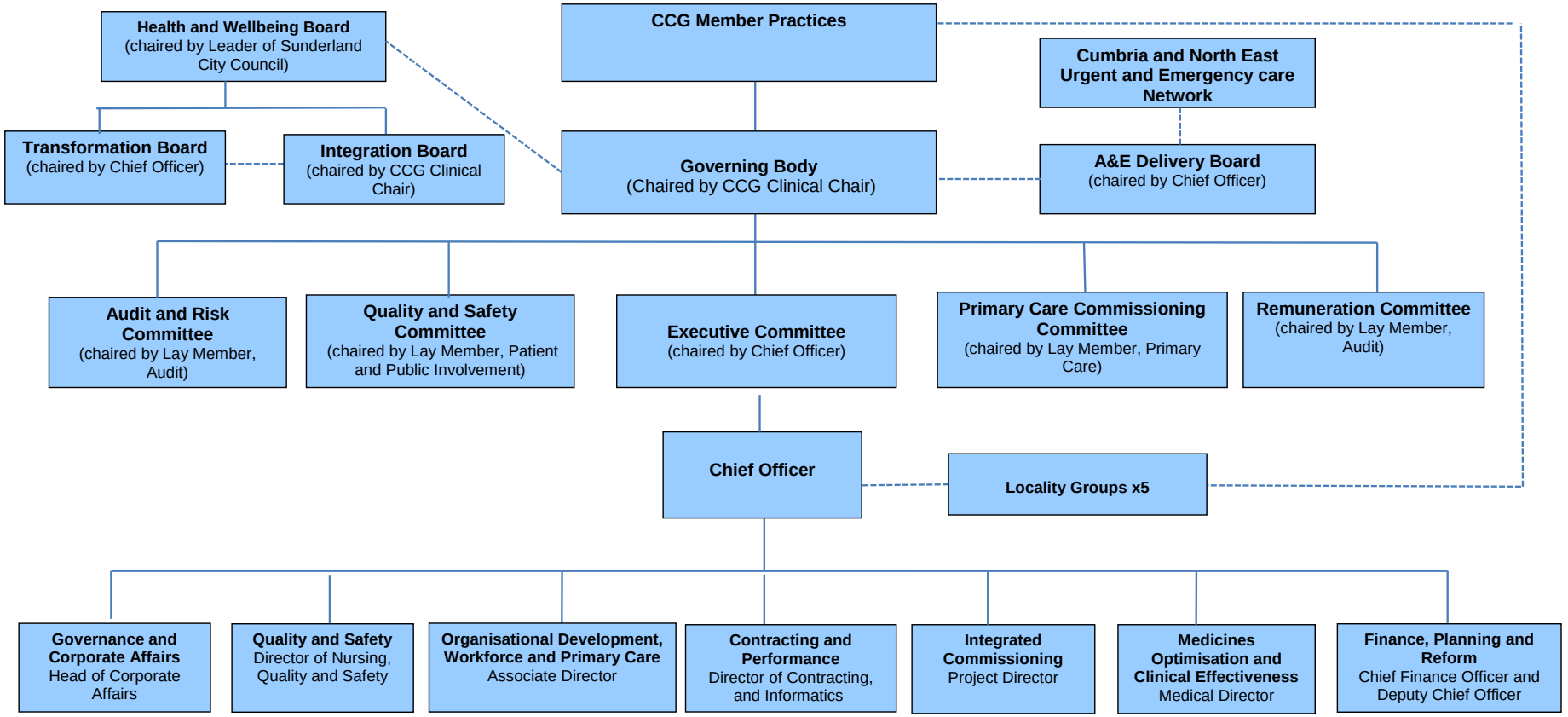
- Medical Director
- Executive Practice Manager
- Head of Corporate Affairs
- Lay Member, Primary Care Commissioning
- Director of Contracting and Informatics
- Associate Director of OD, Workforce and Primary Care
- Director of Public Health, Sunderland City Council
- Executive Director of People Services, Sunderland City Council

The Governing Body's committee structure reflects guidance and best practice and includes an executive committee, audit and risk committee, quality and safety

committee, primary care commissioning committee and a remuneration committee Each committee has agreed terms of reference to outline their key areas of responsibility and accountability to the Governing Body. These terms of reference are reviewed on a regular basis to ensure they remain relevant and reflect the committee's role and responsibilities.

Agendas are structured to deal with strategic, performance, quality, assurance, risk and governance issues, as well as patient experience via patient stories at public governing body meetings. These arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a robust assurance framework is in place and consistently reviewed. They also reflect the public service values of accountability, probity and openness and specify, as chief officer, my responsibility for ensuring these values are met within the CCG.

The Governing Body Structure



*Previously the Quality, Safety and Risk and Audit committees. The committees were renamed the Quality and Safety Committee and Audit and Risk Committee with the effect 1 January 2018 to reflect the transfer of the risk management oversight function.
Committees of the Governing Body

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
Roles and responsibilities				
• Responsible for the delivery of the overall management to support the CCG to work efficiently, effectively and economically • Ensure effective clinical engagement • Promote involvement of all member practices in the work of the CCG • Secure improvements in commissioning of care and services • Strategy and planning • Formulating and implementing	• Responsible for ensuring appropriate governance systems and processes are in place to commission, monitor and ensure the delivery of high quality safe patient care in commissioned services, • Promote continuous improvement and innovation – safety of services, clinical effectiveness and patient experience • Secure public	• Responsible for critically reviewing financial reporting and internal control principles • Provide assurance and independent / objective views to the Governing Body on finance and governance systems and processes • Review the adequacy and effectiveness of governance, risk management and internal control measures • Monitor integrity of	• Responsible for making decisions on the review, planning and procurement of primary medical care services in accordance with the delegation agreement between the CCG and NHS England • Promote increased co-commissioning to increase quality, efficiency, productivity and value for money • Management of GMS, PMS and APMS contracts • Design and	Determine and make recommendations to the Governing Body on: • Pay and remuneration for CCG employees and people who provide services to the CCG • Allowances under any pension scheme established as an alternative to the NHS pension scheme. • Appropriate remuneration and terms and conditions for the Accountable Officer (Chief Officer), GP

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
service change • Delivery of improved outcomes, action planning • Managing performance – financial and non-financial • Review of business cases and supporting processes	involvement - patient and public views are properly reflected in CCG policies and plans • Oversight and scrutiny, supporting NHS England, in securing continuous improvement in the quality of primary medical care • Quality in commissioned services – assurance and improvement • Seek assurance on performance of provider organisations • Seek assurance in relation to medicines	financial statements • Scrutinise the process and delivery of QIPP / resource releasing initiatives • Perform the role of Auditor Panel • Ensure an effective internal audit function that meets mandatory Public Sector Internal Audit Standards • Review the work and findings of external auditors • Ensure adequate counter fraud arrangements are in place • Ensure robust process are in place to manage conflicts	management of enhanced services • Design of local incentive schemes • Decisions on establishing new GP practices in an area, approving practice mergers or branch closures • Review primary medical care services in Sunderland • Financial management of primary medical care services	Executives, Very Senior Managers, Vice Chair • Remuneration and terms of appointment of any lay members. • Proper calculation and scrutiny of termination payments • Fulfil the role of Nominations Committee

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
	optimisation, safety and cost effective prescribing	of interest • Ensure systems are in place to identify, assess and prioritise risks, both actual and potential		
Membership				
Chief Officer (Chair) Chief Finance Officer and Deputy Chief Officer Director of Nursing, Quality and Safety, 6 Executive GPs Strategic Practice Manager **Regular attendees:** Medical Director Director of Contracting and Informatics Associate Director of OD, Workforce and Primary	Lay Member, Patient and Public Involvement (Chair) Director of Nursing, Quality and Safety, Chief Officer Medical Director Secondary Care Clinician GPs x 3 Head of Quality and Patient Safety Head of Safeguarding Head of Corporate Affairs Head of Contracting and	Lay Member, Audit (Chair) Lay Member, Patient and Public Involvement Independent Audit and risk committee Member **Regular attendees:** Chief Finance Officer External Audit Mazars – Partner and Senior Manager Director of Internal Audit, AuditOne Deputy Chief Finance	Lay Member, Primary Care Commissioning (Chair) Lay Member, Patient and Public Involvement Chief Officer Chief Finance Officer Executive GP GP Primary Care Advisor Deputy Chief Officer Regular attendees: Sunderland City Council representative	Lay Member, Audit (Chair) Lay Member for Patient and Public Involvement CCG Chair **Regular attendees:** Chief Officer Head of Corporate Affairs HR Representative

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
Care Head of Corporate Affairs Director of Public Health, Sunderland City Council	Performance Director of Public Health, Sunderland City Council (withdrew June 2018)	Officer Head of Corporate Affairs Counter Fraud Specialist	Local Healthwatch Chair NHS England representative Head of Corporate Affairs	
Key issues covered during the year				
• Financial pressures and performance issues • Community Acquired Brian Injury Service review • Intensive Support Team Service Review • Continuing healthcare and healthcare packages • Ambulance response times • Transforming Care • Medicines optimisation	• CCG quality strategy • Safeguarding • Quality in commissioned services, • Quality in older persons' commissioned services • Continuing health care • Transforming Care/Learning disabilities • Mental health	• Governing Body assurance framework • Corporate risk register • Annual governance statement • Annual report and accounts review and recommendation to the Governing Body • Financial updates (including schedules of losses and special payments) • Sustainability	• Financial updates on the management of delegated general practice budgets • Practice and branch mergers, boundary changes and list closures • General Practice Five Year Forward View • Refreshed general practice strategy • Primary care estates subsidiaries • General practice communications and	• Chief Finance Officer remuneration • Award of a non-recurrent an additional days' leave for staff in recognition for their individual and collective contribution to the success of the CCG • Non-agenda for change pay proposals • Appointment of the Managing Director and GP Chair roles for the All Together Better

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
• Prevention and child health • Children and adolescent mental health services, including perinatal services • Cancer plan • Urgent and ambulatory care • Stop smoking, integrated wellness and sexual health services • Single point of access for the Musculoskeletal Service • Emergency preparedness, resilience and response • Improving Access to	• General practice assurance framework • Quality and safety risks • Medicines optimisation • Patient and public involvement statutory requirements and improvement and assessment framework self-assessment • Medicines optimisation • Clinical assurance visits with providers • Focussed discussions on including enhanced care in care homes;	Delivery Group minutes • Scheme of reservation and delegation • Overview of tender waivers • QIPP/resource releasing initiatives • Register of interests • Internal audit strategy and progress reports • External audit progress and completion reports • Counter fraud annual plan and updates • NHS Counter Fraud Authority self-assessment submission • Cyber security and	engagement • Care Quality Commission inspection reports • General practice transformation funding • General practice quality premium evaluation for 2017/18 • Carers Improvement Scheme • Workforce updates • NHS England General Practice resilience funding • Quality in general practice • Localities updates • New consultation types within general practice	Alliance

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
Psychological Services • Continued development of the multi-specialist community provider model (now the All Together Better Alliance) • Consideration and approval (where appropriate) a number of policies and strategies including information governance; urgent care; cancer; value-based commissioning and organisational development • Assurance from its sub-groups on their performance and delivery of roles and	urgent care; LeDeR; Continuing Health Care and healthcare packages • Assurance from its sub-groups on delivery of their roles and responsibilities (including safeguarding, healthcare acquired infections and quality within local providers) **Some key challenges for the Committee included:** • Provider quality and safety performance issues • Delivery of statutory duties relating to patient and public	information risk • Auditor annual report Some key challenges for the Committee included: • Forecast underspends and the financial impact of over performance in A&E and emergency admissions • Funding allocations and changes to business rules for CCGs • QIPP / Sustainability Delivery Group progress • Continuing health care internal systems and processes review	• Recruitment and retention scheme updates **Some of the key challenges for the Committee included:** • Continued management of conflicts of interest • GP recruitment and retention • Quality issues in primary care • Underspend on delegated general practice budgets • NHS Property Services increase in rent charges for practices	

Executive Committee	Quality and Safety Committee	Audit and Risk Committee	Primary Care Commissioning Committee	Remuneration Committee
responsibilities **Some key challenges faced by the committee included:** • A&E performance • Continuing healthcare packages • Financial pressures • Urgent care consultation • Transfer of Shared Care • Ambulance waiting times and handover delays	involvement • Safeguarding adults and children activity • Delivery of statutory duties relating to continuing health care • Joint commissioning – nursing, residential care; learning disabilities; continuing healthcare and healthcare packages • Medicines optimisation - shared care and joint formulary • Quality within primary medical care services • Childhood immunisations	• NHS Property Services increase in rent charges for practices		

Joint Committee Arrangements

The CCG has joint and collaborative arrangements in place to make commissioning decisions through delegation arrangements. These are as follows:

- Sunderland City Council Health and Wellbeing Board (on which the CCG has three voting seats)
- Joint Health and Social Care Integration Board with Sunderland City Council to manage the Better Care Fund set up from April 2016
- Sunderland City Council (section 75) agreement in place for joint commissioning arrangements for the Better Care Fund
- Northern CCGs' Joint Committee with delegated decision making on a limited number of issues.
- Collaborative arrangements with the other North East and Cumbria CCGs with regard to commissioning arrangements for contracts with NHS healthcare providers across the North East and Cumbria
- Joint arrangements with the North East CCGs to determine commissioning for health gain policies and to review and approve individual funding requests, including conducting an appeals process
- Joint arrangements with the North East CCGs to advise upon and make recommendations to CCGs on high cost cancer drugs and high cost treatments
- Joint arrangements with the North East CCGs to provide a partnership forum to work together with trade union and professional organisation representatives to discuss issues relating to employment matters affecting their employees

The groups identified above have an agreed governance structure in place with specific roles, responsibilities and accountabilities or are covered by individual CCGs' governance arrangements where appropriate and agreed. Any investments and decisions made by these groups are formally documented and reviewed regularly as part of the CCG contracting and performance arrangements.

In addition, we continue to work closely with our partner organisations in the local health community. A significant part of this partnership working continues to be with Sunderland City Council (the Council) in the delivery of the Better Care Fund (BCF) through the Health and Social Care Integration Board. The BCF combines a resource of £73m in 2018/19 between health and social care and is enabling us to make much needed changes to improve services across both sectors whilst making maximum use of the combined resources. Robust governance arrangements are in place around the BCF and demonstrate the strength of the links that we have with the Council.

The CCG and Council have been working in partnership to transform the delivery of care across Sunderland as part of the commitment set out in the Five Year Forward View. As a partnership, we established the 'All Together Better Sunderland' care programme following the securing of national vanguard funding to help strengthen connections between local health services and social care services. We worked together to support the development and delivery of our integrated teams, recovery at home and enhanced primary care work as part of our out of hospital transformation model and avoid delays in delivering care to patients.

As a result of this care programme, we now have a community-based care model that is centred on the patient being managed at home or in the community wherever possible. All Together Better was one of only 14 national multi-specialty community provider schemes (Vanguards) chosen to spread good practice to other areas of the country.

Robust and transparent governance arrangements are in place around the vanguard programmes and the established All Together Better Alliance (ATBA) Executive to monitor delivery against the required objectives and timescales. The ATBA Executive is accountable to the Transformation Board, chaired by the CCG, which includes senior representatives from the CCG, council and providers.

The ATBA brings together all out of hospital or community care services the CCG commissions into one single multi-specialty community provider contract. The single contract will bring together those services commissioned by the CCG to look after people's physical and mental health (including GPs, nurses and other health professionals, the voluntary sector and healthcare managers) to plan and deliver a new form of integrated care designed to bring about better health outcomes for the local population. The ATBA will have a budget of circa £240m per year and is planned to run for 10 years, beginning in April 2019.

The CCG also continues to maintain close links with NHS England. The latest assurance ratings from NHS England rated the CCG as 'outstanding' in all domains of the CCG Improvement and assessment framework (planning, performance, financial management, delegated functions and well-led organisation).

Assessment of the Governing Body Effectiveness

The CCG's governance framework is reviewed by NHS England as part of the CCG assurance framework requirements. During the year, the CCG has undertaken a self-assessment of its leadership and governance processes as part of the framework put in place by NHS England, Cumbria and the North East who were assured that the CCG governance framework was robust and did not raise any issues of concern.

We continuously monitor our process for managing conflicts of interest to ensure any actual or potential interests are managed effectively and robustly. The CCG has submitted quarterly assurance returns to NHS England in relation to any breaches in managing conflicts of interest and to date we have not had any. Our register is publicly available on the CCG's website.

Committee and Governing Body Attendance Record 2018/19

Member Name and Role	Governing Body	Executive Committee	Audit and Risk Committee	Quality and Safety committee	Primary Care Commissioning Committee	Remuneration Committee
Mrs Aileen Sullivan Lay member for Patient and Public Involvement*	4/6		5/5	9/10	4/6	2/2
Mr Chris Macklin Lay Member for Audit and Governing Body Non-Clinical Vice Chair*	6/6		5/5			2/2
Mrs Pat Harle Lay member for Primary Care Commissioning	5/6			6/8	6/6	
Mr Neil Weddle Independent Audit and risk committee Member			5/5			
Mr Derek Cruickshank Secondary Care Clinician	4/6			8/10		
Dr Ian Pattison Executive GP and Governing Body Clinical Chair *	5/6	9/12			4/6	2/2
Dr Raj Bethapudi Executive GP*	5/6	10/12				
Dr Tracey Lucas Executive GP*	5/6	11/12				
Dr Karthik Gellia Executive GP*	5/6	12/12		8/10	5/6	

Member Name and Role	Governing Body	Executive Committee	Audit and Risk Committee	Quality and Safety committee	Primary Care Commissioning Committee	Remuneration Committee
Dr Fadi Khalil Executive GP*	3/6	9/12				
Dr Saira Malik Executive GP*	4/6	11/12		5/9		
Mr David Gallagher Chief Officer*	5/6	10/12		6/10	4/6	2/2
Mrs Ann Fox Director of Nursing, Quality and Safety*	4/6	10/12		8/10	4/6	
Mr David Chandler Chief Finance Officer *	6/6	8/12	5/5		3/6	
Mrs Debbie Burnicle Deputy Chief Officer (until 30 April 2018)	1/1	1/1			1/1	
Dr Claire Bradford Medical Director	4/6	9/12		4/10		
Mr Scott Watson Director of Contracting and Informatics	5/6	9/12				
Mrs Florence Gunn Strategic Practice Nurse		8/12				
Mr Eric Harrison Executive Practice Manager	3/6	10/12				
Dr Geoff Stephenson					6/6	

Member Name and Role	Governing Body	Executive Committee	Audit and Risk Committee	Quality and Safety committee	Primary Care Commissioning Committee	Remuneration Committee
Primary Care Advisor						
Mrs Gillian Gibson Director of Public Health, Sunderland City Council	5/6	10/11		1/10**		
Ms Fiona Brown Executive Director of Peoples Services, Sunderland City Council	1/6				0/6	

* Voting right on the Governing Body

** Agreed that Mrs Gibson would not attend meetings but still be included in the distribution list for information

As well as our formal meetings, the Governing Body has a detailed programme for development sessions throughout the year, utilising external and internal expertise and facilitation, to continuously review, develop and enhance its effectiveness.

The sessions covered a range of key topics such as:

- System-wide development of the integrated care system and partnerships
- Collective and individual leadership
- Strategic direction, planning and priorities
- Assurance and organisational development
- Urgent care strategy development
- Development of the All Together Better Alliance (out of hospital reform)
- The Path to Excellence programme (in hospital reform)
- Joint committee arrangements for Cumbria and the North East

The Governing Body also undertakes an annual self-assessment questionnaire for members to assess their effectiveness and performance, both as individuals and a board, based on principles outlined in relevant corporate governance guidance. The questionnaire focuses on leadership, effectiveness, accountability, remuneration and relationships with stakeholders.

The outcome of the self-assessment is used to help focus on any areas of development in the Governing Body development sessions. It also provides an opportunity for the Governing Body to reflect on its performance throughout the year and assure itself it has acted in line with its agreed Constitution and current legislation.

Having reviewed the effectiveness of the Governing Body's governance framework and associated guidance, I consider that the organisation has followed and applied the principles and standards of best practice.

Discharge of Statutory Functions

The arrangements put in place by the CCG and explained within the corporate governance framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for membership body and Governing Body decision and the scheme of delegation.

In light of recommendations of the 2013 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 legislation and regulations. As a result, I can confirm that the CCG 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. The director teams have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk Management Arrangements and Effectiveness

Effective risk management is an integral part of the work of the CCG in delivering against its corporate objectives and strategic priorities in the stewardship of public funds. The Governing Body has a responsibility to maintain a strategic view of the organisation's risk appetite, as set out in the CCG's risk management framework, and to set boundaries to guide staff on the limits of risk they are able to accept in the pursuit of achieving its organisational objectives.

Risk management is embedded in the activity of the CCG through:

- The risk management framework and its supporting policies and procedures
- The committee structure described earlier in this statement
- A risk management group, including directors and the senior team
- The management processes (e.g. used a risk-based approach to help prioritise planning and work programmes)
- The Governing Body assurance framework
- Risk management skills training, including risk assessments of various types and the mandatory and statutory training programme for all staff
- Raising awareness of a counter fraud culture

The CCG risk management framework takes into account current guidance on risk management as well as established best practice. The framework sets out the CCG's approach to risk and the management of risk in the fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding of an effective risk management framework and processes helps to ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to reform services through innovation, large-scale prevention, improved quality and greater productivity.

The framework provides guidance for the systematic and effective management of risk. Key elements of the framework include:

- Clear statements on the responsibilities of the Governing Body and its sub committees as well as individual accountability for delivery of the framework

- Clear principles, aims and objectives of the risk management process
- Clear processes for the management of risk in commissioned services, partnership working and the delivery of the quality, innovation, productivity and prevention programme
- A clearly defined process for assessing and managing risks, including implementation and dissemination of the framework to all staff
- Details of the approach to be undertaken to assess and report risks, including incident reporting, serious incidents and safeguarding
- Confirmation of the arrangements for reporting of and managing risks through the risk register process
- Arrangements for monitoring and review of the framework

The overall risk management approach ensures that the framework is coordinated across the whole organisation and progress is reported effectively to the Governing Body, Quality and Safety and Audit and Risk Committees.

The risk management framework is embedded into the work of CCG in a number of ways. We have a robust incident reporting system and staff are actively encouraged to report incidents to help identify risks and we also have a clear policy and process in place for staff to raise any concerns in relation to potential fraud risks. The planning and reform processes also include a risk management element to ensure risks are being identified and mitigated as far as possible, with each of the programme boards having a responsibility to escalate risks through to the corporate risk register process as appropriate.

Understanding, monitoring and mitigating risks are fundamental tasks in a successful organisation, as well as basic aspect of good governance. As such, it is the responsibility of the Governing Body to determine the best place for risk management to positioned ensuring effective management and assurance processes are in place.

The Audit and Risk Committee oversees the risk management system and obtains assurances that there is an effective system operating across the CCG. The Committee reports any significant risk management issues to the Governing Body.

The Risk Management Group is part of the business cycle for the director and senior team meetings. The Risk Management Group (as part of the director and senior team meeting) reviews the corporate risk register and any high level risks and reports any significant risk management and assurance issues to the Audit and Risk Committee.

The Risk Management Group continues to meet on a quarterly basis and includes a review of all risks, supported by a rolling programme of in-depth reviews of each individual director's risks. This enables further scrutiny and challenge on the assurances and mitigating actions identified in the risk register and Governing Body Assurance Framework.

The Executive and Quality and Safety committees also continue to review and manage any strategic or operational risks pertaining to the committee's area of focus on exceptional basis.

Additional risk management support

The CCG also has a service line agreement in place with the North of England Commissioning Support Service (NECS) to provide specialist support and advice in relation to risk management in conjunction with the Head of Corporate Affairs. This support includes the management of the Safeguard Incident and Risk Management System which is the system the CCG uses to record and analyse all identified risks.

Other risk management processes

The equality impact assessment process (EIA) is well established within the CCG and staff receive regular training and updates to ensure any risks associated with this are identified and managed. The Governing Body and committee report cover sheets also include reference to the EIA process to demonstrate compliance with this duty and highlight any potential issues.

The CCG involves key stakeholders and the public in the management of risks through its Governing Body meetings held in public. The risk register is a regular item on the public agenda and there is an opportunity for questions to be asked on the register as a whole or any specific risks during the meeting. In addition, key stakeholders and the public are invited to specific events such to discuss issues and topics in detail, which includes identifying and assessing relevant risks.

There is also the opportunity through the CCG's regular engagement activities and collaborative working across the health economy to discuss risks openly and to help identify ways in which they should be managed. By working in an inclusive way with the public, this ensures the CCG takes into account the views of the public and key stakeholders. Any such views form a crucial part of developing robust mitigating action plans for any identified risks.

Risk Appetite

Risk appetite is the organisation's unique attitude towards risk as it is the amount of risk that the organisation is prepared to accept, tolerate or to be exposed to at any point in time. It can be influenced by personal experience, political factors and

external events. Risks were considered in terms of both opportunities and threats and not confined to money.

The CCG tries to reduce risks to the lowest level reasonably practicable. Where risks cannot reasonably be avoided, every effort is made to mitigate the remaining risk. However, an understanding of the organisation's risk appetite will ensure the CCG supports a varied and diverse approach to commissioning, to work proactively and to improve quality, efficiency and value.

In-line with best practice, the Governing Body reviewed all of its corporate objectives and set the risk appetite for each one individually. It is recognised that the risk appetite may differ for each objective depending on the nature of the objective and the required actions necessary to deliver that objective. The Governing Body used the Good Governance Institute risk appetite matrix for NHS organisations to determine the level of risk appetite.

The Governing Body concluded that the CCG's overall organisation and individual risk appetites are:

- **Overall appetite – seek:** eager to be innovative and to choose options offering potentially higher rewards (despite greater inherent risk)
- **Individual corporate objective appetites**:

Table 20: Risk Appetite Matrix

Objective	Risk Appetite
CO1: ensure the CCG meets its public accountability duties	Open / Seek
CO2a: maintain financial control	Open
CO2b: maintain performance targets	Seek
CO3: maintain and improve the quality and safety of CCG commissioned services	Seek
CO4: ensure the CCG involves patients and the public in commissioning and reforming services	Open
CO5: identify and deliver the CCG's key strategic priorities	Seek
CO6: continue to develop the CCG localities	Open
CO7: integrating health and social services, including the Better Care Fund	Seek
CO8: development and delivery of primary medical care commissioning	Seek

Control Mechanisms

The CCG's corporate objectives were reviewed by the Governing Body and did not change for 2018/19. These are outlined in the table above.

Whenever risks to the achievement of the CCG's objectives were identified, an assessment was undertaken to ensure the appropriate controls were put in place (using the existing strategic risks identified on the risk register and aligned to the corporate objectives). In addition, supporting action plans were identified and implemented to mitigate these risks materialising as far as possible. A number of controls and assurances, along with associated gaps in assurance and controls, were also identified and together these formed the Governing Body assurance framework (GBAF) for 2018/19.

The Governing Body maintains oversight of the internal control and risk management frameworks and seeks assurance that these are being managed within appropriate delegated limits, with specified objectives and robust action plans. The Audit and Risk Committee provides the Governing Body with an independent and objective review on the CCG's finance and governance systems, financial information and compliance with laws, guidance, and regulations governing the NHS in so far as they relate to finance and governance. The Audit and Risk Committee ensures the adequacy and effectiveness of the GBAF, using it to guide its work and that of audit and assurance functions that report to it.

Specific risks relating to the CCG's corporate objectives as part of the 2018/19 GBAF are detailed on page 32 of the performance overview section of this annual report.

A number of gaps in assurance and controls were identified in reviewing and agreeing the assurance framework. These have been monitored as appropriate within the committee structure.

A number of audits have also been conducted throughout the year focusing on key governance areas such as standards of business conduct, corporate decision-making, financial systems and risk management. The outcomes of these audits gave the CCG a rating of substantial assurance for each of these areas.

We have a five year commissioning plan which describes the long term vision for health and social care of Sunderland. The risks to delivery of this plan have been systematically identified and quantified for all of the investment and disinvestment initiatives as part of the detailed planning process and in collaboration with all relevant partners, using a risk-based assessment of likelihood and consequence.

The CCG financial framework also used this risk-based approach to develop a balanced financial plan year on year. Contingencies were identified within the financial framework to ensure high level financial risks could be addressed. The CCG used its local prioritisation process to enable the balance of investments and disinvestments to be robustly assessed and reviewed. In addition, the process to develop and approve business cases has also been reviewed in year.

The CCG was part of the Northumberland, Tyne and Wear and North Durham sustainability and transformation partnership (STP). This partnership is a shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention, early intervention and social care. This STP amalgamated with the two other STPs in Cumbria and the North East to create the North Cumbria and North East STP / Integrated Care System.

The CCG is also part of the South Tyneside and Sunderland Partnership leading the Path to Excellence programme which includes NHS South Tyneside CCG, City Hospitals Sunderland NHS Foundation Trust and South Tyneside Hospital NHS Foundation Trust (now combined into South Tyneside and Sunderland NHS FT with effect from 1 April 2019).. This is a transformational programme in relation to acute (in hospital) services across South Tyneside and Sunderland.

Phase one of the programme included a review of obstetrics and gynaecology, stroke and paediatrics services across South Tyneside and Sunderland. A formal consultation process was undertaken during July to October 2017 around the different options, developed by the relevant clinical teams, for the future delivery of these services. Mobilisation of phase one is now underway following the decision by the Governing Bodies of Sunderland and South Tyneside CCG's in February 2018 on which options would deliver the best care possible for the local residents of both areas. Part of this decision-making included consideration of the feedback from the public and this is described in more detail in the patient and public involvement section of the annual report.

Phase two of this programme is now underway and will focus on acute medicine and emergency care, emergency surgery and planned care and outpatients. This pre-engagement phase looks at socialising issues, developing the case for change and ensuring staff and stakeholder involvement in any option development. Formal consultation on these options will take place later in 2019.

The CCG has also updated its two year operational plan (developed in 2016/17) which outlines how we are delivering the Sunderland components of the STP/ ICS plan, using a risk-based approach to develop the plan. Further detail on the STP and ICS can be found in the performance report section of this annual report.

The CCG has a duty to work with partners to improve the health of the local population. Partnerships can involve high levels of risk due to their complexities making robust risk management an essential element of partnership governance.

The CCG has ensured that any work carried out across the health and social care economy adhered to the CCG's principles of robust risk management, focusing on those areas considered to be of highest risk and undertaking appropriate risk assessments and mitigating action plans as necessary.

Capacity to Handle Risk

The CCG is committed to commissioning high quality, safe and sustainable services and demonstrates leadership in risk management through the risk management framework. The framework sets out clear roles and responsibilities within the CCG to implement the risk management process.

The responsibility for risk management is identified at all levels across the CCG, from Governing Body members, directors and to all managers and staff.

As chief officer, I have overall responsibility to ensure the implementation of the framework with supporting risk management systems and internal control. I also ensure an appropriate committee structure is in place to meet all the statutory requirements and ensure positive performance towards the achievement of the CCG's strategic priorities. Day to day responsibility for risk management is delegated to the Head of Corporate Affairs.

The Chief Finance Officer and Deputy Chief Officer provides expert professional advice to the Governing Body on the efficient and economic use of the CCG's financial resources. This includes ensuring the CCG has appropriate arrangements in place for audit and identifying risks and mitigating actions in the delivery of QIPP.

The Medical Director, Director of Nursing, Quality and Safety and six elected GPs promote risk management processes with the CCG's member practices.

All senior leaders within the CCG have a responsibility to incorporate risk management within all aspects of their work in line with the requirements set out in the risk management framework as described in an earlier section of this statement. Appropriate training has also taken place over the year to enable senior leaders to undertake their risk management duties appropriately and enable them to share best practice. The Risk Management Group helps to support this and its membership includes all heads of service.

The structure within the CCG to manage risk is detailed as follows:

Table 21: Structure within CCG to manage risk

Committee	Responsibility for Risk Management	Role
Governing Body	Maintains oversight of the internal control and risk management frameworks	Seek assurance on behalf of the CCG membership that risks are being managed appropriately within delegated limits, with specific objectives and robust action plans to ensure the CCG meets its statutory duties and functions.
Audit and Risk Committee	Main committee with responsibility for oversight of the risk management and internal control arrangements	Receives regular information on risks and provides assurance to the Governing Body progress is being made towards mitigating these. Risk Management Group reports into this Committee. Reviews the Governing Body Assurance Framework and provides assurance to the Governing Body that the CCG is discharging its functions appropriately.
Risk Management Group	Incorporated into the director and senior team meetings.	Provides assurance to the Audit and Risk Committee on the embedding of the CCG's risk management policy and framework, with a particular focus on the risk register system and process.
Executive, Quality and Safety and Primary Care Commissioning Committees	Reviews risks and key issues on an exceptional basis	Undertakes this role for additional scrutiny when required.
Director and Senior team (including Risk Management Group)	Supports the Audit and Risk Committee as a formal sub group in managing risk across the CCG	Provides assurance on the embedding of the CCG's risk management policy and framework, with a particular focus on the risk register system and process.

Risk Assessment

The CCG has ensured that its risk management processes are embedded throughout the organisation and provide a clear process for identifying, analysing, evaluating, managing, controlling, monitoring and communicating risk. The types of risks the CCG faces include corporate (accountability to the public), clinical (associated with our commissioning responsibilities), reputational and financial risks.

The CCG continues to use a standard matrix methodology in the application of a risk rating to ensure a consistent approach to the prioritisation of risks and effective targeting of resources. Risks are assessed using the consequence and likelihood of that risk occurring, giving an overall rating of high, moderate or low. This rating is recorded against the identified risk and managed via a serious of controls and actions and progress is monitored via the CCG's governance processes. The financial impact of the identified risk is also assessed and included on the register.

Each director team has its own risk register, aligned to the CCG's corporate objectives and assurance framework, to identify existing or prospective risks to the organisation. These registers are supported by a corporate register, which focuses on the high risks that have been identified to the delivery of the CCG's strategic objectives and a strategic risk register which supports the Governing Body assurance framework (covered in more detail in the control mechanisms section). In addition, risks are identified through our strategic planning process and monitored via our performance management system that rates all objectives for risk to delivery.

The Audit and Risk Committee oversees the risk management function and has received bi-monthly updates of the corporate risk register throughout the year to ensure though high risks are being monitored and managed effectively to be mitigated as far as possible. The Risk Management Group (as part of the director and senior team meetings) continued to support the Committee throughout the year in managing risks, meeting on a quarterly basis to focus on the lower level operational risks to ensure these were being managed appropriately.

The framework to monitor and manage each level of risk register is as follows:

Table 22: Framework to monitor and manage risk register

Register Type	Managed / reviewed by	Frequency of review	Accountable to
Strategic risk register (moderate / high risks identified as strategic risks to the corporate objectives)	Audit and Risk Committee (as part of the Governing Body Assurance Framework)	Quarterly	Governing Body
	Governing Body (as part of the Governing Body Assurance Framework)	Six monthly	CCG membership
Corporate risk register (moderate and high risks rated 10-25)	Audit and Risk Committee	Bi-monthly	Governing Body
Operational risk register (low risks rated between 1-9)	Director and Senior team (incorporating the Risk Management Group)	Quarterly	Audit and Risk Committee

Using the risk register framework described above has enabled the CCG to maintain a continued focus on those risks with a potential greater impact on the organisation at both committee and Governing Body level.

The CCG identified some high risks during the year (as highlighted previously in the control mechanisms section) and mitigating action plans were put in place to address these. Progress has been monitored closely by the director and senior team, Audit and Risk Committee and Governing Body.

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 risks, to evaluate the likelihood of those risks materialising and the impact should they materialise, and to manage them efficiently, effectively and economically.

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

The committee structure within the CCG has been established to ensure there are robust reporting mechanisms and clear lines of accountability in place to provide assurance to the Governing Body, and ultimately our members, that the CCG is discharging its activities and functions effectively.

The scheme of delegation and reservation sets out the responsibilities of the membership, Governing Body and its sub-committees, the chief officer and other directors to ensure the CCG discharges its functions appropriately. The scheme is explicit in defining where the responsibilities lie in delivering each of these key functions and also provides a framework by which the Governing Body, on behalf of the members, can seek assurance these are being done so appropriately.

The CCG's Constitution sets out the role and responsibilities of the Governing Body as well as each of its formal sub-committees. Each formal sub-committee has its own agreed terms of reference in place to ensure it carries out its delegated functions on behalf of the Governing Body appropriately and within its remit. Each of the committees is subject to an annual review of effectiveness and this is reviewed by the Governing Body.

The Governing Body Assurance Framework (GBAF) is in place to identify gaps in control and provides assurance against the delivery of the CCG's corporate objectives and any key areas of risk (described in more detail in the control mechanisms section).

The controls identified within the GBAF were assessed as the key elements needed to mitigate risks to delivery of the corporate objectives as far as possible, act as a deterrent to risks occurring and provide a structured approach by which identified risks could be managed. The GBAF and risk management framework both support the delivery of the corporate objectives and form part of the internal control framework.

The CCG financial framework also forms part of the internal control framework, with a number of approved policies and procedures in place to ensure the CCG manages its finance in accordance with national policy and guidelines. The CCG Constitution sets out the prime financial policies and the financial scheme of delegation, as approved by the Governing Body, sets out the delegated limits for key individuals within the CCG. This ensures these individuals have a clear framework in place within which they can make financial decisions. Compliance with the scheme is monitored by the Audit and Risk Committee and Governing Body to ensure delegated limits are being adhered to. In addition the limits set out within the scheme have been reviewed by both the Audit and Risk Committee and Governing Body during the year to ensure these remain appropriate and reflect individual levels of responsibility.

Following the delegation of the primary medical care commissioning function from NHS England, control mechanisms are in place to ensure the CCG delivers the requirements of the delegated function appropriately. There is a signed delegation agreement between the CCG and NHS England which sets out the roles and responsibilities of each organisation. The CCG's Constitution was updated with the requirements as part of the application process in early 2015 and a Primary Care Commissioning Committee established to oversee this function.

In relation to the Better Care Fund, the CCG also has a signed agreement in place with Sunderland City Council to set out the roles and responsibilities for each organisation and the delivery requirements for the programme. The CCG monitors delivery of this through the Transformation Board (which the CCG chairs) and the Health and Social Care Integration Board (a sub-committee of the Health and Wellbeing Board) and regular reporting to the Governing Body.

Annual Audit of Primary Care Commissioning

Following the delegation of the primary medical care commissioning function from NHS England, control mechanisms are in place to ensure the CCG delivers the requirements of the delegated function appropriately. There is a signed delegation agreement between the CCG and NHS England which sets out the roles and responsibilities of each organisation. The CCG's Constitution was updated with the requirements as part of the application process in early 2015 and a Primary Care Commissioning Committee established to oversee this function.

NHS England issued an internal audit framework for delegated CCGs covering primary medical care services commissioning and contracting. The scope of the CCG's audit has been aligned with this framework to ensure it meets NHS England's requirements as well as the CCG's requirements.

The CCG has carried out an annual audit of primary medical care commissioning and received a rating of substantial assurance from the CG's internal auditor, AuditOne. This assurance level aligns to the NHS England category of full assurance.

Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published January 2018) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out an annual audit of conflicts of interest and received a rating of substantial assurance from the CCG's internal auditors, AuditOne.
AuditOne noted some examples of good practice such as:

- Conflicts of interest were a standing agenda item on all of the CCG's key committee and contract meetings and clear process were place to manage and record actions taken for any conflicts identified in these meetings
- Mechanisms were in place to require bidders/potential contractors to declare any interests as part of the bidding process
- Processes were in place to ensure anonymised details of any breaches were published on the CCG's website and reported to NHS England.

In addition, some suggestions were made as to how the CCG could further improve the efficiency and effectiveness of the system to manage conflicts of interest including:

- Ensuring all members of staff complete the relevant mandatory training as appropriate
- Ensuring a standardised approach across all corporate committees in completing the chair's checklist
- Reviewing the register of interests to ensure it remains compliant with data protection legislation and does not include unnecessary personal details

The CCG has implemented the above suggestions to ensure our processes for identifying and managing conflicts of interest, both potential and actual, remain as robust as possible.

Data Quality

The Governing Body and member practices are aware of the importance of maintaining high standards of information governance and securing confidentiality of patients' information. As the Accountable Officer, I receive assurance from the Director of Contracting and Informatics as Senior Information Risk Owner (SIRO) that this function is discharged appropriately, with support from the Medical Director as Caldicott Guardian.

The CCG also receives support from NECS via a service line agreement for specialist advice and training for information governance issues. The Governing Body and member practices are satisfied with the quality of data used to inform decision-making and planning to deliver the commissioning agenda and to ensure the CCG meets its statutory requirements.

Information governance

The NHS information governance framework sets out the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS information governance framework is supported by an information governance toolkit and the annual submission process

provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG has undertaken a self-assessment against the specified criteria within the toolkit and assessed ourselves as being overall compliant by the 31 March 2019.

AuditOne conducted an audit of the CCG's Data Security and Protection Toolkit submission for 2018/19. Following a change in AuditOne's processes, it no longer gives an overall assurance rating as in previous years. At the time of the audit review (February 2019), it was noted that 12 out of a sample of 18 requirements had been evidenced and substantiated. However by the submission date of 31 March 2019, the CCG had met and evidenced all the requirements of toolkit.

The Governing Body is aware of the importance of maintaining high standards of information governance and securing confidentiality of patients' information. The CCG's SIRO and Caldicott Guardian ensures this function is discharged appropriately, with the Executive Committee maintaining oversight of this. Both are supported their roles by the Head of Corporate Affairs and via a service line agreement with NECS to provide specialist advice, support and training on information governance issues.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have an established information governance framework, including an approved strategy, both of which are reviewed on an annual basis, and have developed information governance processes and procedures in line with the information governance toolkit.

There are processes in place for incident reporting and investigation of serious incidents and a programme of mandatory training for information risk management and incident management. The CCG's information governance framework helps to ensure all staff are aware of their information governance roles and responsibilities and it is embedded into everyday practice of the CCG.

We have ensured all staff undertake annual information governance training and have a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. The handbook is reviewed on an annual basis to ensure it remains up to date and relevant.

I can confirm the CCG has had no serious information governance breaches in year.

Business Critical Models

I can confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.

Third Party Assurances

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

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all CCGs and is fundamental in producing NHS England group financial accounts through the use of an integrated financial ledger system
- The provision of financial accounting services from the North of England Commissioning Support Unit
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the ESR payroll systems support from IBM
- The provision of practice payment services via the Exeter system processed by NHS England

Assurance on the effectiveness of the controls is received in part from annual service audit reports and internal audit assurance reports from the relevant service providers as well as additional testing of controls by the CCG's internal auditors. The outcome from these audits is reported to the Audit and Risk committee and subsequently the Governing Body via the committee's minutes.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The CCG was deemed by NHS England to be over-funded by 16% and £71m on the baseline allocation funding level of £447m at the start of the year. As such NHS England allocated the CCG just 0.6% of growth funding for the year which was to cover pressures. In addition, a further 0.72% of growth funding was allocated to the CCG from the Governments Autumn budget announcements prior to the start of 2018/19. Despite the additional growth announcement the CCG has continued to be in a challenging position due to the low levels of growth in recent years which have eroded the 'headroom' that previously existed in CCG budgets.

For 2018/19 the business rules for CCGs were determined by NHS England. CCG were required to demonstrate achievement of the following:

- Delivery of a 'cumulative' surplus and carry forward of at least 1%
- Holding of a contingency reserve of at least 0.5% of the CCG's total allocation for 2018/19 (including delegated budgets)
- Spending no more than the running cost allowance
- Commissioner financial plans must triangulate with activity plans and agreed contracts, and with provider financial plans.
- Transparency obligation regarding information on source and use of the Marginal Rate Emergency Threshold and Readmission credits and so on from acute contract to relevant stakeholders.
- Continue to meet national policy commitments such as the mental health investment standard (requirement to increase investment into mental health services at a level which at least matches the CCGs overall programme allocation increase) and better care fund contributions. In 2018/19 the mental health investment standard is subject to an external audit review.

The financial plans and budgets approved by the Governing Body in March 2018 clearly demonstrated plans to achieve these goals. The level of cumulative surplus for the CCG was agreed as £16.26m at the start of the year after drawdown of £4.9m of cumulative surpluses in 2018/19. The Governing Body agreed to deliver a surplus in excess of the minimum in previous financial years to try and protect the organisation from required future financial constraints and support wider financial sustainability across the health and care system in Sunderland. Any surplus in excess of the minimum will be available to the CCG in future years to assist in the management of financial risk.

Throughout the year the CCG has constantly reported to the Governing Body and Audit and Risk Committee on the delivery against its plans which demonstrated robust financial planning, control and effective uses of resources. Quality, innovation, productivity and prevention (QIPP) programmes have been delivered during the year releasing funds for reinvestment into new services. Savings were made in areas such as prescribing, out of hospital reforms, reductions in non-recurrent budgets and re-procurement of services.

The savings above coupled with prudent financial management allowed the CCG to achieve an additional £4.6m of surplus in year (effectively not needing to utilise the full £4.9m it drew down in 2018/19 from the cumulative surplus to manage financial risk). In return for delivering an additional surplus in 2018/19 NHS England has agreed to allow the CCG to drawdown £9m of cumulative surpluses across 2018/19 and 2019/20 which, will allow the CCG to support management of financial risk and transformation of services.

A summary of the CCG's final cumulative surplus position at the end of the financial year is as follows:

Table 23: CCGs final cumulative surplus position

	£m	Percentage of Total Funding
Surplus brought forward from prior financial years	21.16	4.26%
Drawdown of historical surpluses in 2018/19 (utilisation of surplus)	(4.90)	-0.99%
Additional surplus delivered in year	4.61	0.93%
Final cumulative surplus carried forward to 2019/20	**20.87**	**4.20%**

This final surplus balance of £20.87m million is not a 'profit' or surplus generated during the financial year. The majority of it reflects a historical balance carried forward from previous financial years, with an additional £4.5 million of surplus generated during 2018/19 as a result of the CCG agreeing to return surplus drawdown for additional drawdown in future financial years.

CCGs can utilise cumulative surpluses above 1% and it has been agreed with NHS England that the CCGs cumulative surplus above 1% will be utilised as follows:

Table 24: Utilisation of cumulative surpluses

Utilisation	£m
2019/20 drawdown of cumulative surpluses*	4.5
2020/21 drawdown of cumulative surpluses*	4.5
Additional drawdown of cumulative surpluses above 1% requirement**	6.79
Total	**15.79**

*2019/20 to 2020/21 agreed by NHS England following delivery of additional surplus in 2018/19
**Please note that NHS England are yet to inform CCGs how and when they might be able to access additional future drawdown.

AuditOne has undertaken a review during the year of the CCG's financial planning and financial systems. The CCG achieved an outcome rating of substantial assurance for financial planning and a rating of substantial assurance for financial systems.

As part of the annual audit the external auditors are required to form an opinion whether the CCG has proper arrangements in place for securing economy, efficiency

and effectiveness in its use of resources. Mazars are only required to report where they conclude that arrangements are not in place. For 2018/19 we are pleased to confirm that Mazars have not reported any issues to the CCG's Governing Body.

All clinical commissioning groups in England are subject to a comprehensive annual assessment by NHS England. This examines key components and considers the strengths, challenges and areas for improvement before applying a headline rating of outstanding, good, requires improvement or inadequate.

NHS England publishes the CCG assessment outcomes on My NHS www.nhs.uk/mynhs. The latest available results show the CCG quality of leadership Indicator rated as 'green star' (outstanding). It is planned that NHS England will make the year-end quality of leadership Indicator available from July 2019 at https://www.nhs.uk/service-search/Performance/Search

Delegation of Functions

Primary Care Delegated Functions

NHS England delegated authority to the CCG to exercise primary medical care commissioning functions from April 2015 (often referred to as 'level 3 delegated co-commissioning').

For 2018/19 the following sources of assurances relating to the financial reporting with the CCG's accounts are as follows:

- ISA3402 report - NHS Digital – this report provides assurance in relation to this processes used to maintain demographic data on populations used to calculate GMS / PMS payments for the period 2018/19
- ISAE3402 report - NHS Shared Business Services (SBS) ISFE service auditor report - this report covers financial processes operated by NHS SBS, including controls on the National Health Applications and Infrastructure Services (NHAIS) interface between Exeter and the ISFE ledger
- ISAE3402 report – Capita service auditor report – this report covers the services of all primary care support in 2018/19
- CCG controls - control mechanisms that are in place to review and approve recharges posted into the CCG ledger by CCG senior officers
- Financial reporting - review of financial reporting against budget by the Primary Care Commissioning Committee on a monthly basis.

The CCG has received a copy of the ISAE 3402 Type 2 report for Capita for the period 1st April 2018 to 31st March 2019. This report identified exceptions with 3 of the 16 control objectives. KPMG highlighted that this was an improvement from the

7 control objective exceptions noted in the 2017/18 report. A review has been carried out by the CCG on the control exceptions and it has been confirmed that the CCG had in place internal controls to mitigate the control exceptions identified.

These in-house controls were audited by internal audit as part of the financial systems audit in 2018/19 gaining significant assurance.

North of England Commissioning Support Service (NECS)

The CCG contracts with NECS for the provision of a number of commissioning support functions such as human resources, information technology and some finance services. The CCG has established an internal control system to gain assurance from NECS on these functions.

The service auditor report (SAR) from NECS provided assurance on the internal controls and control procedures operated by this service organisation to its customers and their auditors. A finance reporting and payroll services SAR has been received from NECS covering the period 1 April 2018 to 31 March 2019. NHS England and NECS have appointed Deloitte LLP to undertake SARs on their behalf.

The SAR has been prepared in accordance with the guidance set out in the International Standards on Assurance Engagements 3000 (revised) and 3402 (“ISAE 3000 and 3402”) and the Institute of Chartered Accountants in England and Wales Technical Release AAF 01/06 (“AAF 01/06”). The SAR provides the CCG with assurance over the suitability of the design and operating effectiveness of controls to achieve the related control objectives of the services provided by NECS.

When reporting on the internal controls and control procedures, Deloitte issued a qualified opinion and noted four control exceptions. Following publication of the SAR, NECS has reviewed these control exceptions and formulated actions to ensure compliance in future periods.

All of these control exceptions were applicable to the CCG and related to access controls in payroll and human resources services. However following a review by the CCG of these control exceptions, it has been confirmed that the CCG had in place other financial and governance control systems that mitigated the control exceptions identified within NECS. These in-house controls were audited by internal audit as part of the financial systems and governance audits in 2018/19 gaining substantial assurance for both.

Counter Fraud arrangements

The CCG’s counter fraud activity plays a key part in deterring risks to the organisation’s financial viability and probity. An annual counter fraud plan is agreed

by the Audit and Risk committee, which focuses on the deterrence, prevention, detection and investigation of fraud.

Through the contract with AuditOne, the CCG has counter fraud arrangements in place that comply with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption including:

- An accredited counter fraud specialist who is contracted to undertake counter fraud work proportionate to identified risks.
- A report against each of the standards for commissioners received by the Audit and risk committee at least annually.
- Executive support and direction for a proportionate proactive work plan to address identified risks.
- The chief finance officer, as a member of the Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

- Overall opinion
- Basis for the opinion

Overall Opinion

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

Basis for the Opinion

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;
2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
3. Brought forward Internal Audit assurances;
4. An assessment of the organisation's response to Internal Audit recommendations, and
5. Consideration of significant factors outside the work of Internal Audit.

I would like to take this opportunity to thank the staff at NHS Sunderland CCG for the co-operation and assistance provided to my team during the year.

Carl Best
Director of Internal Audit
AuditOne

16 May 2019

Table 25: Summary of the Final Head of Internal Audit Opinion

Audit Area	Assurance Level
Core Audit Areas	
SCCG 2018-19/01: Governance Structures and Risk Management Arrangements	Substantial
SCCG 2018-19/03: Conflicts of Interest	Substantial
SCCG 2018-19/04: Financial and Strategic Planning	Substantial
SCCG 2018-19/05: Cost Improvement and QIPP	Substantial
SCCG 2018-19/06: Primary Medical Care Commissioning	Substantial
SCCG 2018-19/07: Contract and Performance Monitoring	Substantial
SCCG 2018-19/11: Key Financial Controls	Substantial
SCCG 1718/09: Information Governance	At the time of review (February 2019) 12 out of a sample of 18 requirements

Audit Area	Assurance Level
	could be evidenced and substantiated.
Other Assurance Audits	
SCCG 2018-19/02: Delivery of Outsourced Services	Substantial
SCCG 2018-19/08: Quality of Commissioned Services	Substantial
SCCG 2018-19/09: Continuing Healthcare [Draft Report]	Substantial
SCCG 2018-19/10: Mental Health Arrangements – S117 [Draft Report]	Good

Table 26: Appendix B: Definitions of Assurance Levels assigned to individual audit assignments

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

Review of 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 reports.

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles have been reviewed. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by:

- The Governing Body
- The Audit and Risk Committee
- The Quality and Safety Committee
- The Executive Committee
- System of internal control mechanisms
- Internal Audit

The Governing Body and Audit and Risk Committee have concluded through their annual review processes that the CCG has effective governance, risk management and internal control mechanisms in place to ensure the CCG to meet its statutory duties.

The internal control section earlier in this statement describes in detail the process that has been applied in maintaining and reviewing the effectiveness of the CCG's system of internal control.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit Opinion has been included in the previous section.

Conclusion

As chief officer, I have reviewed the governance and risk management processes within the CCG and am assured the CCG had an effective system of internal control over the previous year with no significant control issues.

David Gallagher
Chief Officer (Accountable Officer)

21 May 2019

Remuneration and Staff Report

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

Remuneration Report

Remuneration Committee

The remuneration committee was established to advise the governing body about pay, other benefits and terms of employment for the chief officer and other senior staff. The committee has delegated authority from the governing body to make recommendations on determinations about pay and remuneration. Further details of the membership and roles and responsibilities of this committee can be found in the corporate governance report of this annual report.

Policy on the remuneration of senior managers

The policy for remuneration of very senior managers within the CCG is in line with the national Very Senior Managers (VSM) pay framework, taking into account Sunderland is a medium sized CCG at a level 2.

All senior manager contracts, specifying terms and conditions of service are in line with the VSM pay framework or Agenda for Change as appropriate. The medical director terms and conditions of service are in line with the medical consultant contract. All other senior managers are remunerated in line with Agenda for Change requirements.

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy. Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health and Social Care.

Contracts of employment in relation to all senior managers employed by the CCG on VSM are permanent in nature and subject to six months' notice of termination by either party.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme

Regulations for those who are members of the scheme. No payments have been made during the year (will be subject to audit).

Remuneration of Very Senior Managers

Reporting bodies are required to disclose where the salary of senior managers is in excess of the prime minister's salary of £150,000 on a pro rata basis. There were six senior officers who received a salary in excess of the prime minister's salary in 2018/19 on a pro rata basis (2017/18: six in excess of the prime minister's salary of £150,000). The agreement to reasonable pay and conditions for very senior managers is considered by the CCG's Remuneration Committee, which is chaired by the Lay Member responsible for Audit and Risk.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

Table 27: NHS Sunderland Clinical Commissioning Group Senior Officers Salaries & Allowances (1 of 2)

Name	Title	2018/19						2017/18					
		Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	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 Remuneration (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	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 Remuneration (bands of £5,000) £000
Dr Ian Pattison	Clinical Chair	65 - 70	-	-	-	17.5 - 20.0	80 - 85	65 - 70	-	-	-	17.5 - 20.0	80 - 85
David Gallagher	Chief Officer	115 - 120	104	-	-	7.5 - 10.0	135 - 140	115 - 120	94	-	-	15.0 - 17.5	140 - 145
Dr Claire Bradford	Medical Director	90 - 95	38	-	-	47.5 - 50.0	140 - 145	55 - 60	38	-	-	17.5 - 20.0	80 - 85
Debbie Burnicle	Deputy Chief Officer **(until 30/04/2018)**	5 - 10	7	-	-	-	5 - 10	100 - 105	77	-	-	15.0 - 17.5	120 - 125
David Chandler	Chief Finance Officer and Deputy Chief Officer	100 - 105	94	-	-	10.0 - 12.5	120 - 125	95 - 100	94	-	-	30.0 - 32.5	135 - 140
Ann Fox	Director Of Nursing, Quality And Safety	100 - 105	93	-	-	0.0 - 2.5	110 - 115	100 - 105	83	-	-	15.0 - 17.5	120 - 125
Dr Fadi Khalil	Executive GP	45 - 50	-	-	-	10.0 - 12.5	60 - 65	45 - 50	-	-	-	12.5 - 15.0	60 - 65
Dr Jackie Gillespie	Executive GP **(until 31/03/2018)**							30 - 35	-	-	-	7.5 - 10.0	40 - 45
Dr Saira Malik	Executive GP **(from 01/04/2018)**	25 - 30	-	-	-	140.0 - 142.5	165 - 170						
Dr Tracey Lucas	Executive GP	30 - 35	-	-	-	2.5 - 5.0	35 - 40	30 - 35	-	-	-	10.0 - 12.5	40 - 45
Dr Raj Bethapudi	Executive GP	30 - 35	-	-	-	0.0 - 2.5	30 - 35	30 - 35	-	-	-	7.5 - 10.0	40 - 45
Dr Karthik Gelia	Executive GP	30 - 35	-	-	-	7.5 - 10.0	40 - 45	30 - 35	-	-	-	2.5 - 5.0	35 - 40
Eric Harrison **Note 1**	Practice Manager Representative	20 - 25	-	-	-	-	20 - 25	20 - 25	-	-	-	-	20 - 25

Table 28: NHS Sunderland Clinical Commissioning Group Senior Officers Salaries & Allowances (2 of 2) (subject to audit)

Name	Title	2018/19						2017/18					
		Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	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 Remuneration (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £00	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 Remuneration (bands of £5,000) £000
Florence Gunn **Note 1**	Strategic Practice Nurse	15 - 20	-	-	-	-	15 - 20	15 - 20	-	-	-	-	15 - 20
Aileen Sullivan **Note 1**	Lay Member, Public Patient Involvement (PPI)	10 - 15	2	-	-	-	10 - 15	15 - 20	4	-	-	-	15 - 20
Pat Taylor **Note 1**	Senior Independent Audit Advisor **(from 01/04/2017 to 31/05/2017)**							0 - 5	3	-	-	-	0 - 5
Chris Macklin **Note 1**	Lay Member, Primary Care Committee **(until 31/05/2017)**							0 - 5	3	-	-	-	0 - 5
Chris Macklin **Note 1**	Chair, Audit and Risk Committee **(from 01/06/2017)**	10 - 15	13	-	-	-	15 - 20	10 - 15	18	-	-	-	10 - 15
Pat Harle **Note 1**	Lay Member, Primary Care Committee	10 - 15	0	-	-	-	10 - 15	0 - 5	-	-	-	-	0 - 5
Neil Weddle **Note 1**	Independent Audit Committee Member	0 - 5	0	-	-	-	0 - 5	0 - 5	-	-	-	-	0 - 5
Prof. Mike Bramble **Note 1**	Secondary Care Clinician **(until 31/05/2017)**							0 - 5	3	-	-	-	0 - 5
Cruickshank **Note 1**	Secondary Care Clinician **(from 01/06/2017)**	15 - 20	17	-	-	-	15 - 20	10 - 15	-	-	-	-	10 - 15
Scott Watson **Note 1**	Director of Contracting and Informatics	95 - 100	73	-	-	-	100 - 105	90 - 95	143	-	-	-	105 - 110
Ian Holliday **Note 1**	Project Director of Integrated Commissioning	50 - 55	-	-	-	-	50 - 55	45 - 50	-	-	-	-	45 - 50
Clare Nesbit	Associate Director of OD & Workforce	75 - 80	5	-	-	30.0 - 32.5	110 - 115	70 - 75	2	-	-	27.5 - 30.0	100 - 105
Tarryn Lake	Deputy Chief Finance Officer	75 - 80	48	-	-	22.5 - 25.0	105 - 110	70 - 75	44	-	-	22.5 - 25.0	100 - 105
Matt Thubron	Head of Contracting and Performance	70 - 75	62	-	-	22.5 - 25.0	100 - 105	65 - 70	59	-	-	27.5 - 30.0	100 - 105
Helen Steadman	Strategy & Planning Manager	60 - 65	-	-	-	12.5 - 15.0	75 - 80	60 - 65	-	-	-	20.0 - 22.5	80 - 85

Notes

Note 1: D Cruickshank, E Harrison, F Gunn, A Sullivan, P Taylor, C Macklin, M Bramble, N Weddle, P Harle, I Holliday and S Watson are not in the NHS Pension Scheme.

Expense payments: Expense payments include lease car allowances and mileage claims.

Please note that the Pension Related Benefits include all benefits accruing to senior managers from membership of the NHS Pensions Scheme, which is a defined benefit scheme where annual pension entitlements for retired individuals are based on their final salary. The disclosed amounts represent the increase in pension entitlement upon retiring for individuals and do not represent a cash payment made to individuals in the financial year.

Please note that bandings utilised in the table for each area of remuneration differ in line with national guidance

Pension benefits as at 31 March 2019 (subject to audit)

Table 29: Pension benefits as at 31 March 2019 (subject to audit)

Name	Title	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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Dave Gallagher	Chief Officer	0.0 - 2.5	-	50 - 55	145 - 150	972	101	1120	17
Ian Pattison	Clinical Chair	0.0 - 2.5	0.0 - 2.5	15 - 20	30 - 35	216	39	270	10
Claire Bradford	Medical Director	2.5 - 5.0	7.5 - 10.0	45 - 50	135 - 140	932	140	1,112	13
Ann Fox	Director of Nursing, Quality and Safety	0.0 - 2.5	0.0 - 2.5	40 - 45	125 - 130	780	91	908	15
David Chandler	Chief Finance Officer and Deputy Chief Officer	0.0 - 2.5	-	30 - 35	75 - 80	488	66	582	14
Debbie Burnicle	Deputy Chief Officer **(until 30/04/2018)**	-	-	30 - 35	100 - 105	810	-	-	1
Dr Fadi Khalil	Executive GP	0.0 - 2.5	-	10 - 15	25 - 30	140	27	178	7
Dr Tracey Lucas	Executive GP	0.0 - 2.5	-	15 - 20	45 - 50	266	39	318	5
Dr Raj Bethapudi	Executive GP	0.0 - 2.5	-	10 - 15	25 - 30	120	18	148	5
Dr Karthik Gelia	Executive GP	0.0 - 2.5	0.0 - 2.5	10 - 15	30 - 35	179	31	220	5
Dr Saira Malik	Executive GP **(from 01/04/2018)**	5.0 - 7.5	15.0 - 17.5	15 - 20	40 - 45	108	110	225	5
Eric Harrison **Note 1**	Executive Practice Manager Representative	-	-	-	-	-	-	-	-
Florence Gunn **Note 2**	Strategic Practice Nurse	-	-	-	-	-	-	-	2
Aileen Sullivan **Note 1**	Lay Member, Public Patient Involvement (PPI)	-	-	-	-	-	-	-	-
Chris Macklin **Note 1**	Lay Member, Vice Chair And Chair Of The Audit Committee	-	-	-	-	-	-	-	-
Pat Harle **Note 1**	Lay Member Primary Care Committee	-	-	-	-	-	0	-	-
Neil Weddle **Note 1**	Independent Audit Support	-	-	-	-	-	-	-	-
Derek Cruickshank **Note 1**	Secondary Care Clinican	-	-	-	-	-	-	-	-
Scott Watson **Note 1**	Director of Contracting & Informatics	-	-	-	-	-	-	-	-
Ian Holliday **Note 1**	Project Director Integrated Commissioning	-	-	-	-	-	-	-	-
Tarryn Lake	Deputy Chief Finance Officer	0.0 - 2.5	0.0 - 2.5	10 - 15	25 - 30	123	32	167	10
Clare Nesbit	Associate Director of OD & Workforce	0.0 - 2.5	0.0 - 2.5	20 - 25	45 - 50	324	59	403	11
Matt Thubron	Head of Contracting, Performance & Business Intelligence	0.0 - 2.5	0.0 - 2.5	10 - 15	25 - 30	133	34	179	9
Helen Steadman	Head of Strategy, Planning and Reform	0.0 - 2.5	0.0 - 2.5	10 - 15	5 - 10	139	26	178	9

Notes

Note 1: D Cruikshank, E Harrison, F Gunn, A Sullivan, P Harle, C Macklin, N Weddle, I Holliday and S Watson are not in the NHS Pension Scheme.

Note 2: Employer's contribution relates to the contribution to the NEST pension scheme.

Note 3: Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director / Member of NHS Sunderland CCG in the financial year 2018/19 was £125,000 - £130,000 (2017/18: £125,000 - £130,000). This was 2.96 times (2017/18: 2.93 times) the median remuneration of the workforce, which was £43,041 (2017/18: £43,469).

In 2018/19, 0 (2017/18: 0) employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £2,761 to £118,706 (2017/18 £2,720 to £115,071).

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.

Table 30: Total remuneration

	2018 / 19	2017 / 18
Band of Highest Paid Director / Member Total Remuneration (£000)	125 - 130	125 - 130
Median total Remuneration (£)	43,041	43,469
Ratio	2.96	2.93

There has been an increase in the ratio of the median remuneration of the workforce in comparison to the highest paid director/Member.

2018/19 Highest Paid Director/Member:

Chief Officer	125 - 130

2017/18 Highest Paid Director/Member:

Chief Officer	125 - 130

Staff Report

Number of senior managers

The CCG had a total of 24 senior managers during 2018/19 (2017/18: 25).

Staff numbers and costs (subject to audit)

Table 31: Staff numbers and costs 2018/19 (£'000)

Staff Costs 2018/19	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Salaries and wages	2,398	44	**2,442**	1,408	-	**1,408**	**3,806**	**44**	**3,850**
Social security costs	314	-	**314**	116	-	**116**	**430**	**-**	**430**
Employer contributions to the NHS Pension Scheme	376	-	**376**	134	-	**134**	**510**	**-**	**510**
Apprenticeship Levy	5	-	**5**	-	-	**-**	**5**	**-**	**5**
Total Employee Benefits Expenditure	**3,093**	**44**	**3,137**	**1,658**	**-**	**1,658**	**4,751**	**44**	**4,795**

Table 32: staff numbers and costs 2017/18 (£'000)

Staff Costs 2017/18	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Salaries and wages	2,565	66	**2,631**	1,134	-	**1,134**	**3,699**	**66**	**3,765**
Social security costs	323	-	**323**	89	-	**89**	**412**	**-**	**412**
Employer contributions to the NHS Pension Scheme	344	-	**344**	106	-	**106**	**450**	**-**	**450**
Apprenticeship Levy	5	-	**5**	-	-	**-**	**5**	**-**	**5**
Total Employee Benefits Expenditure	**3,237**	**66**	**3,303**	**1,329**	**-**	**1,329**	**4,566**	**66**	**4,632**

Table 33: Average number of people employed (Number)

	2018/19			2017/18		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Total Staff	80	2	**82**	78	2	**80**

Staff composition

Table 34: Staff composition 2018 / 19

Category of staff 2018 / 19	Total number of staff / members	Number of male staff / members	Number of female staff / members
Governing body* members	19	10	9
Senior officers** (VSM and above)	4	2	2
All other employees	126	27	99
Total employees	149	39	110

*This figure includes substantive voting members and regular attendees as detailed in the accountability report section of this annual report. The Governing Body figures are provided as standalone figures, they do not contribute to the total figure for the whole CCG as some members may also be senior managers and some may not be on the payroll and not included in the total.

**The CCG's VSM are employees and are all members of the Governing Body therefore are included in all the figures shown above

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

Sickness absence data

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

Table 35: Average of 12 months (2018 calendar year)

	Average FTE 2018	FTE Days Available	FTE days Lost to sickness absence	Average Sick Days per FTE	Estimated Cost of Sickness Absence
2.29%	83.25	18,731	429	5.2	£98,764

Table 36: Average of 12 months (2017 calendar year)

	Average FTE 2017	FTE Days Available	FTE days Lost to sickness absence	Average Sick Days per FTE	Estimated Cost of Sickness Absence
4.08%	79.97	17,993	735	9.2	£161,331

Staff policies

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

- Providing employees systematically with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the CCG's performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the CCG
- Membership of the North East Partnership Forum, where staff representatives and CCG managers from across the region meet together

Trade union facility time

As set out in the Trade Union (Facility Time Publication Requirements) Regulations 2017, the CCG is required to publish the number of employees who were trade union officials during this period and any information about paid facility time and trade union activities.

The CCG did not have any employees who were trade union representatives during the year.

Expenditure on consultancy

The CCG has spent a total of £10,061.60 on consultancy during 2018/19 in relation to the development of the All Together Better Sunderland Alliance (2017/18: £68,008.49)

Off-payroll engagements

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

Table 37: Off-payroll engagements as at 31 March 2019

	Number
Number of existing engagements as of 31 March 2019	6
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	4
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

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

All new off-payroll engagements or those that reached six months duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months are detailed below:

Table 38: Off-payroll engagements April 2018 - March 2019

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	6
Of which:	
Number assessed as caught by IR35	4
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	4
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2018 and 31 March 2019.

Table 39: Off-payroll engagements of Board members and / or senior officials (April 2018 – March 2019)

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. 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 should include both on payroll and off-payroll engagements. (2)	24

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months are detailed below:

Table 40: Off-payroll engagements (31 March 2018) that lasted longer than six months

	Number
Number of existing engagements as of 31 March 2018	5
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two 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

All existing off-payroll engagements, have at some point, been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day and that last for longer than six months are detailed below:

Table 41: Off-payroll engagements between April 2017 - March 2018

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	5
Of which:	
No. assessed as caught by IR35	4
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	5
No. of engagements that saw a change to IR35 status following the consistency review	4

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

Table 42: Off-payroll engagements of Board members and / or senior officials (April 2017 – March 2018)

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. 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.	25

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

Table 43: Exit Packages

Exit package cost band (inc. any special payment element) 2018/19	Compulsory Redundancies Number	Compulsory Redundancies £'	Other Agreed Departures Number	Other Agreed Departures £'	Total Number	Total £'	Departures where special payments have been made Number	Departures where special payments have been made £'
£10,001 to £25,000	0	0	0	0	**0**	**0**	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Exit package cost band (inc. any special payment element) 2017/18	Compulsory Redundancies Number	Compulsory Redundancies £'	Other Agreed Departures Number	Other Agreed Departures £'	Total Number	Total £'	Departures where special payments have been made Number	Departures where special payments have been made £'
£10,001 to £25,000	0	0	1	17,245	**1**	**17,245**	0	0
Total	**0**	**0**	**1**	**17,245**	**1**	**17,245**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of the national Agenda for Change terms and conditions of service. Exit costs in this note are accounted for in full in the year of departure.

There were no other departures in 2018/19.

Table 44: Analysis of other departures

Analysis of Other Departures in 2017/18	Agreement Number	Total Value of agreements £000's
Contractual payments in lieu of notice	1	17

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 3 which will be the number of individuals.

Independent auditor's report to the Governing Body of NHS Sunderland Clinical Commissioning Group

Opinion on the financial statements

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

In our opinion, the financial statements:

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

Opinion on regularity

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

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the CCG in accordance with the ethical requirements that are

relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

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

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

We have nothing to report in this regard.

Responsibilities of the Accountable Officer for the financial statements
As explained more fully in the Statement of Accountable Officer's Responsibilities the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to

fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

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

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

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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

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

We have nothing to report in this respect.

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

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

arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

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

Certificate

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

Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

May 2019

Parliamentary Accountability and Audit Report

NHS Sunderland 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.

An audit certificate and report is also included in this annual report at page 139 onwards.

David Gallagher
Chief Officer (Accountable Officer)

May 2019

ANNUAL ACCOUNTS

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	**2018-19 £'000**	2017-18 £'000
Income from sale of goods and services	2	(485)	(3)
Other operating income	2	(1,739)	(907)
Total operating income		**(2,224)**	(910)
Staff costs	3	4,795	4,632
Purchase of goods and services	4	503,873	503,986
Provision expense	4	344	(89)
Other operating expenditure	4	196	216
Total operating expenditure		**509,208**	508,745
Net Operating Expenditure for the year		**506,984**	507,835

Statement of Financial Position as at 31 March 2019

	Note	31/03/2019 £'000	31/03/2018 £'000
Current assets:			
Trade and other receivables	7	2,579	2,884
Cash and cash equivalents	8	241	91
Total current assets		**2,820**	2,975
Total assets		**2,820**	2,975
Current liabilities			
Trade and other payables	9	(34,983)	(34,240)
Provisions	10	(493)	(149)
Total current liabilities		**(35,476)**	(34,389)
Current Assets plus/less Net Current Assets/Liabilities		**(32,656)**	(31,414)
Assets less Liabilities		**(32,656)**	(31,414)
Financed by Taxpayers' Equity			
General fund		(32,656)	(31,414)
Total taxpayers' equity:		**(32,656)**	(31,414)

The notes on pages 5 to 23 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 21 May 2019 and signed on its behalf by:

David Gallagher
Chief Officer (Accountable Officer)
21 May 2019

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 2018-19		
Balance at 01 April 2018	**(31,414)**	**(31,414)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating expenditure for the financial year	(506,984)	(506,984)
Net recognised CCG expenditure for the financial year	**(506,984)**	**(506,984)**
Net Parliamentary funding	505,742	505,742
Balance at 31 March 2019	**(32,656)**	**(32,656)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18		
Balance at 01 April 2017	(29,200)	(29,200)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18		
Net operating costs for the financial year	(507,835)	(507,835)
Net recognised CCG expenditure for the financial year	(507,835)	(507,835)
Net funding	505,621	505,621
Balance at 31 March 2018	(31,414)	(31,414)

Statement of Cash Flows for the year ended
31 March 2019

	Note	**31/03/2019** **£'000**	31/03/2018 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(506,984)	(507,835)
(Increase)/decrease in trade & other receivables	7	305	(1,180)
Increase/(decrease) in trade & other payables	9	743	3,665
Provisions utilised	10	0	(340)
Increase/(decrease) in provisions	10	344	(89)
Net cash outflow from operating activities		**(505,592)**	(505,779)
Net cash outflow before financing		**(505,592)**	(505,779)
Cash flows from financing activities			
Net funding received		505,742	505,621
Net cash inflow from financing activities		**505,742**	505,621
Net increase in cash & cash equivalents	8	**150**	(158)
Cash & cash equivalents at the beginning of the financial year		**91**	249
Cash & cash equivalents at the end of the financial year		**241**	91

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 2018-19 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 items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement.

The clinical commissioning group has entered into a pooled budget arrangement with Sunderland City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the Better Care Fund and note 14 provides details of the income and expenditure.

The pool is hosted by Sunderland City Council. 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.

1.4 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.

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application where applicable.
In the adoption 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 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 FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The clinical commissioning group receives revenue in respect of jointly commissioned services and transformation funding. Details are included in notes two and three.
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.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

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 Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Grants 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 **Leases**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.8.1 **The Clinical Commissioning Group as Lessee**
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.9 **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.

1.10 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

Notes to the financial statements

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.11 **Clinical Negligence Costs**

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

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

1.13 **Financial Assets**
Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

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

1.14.2 **Impairment**
For all financial assets measured at amortised cost the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Notes to the financial statements

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 has expired.

1.15.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

The clinical commissioning group does not have any financial liabilities at fair value through profit and loss.

1.15.2 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. 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 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.17 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions 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. These are reviewed regularly.

1.17.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
- None.

1.17.2 **Sources of estimation uncertainty**

The following is considered to be the main assumption and source of estimation uncertainty that could potentially have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
The assumption applied in the estimation of prescribing liabilities not yet billed as at the Statement of Financial Position date. Nationally derived phasing profiles from the NHS Business Services Authority provided for forecasting the likely prescribing outturn has been utilised in deriving the estimated liability of costs not yet billed for the clinical commissioning group. This was estimated at £8,241,813 as at the Statement of Financial Position date (for the period 31st March 2018 the full value included in the financial statements totalled £8,636,778).

1.18 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Other Operating Revenue

	2018-19 Admin	**2018-19 Programme**	**2018-19 Total**	2017-18 Admin	2017-18 Programme	2017-18 Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Income from sale of goods and services (contracts)						
Non-patient care services to other bodies	0	10	**10**	0	3	3
Other contract income	0	475	**475**	0	0	0
Total Income from sale of goods and services	0	**485**	**485**	0	3	3
Other operating income						
Non cash apprenticeship training grants revenue	2	0	**2**	0	0	0
Other non contract revenue	0	1,737	**1,737**	0	907	907
Total Other operating income	**2**	**1,737**	**1,739**	0	907	907
Total Operating Income	**2**	**2,222**	**2,224**	0	910	910

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

3. Employee benefits and staff numbers

3.1 Employee benefits

	Total		**2018-19**	**Admin**			**Programme**		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Salaries and wages	3,806	44	3,850	2,398	44	2,442	1,408	0	1,408
Social security costs	430	0	430	314	0	314	116	0	116
Employer Contributions to NHS Pension scheme	510	0	510	376	0	376	134	0	134
Apprenticeship Levy	5	0	5	5	0	5	0	0	-
Total gross employee benefits expenditure	**4,751**	**44**	**4,795**	**3,093**	**44**	**3,137**	**1,658**	**0**	**1,658**

	Total		2017-18	Admin			Programme		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	3,699	66	3,765	2,565	66	2,631	1,134	0	1,134
Social security costs	412	0	412	323	0	323	89	0	89
Employer Contributions to NHS Pension scheme	450	0	450	344	0	344	106	0	106
Apprenticeship Levy	5	0	5	5	0	5	0	0	-
Total gross employee benefits expenditure	4,566	66	4,632	3,237	66	3,303	1,329	0	1,329

3.2. Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**80**	**2**	82	78	2	80

None of the above people were engaged on capital projects (2017-18: None).

3.3. Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		**2018-19 Other agreed departures**		**2018-19 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
£10,001 to £25,000	0	0	0	0	0	0
Total	0	0	0	0	0	0

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
£10,001 to £25,000	0	0	1	17,245	1	17,245
Total	0	0	1	17,245	1	17,245

3.4. Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	**£**	Number	£
Contractual payments in lieu of notice	0	0	1	17,245
Total	0	0	**1**	**17,245**

Redundancy costs have been paid in accordance with the provisions of the national Agenda for Change terms and conditions of service.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

3.5 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 in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

3.5.1 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.5.2 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

4. Operating expenses

	2018-19 Admin £'000	2018-19 Programme £'000	2018-19 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2017-18 Total £'000
Purchase of goods and services						
Purchase of healthcare from NHS and DHSC bodies: Services from other CCGs and NHS England	1,099	3,878	**4,977**	1,061	1,859	2,920
Purchase of healthcare from NHS and DHSC bodies: Services from foundation trusts	0	320,740	**320,740**	0	323,002	323,002
Purchase of healthcare from NHS and DHSC bodies: Services from other NHS trusts	0	637	**637**	0	441	441
Services from Other WGA bodies	0	521	**521**	0	587	587
Purchase of healthcare from non-NHS/DHSC bodies	0	75,271	**75,271**	0	74,882	74,882
Purchase of social care	0	8,661	**8,661**	0	8,452	8,452
Prescribing costs	0	47,777	**47,777**	0	51,831	51,831
GPMS/APMS and PCTMS	0	38,703	**38,703**	0	38,560	38,560
Supplies and services – general	123	3,053	**3,176**	209	575	784
Consultancy services	10	0	**10**	2	66	68
Establishment	199	58	**257**	228	80	308
Transport	19	22	**41**	16	20	36
Premises	286	2,232	**2,518**	189	1,322	1,511
External audit fees	56	0	**56**	65	0	65
Other non statutory audit expenditure						
· Other services	9	-	**9**	-	-	-
Other professional fees	57	86	**143**	48	1	49
Legal fees	34	57	**91**	106	103	209
Education, training and conferences	150	135	**285**	230	51	281
Total purchase of goods and services	**2,042**	**501,831**	**503,873**	2,154	501,832	503,986
Provision expense						
Provisions	0	344	**344**	0	(89)	(89)
Total provision expense	0	**344**	**344**	0	(89)	(89)
Other operating expenditure						
Chair and Non Executive Members	158	0	**158**	150	0	150
Grants to other bodies	0	38	**38**	0	66	66
Total other operating expenditure	**158**	**38**	**196**	150	66	216
Total operating expenditure	**2,200**	**502,213**	**504,413**	2,304	501,809	504,113

Included within Premises is £2,173k (2017-18: £1,269k) for rentals under operating leases paid to NHS Property Services and the University of Sunderland which is reported in note 6.

4.2. Analysis of non NHS healthcare operating expenditure

	2018-19 Total £000s	2018-19 Independent/ Private £000s	2018-19 Voluntary / Not-for-Profit £000s	2018-19 Local Authorities £000s	2018-19 Devolved Administrations £000s
Total primary healthcare purchased	**463**	463	0	0	0
Purchase of secondary healthcare					
Social care (learning difficulties)	0	0	0	0	0
Mental health	11,021	1,325	434	9,262	0
Maternity	81	0	81	0	0
General and acute	6,102	5,126	48	801	127
Accident and emergency	2,847	2,847	0	0	0
Community health services	23,908	13,626	1,129	9,153	0
Continuing care incl different types of NHS funded care provided on continuous basis	30,849	1,109	0	29,740	0
Total secondary healthcare purchased	**74,808**	**24,033**	**1,692**	**48,956**	**127**
Social Care	**8,661**	0	0	8,661	0
Total non NHS healthcare operation expenditure	**83,932**	**24,496**	**1,692**	**57,617**	**127**

	2017-18 Total £000s	2017-18 Independent/ Private	2017-18 Voluntary £000s	2017-18 Local Authorities £000s	2017-18 Devolved Administrations £000s
Total primary healthcare purchased	2,359	2,359	0	0	0
Purchase of secondary healthcare					
Mental health	9,990	1,622	342	8,026	0
Maternity	65	0	65	0	0
General and acute	4,974	4,832	1	0	141
Accident and emergency	2,855	2,855	0	0	0
Community health services	25,748	13,507	2,636	9,605	0
Continuing care incl different types of NHS funded care provided on continuous basis	28,891	1,188	0	27,703	0
Total secondary healthcare purchased	72,523	24,004	3,044	45,334	141
Social Care	8,452	0	0	8,452	0
Total non NHS healthcare operation expenditure	83,334	26,363	3,044	53,786	141

5. Better Payment Practice Code

5.1. Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	6,369	130,230	6,499	119,214
Total Non-NHS Trade Invoices paid within target	6,320	129,714	6,425	118,870
Percentage of Non-NHS Trade invoices paid within target	**99.23%**	**99.60%**	98.86%	99.71%
NHS Payables				
Total NHS Trade invoices paid in the year	2,264	331,005	2,183	330,302
Total NHS Trade invoices paid within target	2,262	330,987	2,182	330,253
Percentage of NHS Trade Invoices paid within target	**99.91%**	**99.99%**	99.95%	99.99%

The Better Payment Practice Code requires the clinical commissioning group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6. Operating leases

6.1. As lessee

The clinical commissioning group has entered into a small number of formal operating lease arrangements, relating to leased cars and photocopiers, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

The clinical commissioning group also has arrangements in place with NHS Property Services in respect of the utilisation of various clinical and non-clinical properties. These largely relate to payments made in respect of void and sessional space in clinical properties, as well as for the clinical commissioning group's accommodation costs. Funding in respect of void and sessional spaces was made available from NHS England in the clinical commissioning group's allocation.

Although formal signed leases are not in place for void spaces in these properties, the transactions involved do convey the right of the clinical commissioning group to use property assets. The clinical commissioning group has considered the substance of these arrangements under IFRIC 4 'Determining whether an arrangement contains a lease' and determined that the arrangements are (or contain) leases.

Accordingly the payments made in 2018-19 for void and sessional spaces are disclosed as minimum lease payments in the buildings category in note 6.1.1 below. In the absence of formal contracts however, it is not possible to confirm minimum lease payments for future years hence no figures are included in note 6.1.2 below for these arrangements. It is expected that the payments recognised in 2018-19 would continue to be minimum lease payments in 2019-20.

6.1.1. Payments recognised as an expense

	2018-19 Buildings £'000	**2018-19 Other £'000**	**2018-19 Total £'000**	2017-18 Buildings £'000	2017-18 Other £'000	2017-18 Total £'000
Payments recognised as an expense						
Minimum lease payments	2,173	21	**2,194**	1,269	17	1,286
Total	**2,173**	**21**	**2,194**	1,269	17	1,286

6.1.2. Future minimum lease payments

	2018-19 Buildings £'000	**2018-19 Other £'000**	**2018-19 Total £'000**	2017-18 Land £'000	2017-18 Buildings £'000	2017-18 Total £'000
Payable:						
No later than one year	105	12	**117**	88	14	102
Between one and five years	395	10	**405**	441	9	450
After five years	0	0	**0**	42	0	42
Total	**500**	**22**	**522**	571	23	594

7.1. Trade and other receivables

	Current 31/03/2019 £'000	Current 31/03/2018 £'000
NHS receivables: Revenue	1,000	1,676
NHS prepayments	1,136	931
Non-NHS and Other WGA receivables: Revenue	244	201
Non-NHS and Other WGA prepayments	168	66
VAT	21	8
Other receivables and accruals	10	2
Total Trade & other receivables	**2,579**	2,884
Total current	**2,579**	2,884

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring for NHS England is considered necessary.

7.2. Receivables past their due date but not impaired

	31/03/2019 DHSC Group Bodies £'000	**31/03/2019 Non DHSC Group Bodies £'000**	**31/03/2019 Total £'000**	31/03/2018 DHSC Group Bodies £'000	31/03/2018 Non DHSC Group Bodies £'000	31/03/2018 Total £'000
By up to three months	70	94	164	18	113	131
By three to six months	63	0	63	0	0	-
By more than six months	18	0	18	0	0	-
Total	**151**	**94**	**244**	**18**	**113**	**131**

8. Cash and cash equivalents

	31/03/2019 £'000	31/03/2018 £'000
Balance at 01 April	91	249
Net change in year	150	(158)
Balance at 31 March	**241**	**91**
Made up of:		
Cash with the Government Banking Service	241	91
Cash and cash equivalents as in statement of financial position	**241**	**91**
Balance at 31 March	**241**	**91**

The clinical commissioning group held no cash and cash equivalents at 31 March 2019 on behalf of patients (31 March 2018 : £0)

9. Trade and other payables

	Current 31/03/2019 £'000	Current 31/03/2018 £'000
NHS payables: Revenue	2,496	2,618
NHS accruals	3,480	2,122
Non-NHS and Other WGA payables: Revenue	4,410	5,768
Non-NHS and Other WGA accruals	22,221	21,053
Social security costs	68	59
Tax	69	55
Other payables and accruals	2,239	2,565
Total Trade & Other Payables	**34,983**	34,240
Total current	**34,983**	34,240

At 31 March 2019, the clinical commissioning group had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2018: £0)

10. Provisions

	Current 31/03/2019 £'000	Current 31/03/2018 £'000
Other	493	149
	493	149
Total current	**493**	149

	Other £'000	**Total £'000**
Balance at 01 April 2018	**149**	**149**
Arising during the year	344	344
Balance at 31 March 2019	**493**	**493**
Expected timing of cash flows:		
Within one year	493	493
Balance at 31 March 2019	**493**	**493**

	Other £'000	Total £'000
Balance at 01 April 2017	578	578
Arising during the year	149	149
Utilised during the year	(340)	(340)
Reversed unused	(238)	(238)
Balance at 31 March 2018	149	149
Expected timing of cash flows:		
Within one year	149	149
Balance at 31 March 2018	149	149

The clinical commissioning group has included a provision relating to a potential sustainability issue with a provider organisation.

11. Contingencies

The clinical commissioning group has no contingent liabilities as at 31 March 2019 (31 March 2018: None).

The clinical commissioning group had no contingent assets as at 31 March 2019 (31 March 2018: None).

12. Financial instruments

12.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Sunderland clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

12.1.1. Credit risk

Because the majority of the NHS clinical commissioning group's revenue comes from parliamentary funding, the NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.2. Liquidity risk

The NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

12.1.3. Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

12. Financial instruments cont'd

12.2 Financial assets

	Financial Assets measured at amortised cost* 31/03/2019 £'000	**Total 31/03/2019 £'000**
Trade and other receivables with NHSE bodies	544	544
Trade and other receivables with other DHSC group bodies	456	456
Trade and other receivables with external bodies	244	244
Other financial assets	9	9
Cash and cash equivalents	241	241
Total at 31 March 2019	**1,494**	**1,494**

	Loans and Receivables* 31/03/2018 £'000	Total 31/03/2018 £'000
Receivables:		
· NHS	1,676	1,676
· Non-NHS	201	201
Cash at bank and in hand	91	91
Other financial assets	1	1
Total at 31 March 2018	1,969	1,969

*Accounting standards for financial instruments have changed between financial years. In 2017/18 the accounting standard was International Accounting Standard (IAS) 39, which changed to International Financial Accounting Standard (IFRS) 9 in 2018/19. This change in accounting standard has not changed the CCG treatment of financial instruments.

12.3 Financial liabilities

	Financial Liabilities measured at amortised cost* 31/03/2019 £'000	**Total 31/03/2019 £'000**
Trade and other payables with NHSE bodies	1,006	**1,006**
Trade and other payables with other DHSC group bodies	15,335	**15,335**
Trade and other payables with external bodies	16,266	**16,266**
Other financial liabilities	2,239	**2,239**
Total at 31 March 2019	**34,846**	**34,846**

	Other* 31/03/2018 £'000	Total 31/03/2018 £'000
Payables:		
· NHS	4,739	4,739
· Non-NHS	29,386	29,386
Total at 31 March 2018	34,125	34,125

*Accounting standards for financial instruments have changed between financial years. In 2017/18 the accounting standard was International Accounting Standard (IAS) 39, which changed to International Financial Accounting Standard (IFRS) 9 in 2018/19. This change in accounting standard has not changed the CCG treatment of financial instruments.

13. Operating segments

The clinical commissioning group has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the clinical commissioning group's governing body, considered to be the 'chief operating decision maker' of the clinical commissioning group, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the clinical commissioning group relates to its role as a commissioner of healthcare for its relevant population. As a result, the clinical commissioning group considers that it has only one operating segment, being the commissioning of healthcare services.

14 Joint arrangements - interests in joint operations

The clinical commissioning group has entered into a pooled budget with Sunderland City Council. The pool is hosted by Sunderland City Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund and a Mental Capacity Act safeguarding practitioner.

The clinical commissioning group's shares of the income and expenditure handled by the pooled budget in the financial year were:

			Amounts recognised in Entities books 2018-19		Amounts recognised in Entities books 2017-18	
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Income**	**Expenditure**	Income	Expenditure
			£'000	**£'000**	£'000	£'000
Better Care Fund	NHS Sunderland Clinical Commissioning Group and Sunderland City Council	Commissioning of out of hospital care	0	(56,018)	0	(59,198)
Mental Capacity Act Safeguarding Practitioner	NHS Sunderland Clinical Commissioning Group and Sunderland City Council	Contribution to Deprivation of Liberty Funding	0	(36)	0	(36)

15. Related party transactions

During the year 2018-19 the clinical commissioning group has undertaken transactions with the following clinical commissioning group Governing Body members or key management staff, or parties related to any of them:

Name	Title	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Ian Pattison	Governing Body Chair	GP Partner at Southlands Medical Group	Southlands Medical Group	1,280	0	84	0
Ian Pattison	Governing Body Chair	Partner is a locum GP at Southlands Medical Group	Southlands Medical Group	1,280	0	84	0
Ian Pattison	Governing Body Chair	GP Appraiser	NHS England	462	2,965	255	14
David Gallagher	Chief Officer	Daughter is store manager at Specsavers Peterlee Ltd.	Specsavers Hearcare Ltd.	773	0	130	0
David Chandler	Chief Finance Officer	Friends with Assistant Finance Director income and Contracting, Newcastle Hospitals NHS Foundation Trust	Newcastle Hospitals NHS Foundation Trust	11,273	0	78	0
David Chandler	Chief Finance Officer	Friends with Head of Finance and Business Development - South Locality, Northumberland Tyne & Wear NHS Foundation Trust	Northumberland, Tyne and Wear NHS Foundation Trust	56,240	0	0	74
David Chandler	Chief Finance Officer	Wife is Assistant Director of Finance – Costing & Contracting at Gateshead Health NHS Foundation Trust	Gateshead Health NHS Foundation Trust	21,215	0	12	0
David Chandler	Chief Finance Officer	Sister is nurse in ITU unit South Tyneside NHS Foundation Trust	South Tyneside NHS Foundation Trust	31,148	7	1,399	217
David Chandler	Chief Finance Officer	HFMA Northern Branch Chair	HFMA	7	0	0	0
Ann Fox	Director of Nursing, Quality and Safety	Honorary title from University of Sunderland	University of Sunderland	101	4	53	0
Scott Watson	Director of Contracting and Informatics	Mother employed by City Hospitals Sunderland NHS Foundation Trust	City Hospitals Sunderland NHS Foundation Trust	181,045	18	0	602
Scott Watson	Director of Contracting and Informatics	Sister is employed by Ward Hadaway solicitors	Ward Hadaway Solicitors	52	0	0	0
Scott Watson	Director of Contracting and Informatics	Aunt is member of Sunderland City Council	Sunderland City Council	57,714	746	6,412	168
Scott Watson	Director of Contracting and Informatics	Step mother is member of Sunderland City Council	Sunderland City Council	57,714	746	6,412	168
Scott Watson	Director of Contracting and Informatics	Aunt is employed by City Hospitals Sunderland NHS Foundation Trust	City Hospitals Sunderland NHS Foundation Trust	181,045	18	0	602
Scott Watson	Director of Contracting and Informatics	Friends with Director at City Hospitals NHS Foundation Trust	City Hospitals Sunderland NHS Foundation Trust	181,045	18	0	602
Tarryn Lake	Deputy Chief Finance Officer	HFMA Northern Branch Treasurer	HFMA	7	0	0	0
Claire Bradford	Medical Director	Deputy medical referee Newcastle City Council	Newcastle City Council	0	17	0	0
Claire Bradford	Medical Director	Deputy Chairman of Northern Cancer Alliance (hosted by NHS England)	NHS England	462	2,965	255	14
Derek Cruickshank	Secondary Care Clinician	Secondary Care Clinician at NHS South Tees CCG	NHS South Tees CCG	40	0	0	4
Raj Bethapudi	Executive GP	GP Partner, Bridgeview Medical Group	Bridgeview Medical Group	1,415	0	83	0
Raj Bethapudi	Executive GP	Part-time GP Partner the Galleries Medical Group	The Galleries Medical Group	1,389	0	79	0
Raj Bethapudi	Executive GP	Brother is a consultant radiologist at County Durham and Darlington NHS Foundation Trust	County Durham and Darlington NHS Foundation Trust	6,739	0	22	0
Karthik Gellia	Executive GP	GP Partner, Dr Gellia and Dr Balaraman	Dr Gellia and Dr Balaraman	716	0	58	0
Fadi Khalil	Executive GP	GP Partner at Broadway Medical Practice	Broadway Medical Practice	1,043	0	42	0
Fadi Khalil	Executive GP	GP Partner at New Silksworth Medical Practice (Sunderland GP Alliance)	Sunderland GP Alliance	8,499	0	1,836	0
Fadi Khalil	Executive GP	Partner provides consultancy support to Sunderland GP Alliance	Sunderland GP Alliance	8,499	0	1,836	0
Tracey Lucas	Executive GP	GP Partner at Deerness Park Medical Group	Deerness Park Medical Group	2,056	0	155	0
Saira Malik	Executive GP	GP Partner at Sunderland GP Alliance	Sunderland GP Alliance	8,499	0	1,836	0
Saira Malik	Executive GP	Father is a member of the South Tyneside NHS Foundation Trust Board	South Tyneside NHS Foundation Trust	31,148	7	1,399	217
Saira Malik	Executive GP	Provides advice re ICAR services to South Tyneside NHS Foundation Trust	South Tyneside NHS Foundation Trust	31,148	7	1,399	217
Saira Malik	Executive GP	Member of Sunderland Local Medical Council	Sunderland LMC	64	0	0	0
Eric Harrison	Executive Practice Manager	Practice Manager at Deerness Park Medical Group	Deerness Park Medical Group	2,056	0	155	0
Claire Nesbit	Associate Director of OD and Workforce	Ex daughter-in-law is employed by Gateshead Health NHS Foundation Trust	Gateshead Health NHS Foundation Trust	21,215	-	12	-
Claire Nesbit	Associate Director of OD and Workforce	Sister employed by Gateshead Health NHS Foundation Trust as the integration agenda lead.	Gateshead Health NHS Foundation Trust	21,215	0	12	0
Florence Gunn	Executive Practice Nurse	Practice Nurse at Pallion Family Practice	Pallion Family Practice	1,723	0	104	0
Florence Gunn	Executive Practice Nurse	Son is project lead for value based commissioning at the North of England Commissioning Support Unit	North of England Commissioning Support Unit	3,957	21	462	4
Matt Thubron	Head of Contracting and Performance	Sister-in-law is employed by City Hospitals NHS Foundation Trust	City Hospitals Sunderland NHS Foundation Trust	181,045	18	0	602
Helen Steadman	Head of Strategy and Planning	Brother is Estates Officer at Newcastle Hospitals NHS Foundation Trust	Newcastle Hospitals NHS Foundation Trust	11,273	0	78	0

During the year 2017-18 the clinical commissioning group has undertaken transactions with the following clinical commissioning group Governing Body members or members of the key management staff, or parties related to any of them:

Name	Title	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Ian Pattison	Governing Body Chair	GP Partner at Southlands Medical Group	Southlands Medical Group	861	0	40	0
Ian Pattison	Governing Body Chair	Partner is a locum GP at Southlands Medical Group	Southlands Medical Group	861	0	40	0
Ian Pattison	Governing Body Chair	GP Appraiser	NHS England	214	829	69	1,593
Mike Bramble	Secondary Care Clinician (to May 2017)	Consultant Gastroenterologist	South Tees Hospitals NHS Foundation Trust	428	0	200	0
David Chandler	Chief Finance Officer	Friends with Assistant Finance Director Income and Contracts, Newcastle Hospitals NHS Foundation Trust	Newcastle Hospitals NHS Foundation Trust	11,125	0	149	0
David Chandler	Chief Finance Officer	Friends with Head of Finance and Budgeting, Northumberland Tyne & Wear NHS Foundation Trust	Northumberland, Tyne and Wear NHS Foundation Trust	53,659	0	626	0
David Chandler	Chief Finance Officer	Wife is Assistant Director of Finance – Costing & Contracting at Gateshead Health NHS Foundation Trust	Gateshead Health NHS Foundation Trust	22,861	0	69	0
David Chandler	Chief Finance Officer	Sister is a nurse in ITU unit South Tyneside NHS Foundation Trust	South Tyneside NHS Foundation Trust	31,436	88	528	18
David Chandler	Chief Finance Officer	HFMA Northern Branch Chair	HFMA	9	0	0	0
David Chandler	Chief Finance Officer	Friends with Finance Lead NHS Property Services	NHS Property Services Limited	1,598	0	1,652	0
Ann Fox	Director of Nursing, Quality and Safety	Visiting Professor at University of Sunderland	University of Sunderland	1	8	0	16
Scott Watson	Director of Contracting and Informatics	Father was leader of Sunderland City Council	Sunderland City Council	52,430	553	4,919	1,570
Tarryn Lake	Deputy Chief Finance Officer	HFMA Northern Branch Treasurer	HFMA	9	0	0	0
Claire Bradford	Medical Director	Deputy medical referee Newcastle City Council	Newcastle City Council	0	17	0	0
Raj Bethapudi	Executive GP	GP Partner, Dr Cloak and Partners	Dr Cloak and Partners	1,307	0	71	0
Raj Bethapudi	Executive GP	Brother is a consultant radiologist at County Durham and Darlington NHS Foundation Trust	County Durham and Darlington NHS Foundation Trust	6,592	0	22	6
Karthik Gellia	Executive GP	GP Partner, Dr Gellia and Dr Balaraman	Dr Gellia and Dr Balaraman	430	0	40	0
Jackie Gillespie	Executive GP	GP Partner, Millfield Medical Centre	Millfield Medical Centre	1,819	0	84	0
Fadi Khalil	Executive GP	GP Partner at Broadway Medical Practice	Broadway Medical Practice	767	0	87	0
Fadi Khalil	Executive GP	Partner provides consultancy support to Sunderland GP Alliance	Sunderland GP Alliance	7,060	0	541	9
Tracey Lucas	Executive GP	GP Partner at Deerness Park Medical Group	Deerness Park Medical Group	1,847	0	160	0
Eric Harrison	Executive Practice Manager	Practice Manager at Deerness Park Medical Group	Deerness Park Medical Group	1,847	0	160	0
Chris Macklin	Lay Member, Audit and Risk Committee	Carer Governor for Adult Mental Health at Northumberland, Tyne and Wear Mental Health Trust 1 December 2015 to 21 June 2017	Northumberland, Tyne and Wear NHS Foundation Trust	53,659	0	626	0
Clare Nesbit	Associate Director of OD and Workforce	Ex daughter-in-law is Directorate Manager for Trauma and Orthopaedics with Gateshead Health NHS Foundation Trust	Gateshead Health NHS Foundation Trust	22,861	0	69	0
Clare Nesbit	Associate Director of OD and Workforce	Sister is employed by Gateshead Health NHS Foundation Trust as the integration agenda lead.	Gateshead Health NHS Foundation Trust	22,861	0	69	0
Florence Gunn	Executive Practice Nurse	Practice Nurse at Pallion Family Practice	Pallion Family Practice	1,307	0	182	0
Matt Thubron	Head of Contracting and Performance	Sister-in-law is employed by City Hospitals Sunderland NHS Foundation Trust	City Hospitals Sunderland NHS Foundation Trust	185,306	46	2,139	946
Helen Steadman	Head of Strategy and Planning	Brother is Estates Officer at Newcastle Hospitals NHS Foundation Trust	Newcastle Hospitals NHS Foundation Trust	11,125	0	149	0

15. Related party transactions (continued)

The clinical commissioning group is a membership organisation. The GP Practices of Sunderland are all members of the clinical commissioning group. The table below lists the 2018-19 related party transactions with the Member Practices of Sunderland. In addition, the clinical commissioning group works with the Sunderland GP Alliance who are part of a collobaration agreement with practices in Sunderland. The table below outlines the transactions with this organisation and outlines the practices who are members of each GP alliance.

Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Deerness Park Medical Group*	2,056	0	155	0
Drs Bhate & El-Shakankery (Riverview Health Centre)*3	853	0	58	0
Hetton Group Practice*	1,823	0	45	0
Villette Surgery*	897	0	46	0
Wearside Medical Practice*	1,159	0	46	0
Pallion Family Practice*	1,723	0	104	0
Redhouse Medical Centre*	724	0	35	0
Herrington Medical Centre*	1,281	0	61	0
Dr Stephenson & Partners*	1,769	0	88	0
Village Surgery*	760	0	30	0
The Galleries Medical Group	1,389	0	79	0
The New City Medical Group	905	0	38	0
Fulwell Medical Centre*	1,315	0	84	0
St. Bede Medical Centre*	1,181	0	75	0
Millfield Medical Group*	1,936	0	90	0
Ashburn Medical Centre*	759	0	38	0
Bridgeview Medical Group*	1,415	0	83	0
Old Forge Surgery*	1,328	0	70	0
Kepier Medical Practice*	1,298	0	79	0
Concord Medical Practice	842	0	0	0
Houghton Medical Group*	1,172	0	58	0
The Broadway Medical Practice*	1,043	0	42	0
Sunderland GP Alliance	8,499	0	281	0
New Washington Medical Group4	1,199	0	136	0
Springwell Medical Group*	987	0	46	0
Grangewood Surgery*	1,099	0	40	0
Westbourne Medical Group*	912	0	58	0
Hylton Medical Group	810	0	55	0
Colliery Medical Group1	45	0	0	0
Park Lane Practice*	593	0	22	0
Southlands Medical Group*	1,280	0	84	0
Castletown Medical Centre*	311	0	14	0
Dr Gellia and Dr Balaraman *	716	0	58	0
Happy House Surgery	811	0	45	0
Church View Medical Centre*1	0	0	0	0
Dr Obonna*	339	0	13	0
Dr Weatherhead & Associates*	628	0	32	0
Conishead Medical Group (Dr Hipwell)*2	39	19	25	0
Dr Nathan*3	42	0	69	0
South Hylton Surgery*	653	0	32	0
Rickleton Medical Centre*	318	0	13	0
Harraton Surgery	588	0	32	0
Chester Surgery*	405	0	18	0

* Member Practice of Sunderland GP Alliance

[1] Church View Practice (owened by City Hospitals Sunderland NHS Foundation Trust) and Colliery Medical Group merged in June 2017 to form New Silksworth Medical Practice. Transactions shown for Colliery Medical Group relate to reconciling balances prior to the merger; transactions relating to New Silksworth Medical Practice are shown within the transactions for Sunderland GP Alliance.

[2] Conishead Practice was closed and the patient list dispersed in 2017; transactions relate to outstanding 2017/18 balances.

[3] Dr Nathan merged with Drs Bhate & El-Shakankery (Riverview Health Centre) on 01 April 2018.

[4] Dr Thomas, Drs Bhatt and Ben, and Dr Ray merged on 2 May 2018 to form New Washington Medical Group.

The Department of Health and Social Care is regarded as a related party. During the year 2018-19 the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

Department of Health Entity
City Hospitals Sunderland NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
South Tyneside NHS Foundation Trust
Gateshead Health NHS Foundation Trust
North East Ambulance Services NHS Foundation Trust

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies in 2018-19. Most of these transactions have been with Sunderland City Council as outlined below.

Other Government Bodies	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Sunderland City Council	57,714	746	6,412	168

15. Related party transactions (continued)

The clinical commissioning group is a membership organisation. The GP Practices of Sunderland are all members of the clinical commissioning group. The table below lists the 2017-18 related party transactions with the Member Practices of Sunderland. In addition, the clinical commissioning group works with the Sunderland GP Alliance who are part of a collobaration agreement with practices in Sunderland. The table below outlines the transactions with this organisation and outlines the practices who are members of each GP alliance.

Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Deerness Park Medical Group*	1,847	0	161	0
Drs Bhate & El-Shakankery (Riverview Health Centre)*	540	0	486	0
Dr Vakharia & Hegde (The Galleries Health Centre)[1]	227	0	22	0
Dr H Pepper & Partners (Hetton Group Practice)*	1,632	0	92	0
Dr Brigham & Partners (Villette Surgery)*	852	0	30	0
Dr Shetty & Partners*	898	0	105	0
Pallion Family Practice*	1,307	0	182	0
Dr Reddy & Partners (Redhouse Medical Centre)*	693	0	26	0
Dr Lilley & Partners (Herrington Medical Centre)*	1,053	0	43	0
Dr Stephenson & Partners*	1,589	0	67	0
Dr Joshi (Village Surgery)*	564	0	72	0
The Galleries Medical Group (formerly Dr Dixit Practice)[1]	1,002	0	49	0
New City Medical Group	728	0	28	0
Roker Family Practice [3]	112	0	0	0
Dr Rutherford & Partners (Fulwell Medical Group)*	1,238	0	40	0
Dr Ford & Partners (St. Bede's Medical Practice)*	1,045	0	33	0
Dr Wright & Partners (Millfield Medical Group)*	1,819	0	84	0
Ashburn Medical Centre (Dr Parry & Partners)*	746	0	61	0
Dr Cloak & Partners*	1,307	0	71	0
Old Forge Surgery*	1,319	0	53	0
Dr Mishreki & Partners (Kepier Medical Practice)*	1,150	0	48	0
Dr Mazarelo & Partners (Concord Medical Practice)	731	0	70	0
Houghton Medical Group*	928	0	62	0
Broadway Medical Practice (Dr Mekkawy & Partners)*	767	0	87	0
Victoria Medical Practice (Dr Ray)	380	0	50	0
Springwell Medical Group (Dr Sharma & Partners)*	789	0	68	0
Grangewood Surgery (Dr Wallace & Partners)*	956	0	46	0
Springwell House (Dr Singh Sunderland) [5]	147	0	1	0
Westbourne Medical Group*	805	0	39	0
Colliery Medical Group (Dr K Stephenson)*[2]	470	0	70	0
Park Lane Practice (Drs Mackrell & Joseph)*	430	0	46	0
Southlands Medical Group	861	0	40	0
Castletown Medical Group*	280	0	10	0
Monkwearmouth Medical Centre*	430	0	40	0
Happy House Surgery	724	0	27	0
Church View Medical Centre*[2]	528	0	26	0
Dr Obonna*	348	0	15	0
Dr Weatherhead & Associates*	542	0	59	0
Conishead Medical Group (Dr Hipwell)*[3]	277	0	12	0
Dr Nathan (Riverview)*	343	0	27	0
South Hylton Surgery (Dr Widdrington & Partner)*	613	0	26	0
Rickleton Medical Centre (Dr Aiyegbayo)*	265	0	13	0
Harraton Surgery [5]	426	0	34	0
Dr Thomas (Victoria Road Health Centre)*	352	0	13	0
Chester Surgery (Dr El Safy)*	370	0	11	0
Dr Bhatt & Dr Benn*	338	0	26	0
Pallion Health Centre*	770	0	36	0
Sunderland GP Alliance (Collaboration of Local Practices) [4]	7,060	0	541	0

* Member Practice of Sunderland GP Alliance

[1] Drs Vakharia and Hegde Practice merged with Dr Dixit Practice in July 2017. Dr Dixit Practice is now the provider and is known as the Galleries Medical Group.

[2] Church View Practice and Colliery Medical Group merged in June 2017. Colliery Medical Group is now the provider.

[3] This practice was closed and the patient list dispersed in 2017.

[4] The Sunderland GP Alliance in addition to being a collaboration of local practices also directly provides primary care medical services.

[5] The Springwell House and Harraton Surgery merged in August 2017. Harraton Surgery is now the provider.

The Department of Health and Social Care is regarded as a related party. During the year 2017-18 the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

Department of Health Entity
City Hospitals Sunderland NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
South Tyneside NHS Foundation Trust
Gateshead Health NHS Foundation Trust
North East Ambulance Services NHS Foundation Trust

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies in 2017-18. Most of these transactions have been with Sunderland City Council as outlined below.

Other Government Bodies	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Sunderland City Council	52,430	553	4,919	1,570

16. Events after the end of the reporting period

There are no post balance sheet events which would have a material effect on the financial statements of the clinical commissioning group (2017-18: None)

17. Financial performance targets

NHS Act Section	Duty	2018-19 Target £'000	2018-19 Performance £'000	Duty Achieved?	2017-18 Target £'000	2017-18 Performance £'000	Duty Achieved?
223H (1)	Expenditure not to exceed income	**513,817**	**509,208**	**Yes**	511,724	508,745	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	**0**	**0**	**Yes**	0	0	Yes
223I (3)	Total Revenue resource use does not exceed the amount specified in Directions	**511,593**	**506,984**	**Yes**	510,814	507,835	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**	0	0	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**	0	0	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	**5,949**	**5,336**	**Yes**	5,941	5,606	Yes

The clinical commissioning group received no capital resource during the year ended 31 March 2019 and incurred no capital expenditure (year ended 31 March 2018: £0)

The financial targets included in the table above are as per CCG Allocations Directions published by NHS England.

Performance against the revenue expenditure duties is further analysed below:

	2018-19 Programme £'000	2018-19 Administration £'000	2018-19 Total £'000	2017-18 Programme £'000	2017-18 Administration £'000	2017-18 Total £'000
Revenue resource	501,144	5,949	507,093	502,051	5,941	507,992
Net operating cost for the financial year	501,648	5,336	506,984	502,229	5,606	507,835
Underspend against in year revenue resource available	**(504)**	**613**	**109**	(178)	335	157

Prior to the start of the 2018/19 financial year the CCG agreed with NHS England to drawdown (£4,900,000) of cumulative surpluses to support transformation, which is inluded within the programme revenue resource totals provided above. The 2018/19 finanial year underspend against the revenue resource includes £4,500,000 additional surplus agreed by the CCG Governing Body to support system wide pressures.

The in year underspend against the revenue resource for 2017-18 included £2,821,666 mandated by NHS England to be delivered as an additional surplus in order to support national system wide pressures. In addition the CCG with approval from NHS England has drawdown £5,400,000 of cumulative surpluses in 2017-18 to support transformation. This is included within the programme revenue resource totals provided above.

The revenue resources outlined in the table above only includes the financial performance against in year resources available to the clinical commissioning group. The table below outlines the clinical commissioning groups cumulative financial position incorporating brought forward surpluses from previous financial years which have not been utilised.

	2018-19 Programme £000	2018-19 Administration £000	2018-19 Total £000	2017-18 Programme £000	2017-18 Administration £000	2017-18 Total £000
In year revenue resource available to the clinical commissioning group	521,904	5,949	527,853	523,054	5,941	528,995
Net operating cost for the financial year	501,648	5,336	506,984	502,229	5,606	507,835
Underspend against revenue resource	**20,256**	**613**	**20,869**	20,825	335	21,160