NHS
Vale of York
Clinical Commissioning Group

Annual Report and Accounts

2013-14

The best health and wellbeing for everyone.

Annual Report and Accounts 2013-14

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Section A: Annual Report 2013-14

Welcome to the inaugural Annual Report and Accounts of NHS Vale of York Clinical Commissioning Group (CCG) for 2013-14. All NHS organisations are required to publish an annual report and financial accounts at the end of each financial year.

This report provides an overview of the CCG's work between 1 April 2013 and 31 March 2014. The report is made up of two parts. The first part is a summary of the CCG's business, performance and projects over the past year, as well as commentary on wider events which have shaped its work and priorities as an organisation. The second is the financial accounts for the year 2013-14.

As a publicly accountable body, the CCG is committed to being transparent with its staff, partners, patients and the public.

The CCG held ten Board Meetings and two Public and Patient Engagement (PPE) events in 2013-14. These events are open to the public. Dates, times and venues of the CCG's events can be found on the website: http://www.valeofyorkccg.nhs.uk/

Information contained in this report can also be requested in other languages. If you would like additional copies of this report, please contact the CCG via the details below. An electronic copy of this report is also available online at:
http://www.valeofyorkccg.nhs.uk/

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Welcome from the Chair and Chief Clinical Officer

Dr Mark Hayes
Chief Clinical Officer

Professor Alan Maynard
Lay Chair

With energy and skill, 2013-14 has been a year of implementing innovative solutions, addressing an inherited financial deficit; bedding in governance change; and laying the foundations for a positive future for local healthcare services.

During the past 12 months the CCG focussed upon establishing clinical leadership and programme delivery arrangements, developing key relationships with local authorities and voluntary groups, and collaborating with neighbouring CCGs and providers. Driven by intelligence of population health needs, the CCG established its priority programmes by drawing on the NHS Mandate and Planning Guidance for 2013-14, the NHS Outcomes Framework and NHS Constitutional Rights.

There are inequalities in the Vale of York in terms of health outcomes and opportunities that are attributable to relative deprivation. Reducing these inequalities will improve health and wellbeing outcomes for the whole community. The local population is ageing and the changing demographic profile impacts on future commissioning decisions and plans.

The integration of health and social care

The CCG has worked closely with partners at City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council to identify and implement opportunities for joint working. Projects to date have included the implementation of joint mental health schemes and work to establish methods to and share and link into information and data.

Throughout 2013-14 the CCG has been working on its plans to integrate health and social care services through a new initiative to implement integration pilots in the Vale of York. Initially these will focus upon providing for the growing demand of services for older people. During the development of the delivery model through 2014-15, the CCG will formally evaluate outcomes to ensure the expected level of transformational change is delivered. These pilots will inform the longer term development of Care Hubs which

will aim to contribute to increasing the independence and wellness of the community and where appropriate, proactively manage the care of patients, including the self-management of conditions.

In 2014-15 the CCG will continue to address long-standing health inequalities and ensure that the best services are available at the right time whilst effectively generating positive outcomes.

Engaging and involving patients and the public

The CCG recognises the importance of creating open, honest conversations at the right time so local people are given the opportunity to have their say and influence local healthcare services.

Throughout 2013-14, the CCG's active engagement and involvement of stakeholders has helped to ensure that the planning and decisions around the delivery of local services has been driven by local need and opinion.

Quality

The safety of patients is fundamental and this has been embedded throughout the 2013-14 commissioning cycle. Quality assurance reports to the Governing Body have reported several successful schemes. Examples include:

- The implementation of the Friends and Family Test (FFT), throughout inpatient, emergency and maternity services at York Hospital has delivered a month on month increase in reporting at 30.43%;
- The assessment of patients no later than twelve hours after admission to hospital has had a positive impact on the 2013-14 result for SHMI (measure of hospital mortality) which was 7% lower than the median England value (102.5);
- There has also been a reduction in adverse incidents around deteriorating patients. The CCG will continue to work closely with York Teaching Hospital NHS Foundation Trust to embed policy, measure competence and design frameworks for future assessments.

Financial Delivery

The financial results for 2013-14 confirmed the CCG as financially sustainable. The implementation of effective solutions and the hard work of staff who; in an exceptional year, have worked hard to meet the needs of our community to achieve this.

Dr Mark Hayes
Chief Clinical Officer

Professor Alan Maynard
Lay Chair

1. Member Practices Introduction

Successfully tackling key challenges; including its journey to achieve financial balance and create financial stability, NHS Vale of York Clinical Commissioning Group (CCG) has developed well during its first year.

Member practices are pleased with the CCG's continued work with acute and mental healthcare providers that have ensured the provision of high quality care for local people. In pursuit of delivering innovative healthcare services, and in conjunction with the CCG and local Health and Wellbeing Boards, the members will continue to support the CCG in its commissioning of quality and high performing healthcare that provides the right care, in the best setting, at the right time.

In 2013-14 the CCG and its members focussed on the areas of greatest need to improve service quality and performance. Examples of this work include:

- Improving the quality of local healthcare services
  The CCG's vision 'My health, My life, My way' created a platform for significant and positive changes to the future provision of services in the Vale of York. Throughout its first year, the CCG has engaged with local patients, partners and members of the public to talk about its draft five year strategy. Important conversations with these stakeholders continue to take place.

- Medicines management
  Throughout 2013-14 the CCG has concentrated on enabling viable plans for future medicines management in the Vale of York. This work; based on potential cost efficiency savings, formulary implementation in practices and the larger transformational work that will implement the mitigating actions for emerging cost pressures, has set the foundations for important work in 2014-15.

- Referral Support Service (RSS)
  Innovative in its design and providing tangible benefits for patients and local healthcare services, RSS has paved the way to improve care pathways that ensure patients are seen by the right person at the right time. Since its launch in November 2013, all referrals, a total of 12,597, were booked into clinics within 48hrs of the referral request. Throughout the development of RSS and its associated guidelines, the CCG continues to receive excellent feedback from patients about the service.

- 'Stop before your op' policy
  The Stop before your op policy was created by the CCG to help give patients the opportunity to improve their recovery from elective surgery and to help them make a potentially life-changing decision that will improve their health and wellbeing.

The policy is applicable to all elective procedures, excluding patients in two categories; where the two week wait criteria is applicable and patients with mental health issues. It is supported by the North Yorkshire Smoking Cessation Service where monitoring is underway and on-going.

The Council of Representatives is pleased to report that all practices in the Vale of York area have adopted the policy and that secondary care surgeons at York Teaching Hospital Foundation Trust have welcomed and support the policy and the quality standards it provides.

- Reduction in emergency admissions that should not usually require urgent hospital care

  The CCG's work and combined influence to enhance staffing in the Emergency Department alongside innovative alternatives to Accident and Emergency attendances, quickly showed clear benefits in the 2013-14 winter period. Attendances were reduced during the period of intervention. This demonstrated that the right patients were being managed in hospital and it helped the Emergency Department at York Teaching Hospital Foundation Trust to achieve its four hour target in Quarter 4.

  A number of schemes provided excellent evidence of both performance and quality improvements for patients and staff. In addition, the partnership working between health, social and voluntary sector organisations has improved relationships and made for better forward planning through the Urgent Care Working Group.

- Improving outcomes for people with long-term conditions

  To understand the views of patients with a long term condition and those who care for someone affected the CCG held themed engagement events to ask 'What does good support look like?' Representatives from the community, patients, carers and professionals attended a range of events throughout 2013-14, allowing the CCG to gather important views that will be used to help shape decisions about the commissioning of future healthcare services.

1.1 Annual evaluation of Membership Body effectiveness

The Membership Body is pleased to report that the CCG has established robust performance evaluation and governance measures. The appointment of key staff members along with feedback from external assurance channels has ensured the continued evaluation of the CCG's effectiveness throughout its first year.

The CCG has undergone significant organisational development in enhancing the Governing Body and the internal CCG capacity and capability. This has included external support and development facilitated by Organisational Development (OD) specialists who

have worked with other CCGs and can share best practice. The Governing Body members have undertaken 360 feedback and Coaching and mentoring arrangements have been put in place.

In addition to the on-going evaluation of effectiveness from external sources, internal governance functions drive the delivery of the CCG's Integrated Commissioning Plan whilst monitoring its delivery, reporting on progress and providing assurance. The CCG's internal governance and assurance measures include:

Chief Clinical Officer - as Accountable Officer, the Chief Clinical Officer is accountable for achieving organisational objectives within an appropriate business framework;

Chief Finance Officer - the Chief Finance Officer is the Responsible Officer for organisational finances and is accountable for delivery of financial balance and compliance with standing financial instructions;

NHS England Area Team - NHS England's North Yorkshire and Humber Area Team review the CCG on a quarterly basis. The 2013-14 quality and assurance reviews have been very positive and have strengthened the joint co-commissioning relationship with NHS England. All reviews have covered the domains required to achieve authorisation as well as the national CCG Assurance Framework.

The important check and balance of the CCG's work provided by governance and assurance frameworks will continue into 2014-15 and cross-cutting priorities

- Reducing inequalities
- Delivering outcomes frameworks
- Choice and shared decision making
- Integration of care
- Quality of information
- Promoting growth, innovation and research
- NHS Constitution

The membership congratulates the CCG on its ability to confront its financial inheritance, a deficit of £3.5 million, and achieve financial balance in its first year, whilst delivering innovative healthcare projects that pave the way for opportunities to invest in 2014-15.

Dr Tim Hughes
Chair of the Council of Representatives (Membership Body)

2. Strategic Report

2.1 Legislative requirements

We certify that the CCG has complied with the statutory duties (below) that have been laid down by the National Health Service Act 2006 (as amended).

- Acted with a view to ensuring that health services are provided in a way which promotes the NHS Constitution, and that it has promoted awareness of the NHS;
- Constitution among patients, staff and members of the public;
- Assisted and supported NHS England in discharging its duties relating to securing the continuous improvement in the quality of primary medical services;
- Promoted the involvement of patients, their carers and representatives in decisions that relate to the prevention or diagnosis of illness in the patient, their care and treatment;
- Enabled patients to make choices with respect to the aspects of health services provided to them;
- Promoted innovation, research, education and training;
- Consulted widely when devising its commissioning plans;
- Taken appropriate steps to secure that it is properly prepared for dealing with a relevant emergency;
- Cooperated with its Health and Wellbeing Board in relation to the discharge of the Health and Wellbeing Board's functions;
- Discharged its functions with regard to the need to safeguard and promote the welfare of children;
- Cooperated in relation to the preparation of local Joint Strategic Needs Assessments.

The CCG's constitution makes explicit reference to the legislative duties of the CCG and sets out the CCG's approach to meeting our statutory duties. The CCG holds providers to account for meeting requirements within the NHS Constitution and includes this in induction information for staff.

The CCG's prospectus is available at http://www.valeofyorkccg.nhs.uk/data/uploads/publications/patient-prospectus-final.pdf and the 2013-14 operational plan can be found at http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/4-april-2013/item-6-operational-plan.pdf.

These documents articulate the CCG's approach to meet the NHS constitution, its work to ensure efficient, effective and economic working whilst supporting patient choice, public involvement and the promotion of innovation and research.

The CCG has been proactive in delivering its Communication and Engagement Strategy through 2013-14, with engagement events held with stakeholders and the public on topics including diabetes, long term conditions, the Better Care Fund, pain management, dermatology, out of hours services and its strategic plan. The Strategic Plan and Better Care Fund development was carried out in partnership with local Health and Well-Being Boards and partner agencies, promoting the integration in health and social care services.

The CCG is a member on three Health and Well-Being Boards covering the Vale of York, with Governing Body representation at each Board level. The CCG was been actively involved in the refresh of local Joint Strategic Needs Assessments (JSNA) with participation in JSNA working groups.

During 2013-14 the CCG established the clinically led Primary Care Strategy and supporting working group to promote continuous improvement in Primary Care, working to the NHS England Compact. This has included piloting the Practical Practice Improvement Programme and introduction of the Primary Care web Tool to map variations across practices. The CCG is committed to the promotion of education and training, and has implemented performance and development plans for its own staff.

The CCG works in collaboration with the three other North Yorkshire Clinical Commissioning Groups to safeguard and promote the welfare of children and works in partnership with them through the local Safeguarding Children Boards. In 2013-14 the CCG took steps to enhance its internal capacity for this work through the appointment of its dedicated Chief Nurse and Deputy Chief Nurse. All staff have completed level 1 safeguarding training as part of its statutory and mandatory training schedule.

2.2 An overview of NHS Vale of York Clinical Commissioning Group (CCG)

Under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006, the CCG was formally established (with conditions and directions) on the 1st April 2013.

As part of a major restructure of the NHS, the CCG became responsible for a geographical area; within the former NHS North Yorkshire and York Primary Care Trust (PCT) operating area, to commission the following healthcare services for the Vale of York community:

- Planned hospital care
- Urgent and emergency care
- Community health services
- Mental health and learning disability services
- Tackling inequality including children's health and wellbeing

The CCG is an NHS organisation which is led by clinicians who see patients every day and understand both the needs of the community and the impact that local services have on patients' health.

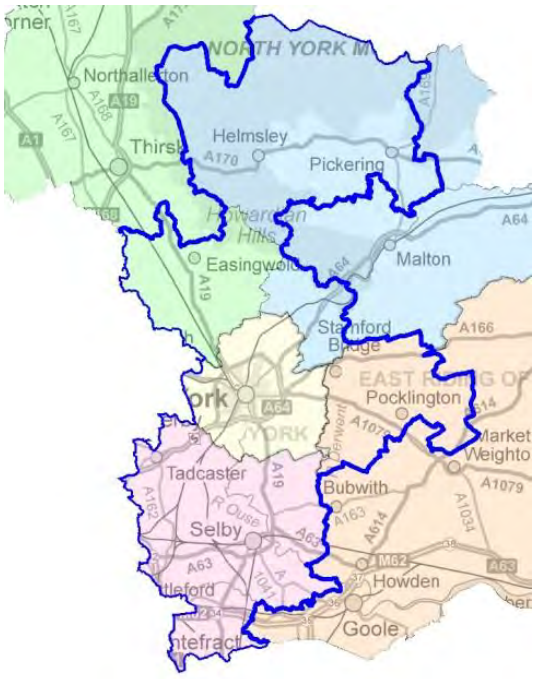


Fig 1 The NHS Vale of York CCG operating area

2.2.1 CCG footprint

The CCG serves towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of around 336,330 people.

Its vision is to achieve **'the best in health and wellbeing for everyone in our community'** and it works closely with a range of partners to achieve this goal.

In 2013-14, the CCG had 33 member GP practices in its operating area and an annual commissioning budget of £362 million. The budget is set by central government and based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

The CCG's footprint or operating area covers the urban city of York and surrounding rural areas. It also shares administrative boundaries with three local authorities – City of York Council, parts of North Yorkshire County Council and the East Riding of Yorkshire Council boundary.

2.2.2 CCG accountability

The CCG is accountable to its members, patients and the public and it is overseen by the executive, non-departmental public body for the Department of Health, NHS England.

The Governing Body plays a central role in the organisation. It has responsibility for ensuring that the CCG operates effectively, efficiently and in accordance with the CCG's principles of good governance.

2.2.3 Location of the CCG

The CCG is co-located with City of York Council at their headquarters at West Offices in York city centre.

2.2.4 The establishment of the CCG's function, systems and processes

To allow for the completion of the licencing process and the establishment of functions, systems and processes, the CCG operated in shadow form prior to 1 April 2013.

As at 1 April 2013, the CCG took on its full powers and was licensed with nine conditions and two legal directions. These and the support options available to remove the conditions are detailed in the table below. Further information about authorisation for CCGs is available at http://www.england.nhs.uk/wp-content/uploads/2013/07/2nd-con-rev-out-sum.pdf

Table 1: The CCG's conditions as of the 1 April 2013

Criteria	Condition	Support
1.3A	Arrangements in place for CCG to involve and seek advice from healthcare professionals from secondary, community, mental health, learning disabilities and social care.	II
1.3B	CCG governing body includes nurse and secondary care doctor.	I
3.1.1B	CCG has a clear and credible integrated plan, which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15.	IV
3.1.1C	CCG has detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and any other requirements set by the NHSCB and is integrated with the commissioning plan.	IV
3.1.1D	Quality, Improvement, Performance and Productivity is integrated within all plans. Clear explanation of any changes to existing Quality, Improvement, Performance and Productivity plans	IV
4.3.1C	CCG can demonstrate how its proposed staff resource and any contracted commissioning support will provide capacity and capability to deliver its full range of responsibilities.	IV
5.3B	Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	I
5.3D	CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.	I
6.4G	Senior in-house management roles in CCG provide adequate capacity and capability to maintain strategic oversight with available resources.	I

Key to support options

I	II	III	IV	V	VI	VII
Model document or toolkit.	Make advice or expertise available.	Decision sign off or approval by NHS England	Insert or provide specific expertise, team or individual.	Accountable Officer (AO) not ratified or alternative AO appointed.	Specific functions removed.	All functions removed.

The CCG has been supported by NHS England's North Yorkshire and Humber Area Team during 2013-14 to work towards removal of the conditions. Rectification plans were put in place which included:

- A review of the financial position and Quality, Improvement, Performance and Productivity plans. The financial plan was revised in August 2013 and the organisation was subject to an extensive financial review by the Area Team in autumn 2013. Greater financial controls have been introduced through the detailed financial policies and supporting detailed scheme of financial and operational delegation. The Quality, Improvement, Performance and Productivity planning process has been revised and improved to ensure robust financial modelling of efficiency plans and the contracting team has been significantly expanded;

- A revised and significantly enhanced staffing structure. The original structure had shared teams for finance and contracting, and quality and performance across the NHS Vale of York CCG and NHS Scarborough and Ryedale CCG. The CCG has now established its own dedicated structures for finance, contracting, quality and performance;

- The CCG has significantly expanded teams across all areas and dedicated finance and contracting and quality and performance functions. The CCG now has a Chief Finance Officer and Chief Nurse in place and continues to enhance the structure to ensure the CCG capacity is fit for purpose.

The CCG was fully authorised in January 2014 at the fourth conditions review and all legal directions were removed.

2.2.5 The CCG as a going concern

Management and those charged with governance are required to form a view as to the going concern status of the CCG as it governs the basis on which accounts are prepared for 2013-14 and services are commissioned in 2014-15. The Audit Committee and Governing Body considered a number of criteria and have recommended that the Annual Accounts for 2013-14 are prepared on a going concern basis.

2.2.6 The CCG's Strategy

Led by a number of local GPs and other health professionals, the CCG works with the community and its partners to understand the needs of patients. It is dedicated in its work

to ensure local people have access to the right services, in the best place, at the right time through:

- Clinical input in every aspect of the commissioning cycle;
- Commissioning for outcomes prioritising quality and continuous improvement;
- Informed commissioning through insights from GP daily practice;
- Wider engagement with patients, carers and communities;
- Ensuring all local resources are utilised including the third sector and localised community services;
- Work with strategic partners ensuring delivery of most effective services;
- Commissioning jointly with local authority partners where the integration of health and social care is vital.

2.2.7 The CCG's Vision

Ensuring that there is clinical input in every aspect of the commissioning cycle and through its work with stakeholders and strategic partners to commission the best in integrated health and social care services, the CCG's vision is:

To achieve the best health and wellbeing for everyone in our community

2.2.8 The CCG's Mission

- Commission excellent healthcare on behalf of and in partnership with everyone in our community.
- Involve the wider clinical community in the development and implementation of services.
- Enable individuals to make the best decisions concerning their own health and wellbeing.
- Build and maintain excellent partnerships between all agencies in Health and Social Care.
- Lead the local Health and Social Care system in adopting best practice from around the world.
- Ensure that all this is achieved within the available resources.

2.2.9 The CCG's Values

- Communication – Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
- Courage – We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.

- Empathy – We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.
- Equality – We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.
- Innovation – We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
- Integrity – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.

2.2.10 The CCG's business model

The CCG is led by the Chief Clinical Officer (the Accountable Officer) and supported by the CCG's Executive GPs and its Senior Management Team. These consist of:

Executive GPs (GP leads)

Planned Care and Prescribing
Primary Care
Women's health
Mental Health and Continuing Health
Urgent Care
Long Term Conditions and Older People

Senior Management Team

Chief Operating Officer
Chief Finance Officer
Chief Nurse
Deputy Chief Operating Officer
Deputy Chief Finance Officer
Deputy Chief Nurse

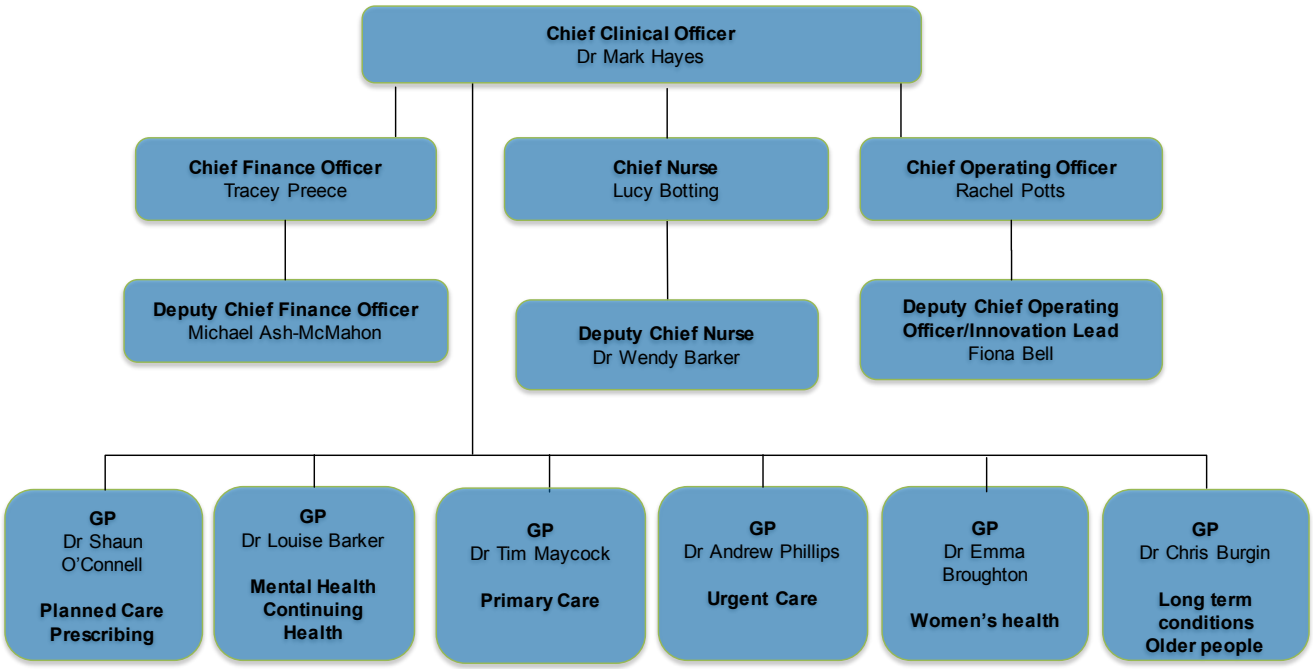


Fig 2 The CCG's Senior Management Team structure

The CCG has a robust governance structure to support its decision making, planning and commissioning processes. The following governance structure describes the CCG's immediate operating environment and the framework of the organisation's business environment that includes policy setting and agreement, standard operating procedures, rules and guidelines.

For information about the CCG's committee structure, membership, performance and highlights please see the Annual Government Statement in section 6 of this report.

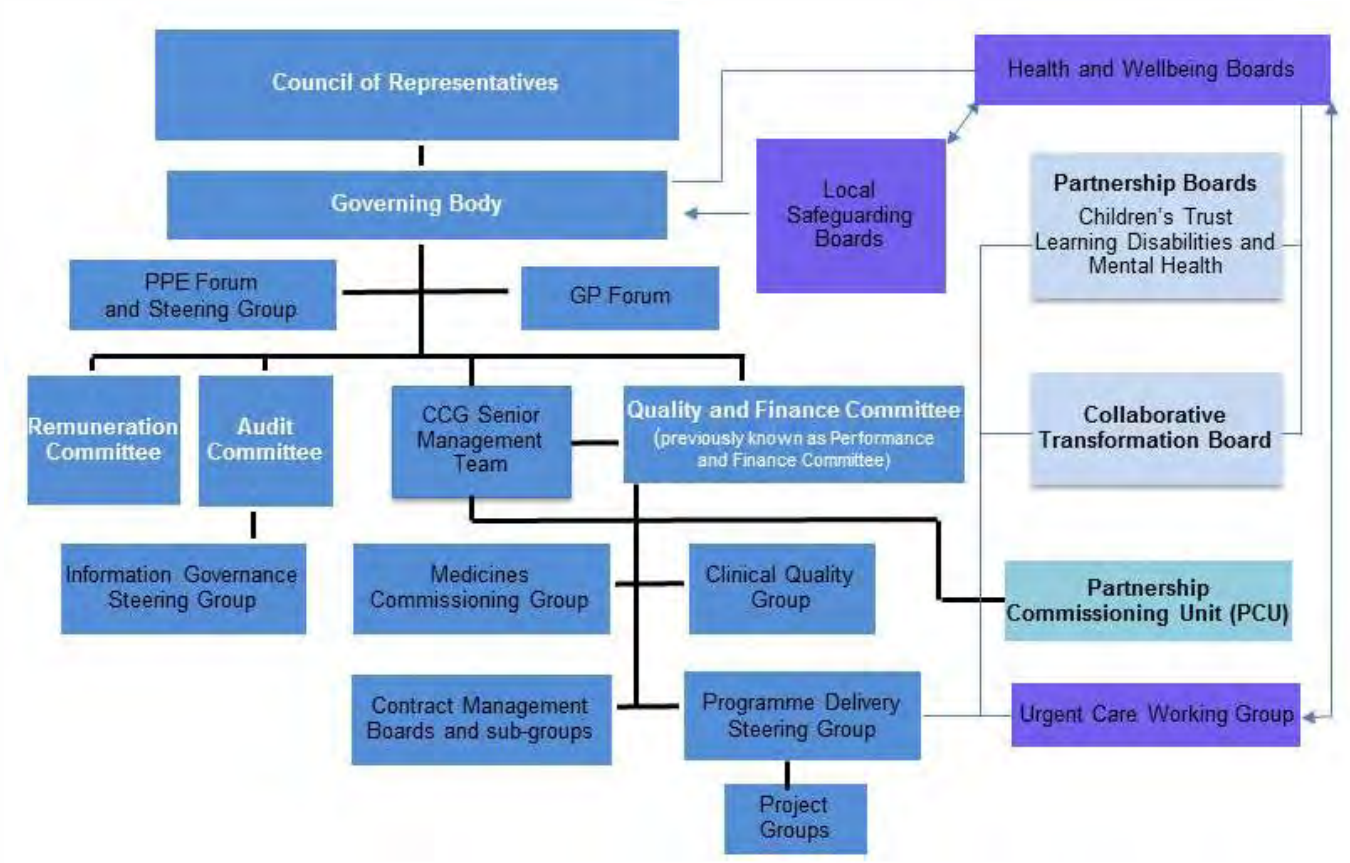


Fig 3 The CCG's Governance Structure

2.2.11 Health and Wellbeing Boards

The CCG is a member on three health and well-being boards. These are North Yorkshire, City of York and East Riding of Yorkshire and the CCG has Governing Body representation on each board that provides update reports on progress at regular intervals.

The priorities of Health and Wellbeing Boards are incorporated into the CCG's planning and can be summarised as:

- Improved care planning for people with long term conditions
- Integrated solutions of complex needs and end of life care
- Community based models of care, preventing unnecessary hospital admissions and reducing lengths of stay
- Supporting the older population and associated increase in Dementia
- Workforce reform
- Promoting healthy lifestyles
- Safeguarding children and young people.

The CCG's Integrated Operational Plan for 2013-14 reflected these local priorities through its work programmes and developed specific programmes of work and projects to take them forward. These included:

- Older People and Long Term Conditions programme
- Projects to increase dementia diagnosis
- The urgent care programme and winter pressures schemes
- The integration of health and social care through the Better Care Fund
- Providing funding to open a Section 136 Place of Safety facility for the Vale of York.

The CCG's strategic plan for 2014-2019 has ensured that local priorities will continue to be placed at the centre of the planning cycle and its objectives and improvement interventions are targeted to support our Health and Wellbeing Board priorities.

2.2.11.1 Mental Health and Learning Disabilities Partnership Board

Accountable to the Health and Wellbeing Board for delivering a range of priorities and objectives, the Board has several specific responsibilities relating to mental health and learning disabilities.

These include taking joint leadership and responsibility and setting priority objectives, for health and wellbeing and matters relevant to mental health and learning disabilities.

Involving those who use services is a priority objective for the Board as is appreciating public and patient views that can influence the work of the Board and its sub-groups. Understanding these views will ensure that members of the local community that use services can inform the planning, commissioning, design and service delivery.

2.2.11.2 North Yorkshire Collaborative Transformation Board and City of York Collaborative Transformation Board

These boards involves health and social care partners and oversees the development of integrated care and support across the Vale of York footprint and the creation of a five year strategy. It leads the delivery of an implementation plan for whole system change across all appropriate care and support services in the Vale of York and ensures that the strategy and plans are deeply rooted in patient/carer experience as well as the needs and views of local residents. It works on the principles of co-production and co-design.

2.2.11.3 Older Peoples and People with Long Term Conditions (OPPLTC) Board

The OPPLTC Board worked to ensure that the contribution of the voluntary sector, older people and carers in 'making York a great place for older people to live' was recognised. It especially focussed upon supporting people with long term conditions to live independently, preventing admissions to hospital, encouraging physical activity, addressing loneliness and social isolation and preparing for an increase in dementia.

2.2.12 Collaborative Improvement Board

To achieve the degree of change necessary all key partners and stakeholders need to work together in a 'whole system' approach to meeting the needs of the population within the resources available.

The CCG has successfully initiated a high level Collaborative Improvement Board consisting of the Executive Directors of the York Teaching Hospital Foundation Trust, CCGs in East Riding and Scarborough and Ryedale to ensure alignment of commissioning for the majority of patients attending the shared acute provider York Teaching Hospital Foundation Trust.

The Collaborative Improvement Board has an agreed set of shared objectives and commits partner organisations to close collaborative working to transform services that will deliver sustainable change to achieve maximum benefit for its populations.

2.2.13 Strategic Collaborative Commissioning Groups

The CCG works closely with the other three 'North Yorkshire' Clinical Commissioning Groups and all the CCGs across North Yorkshire and Humber through two strategic collaborative commissioning groups. Through these arrangements the CCG sets out lead commissioner and risk-share arrangements to commission services for the local population in each CCG locality.

2.2.14 Urgent Care Working Group

Through the local Urgent Care Working Group, the CCG works with partners to manage demand and capacity within the urgent care system. The group comprises representation from Vale of York, Scarborough and Ryedale and East Riding CCG's; Yorkshire Ambulance Service; City of York Council and North Yorkshire County Council; Mental Health Trusts from Tees, Esk and Wear Valley and Leeds and York Partnership Foundation Trust; (Healthwatch and NHS England. The group leads on the implementation of the Urgent Care Strategy.

2.2.15 Local Safeguarding Boards

2.2.15.1 City of York, North Yorkshire and East Riding of Yorkshire Safeguarding Children Boards

The CCG held membership on the above Local Safeguarding Children Boards. These statutory inter-agency forums agree how different services co-operate to protect children in the Vale of York and to ensure that these children are protected from all forms of abuse and neglect though effective joint working.

2.2.15.2 City of York, North Yorkshire and East Riding of Yorkshire Safeguarding Adults Boards

The CCG held membership on the above Local Safeguarding Adults Boards. These statutory inter-agency forums agree how different services co-operate to protect adults in the Vale of York and to ensure that these adults are protected from all forms of abuse and neglect though effective joint working.

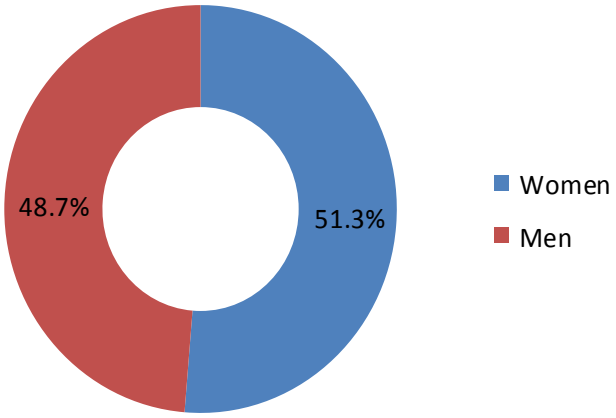
2.3 Nature, objectives and strategies of the CCG

2.3.1 Local population demographics

The Vale of York population comprises of 51.3% women and 48.7% men, with a higher proportion of people over the age of 50 compared to the national average. There is also a significant transient student population.

Over the next five years it is anticipated that the local population will grow by 3.9% to 356,360 people; within this it is expected that the percentage of people over 65 will increase by 10% and the percentage of people over 85 will increase by 18%.

Fig 4 Population split of the Vale of York Community



As the CCG celebrates people living longer, it needs to ensure that it has planned to meet the community's complex needs and support their quality of life in their later years.

In the 2011 census, 9% of the population reported that their day to day activities were limited by their health a little bit and 6.8% of people reported that their day to day activities were limited a lot by their health. This shows that for many residents (approx. 53,000 people) managing health conditions can be an issue for them.

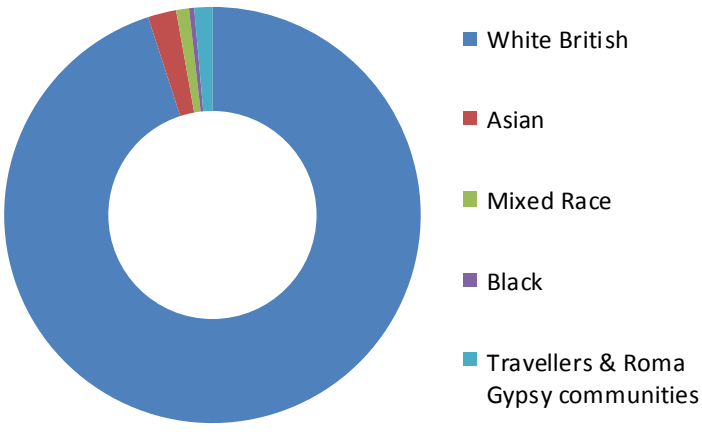


Fig 4a Demographic split of the Vale of York

The population is majority white British (95%) and report their religious beliefs as Christian (64%) or of no religion (26%).

The Vale of York has a number of ethnic groups including, Asian (2.2%), mixed race (1%), black (0.4%) and travellers and Roma Gypsy communities.

There is also a diverse range of religious beliefs, including Muslim (0.7%), Buddhist (0.4%), Sikh (0.1%) and Jewish (0.1%). The CCG is focussed upon planning effectively for the different cultural, social and health needs in the area to enable everyone in the community achieve the best in health and wellbeing.

2.3.2 The CCG's external business environment

Complementing the regulatory framework that determines the organisation's activities and how they are carried out, the CCG operates within the guidelines of NHS England, the Department of Health, Monitor, the Care Quality Commission and those set down by government. An overview of the CCG's external business environment is described in the diagram below.

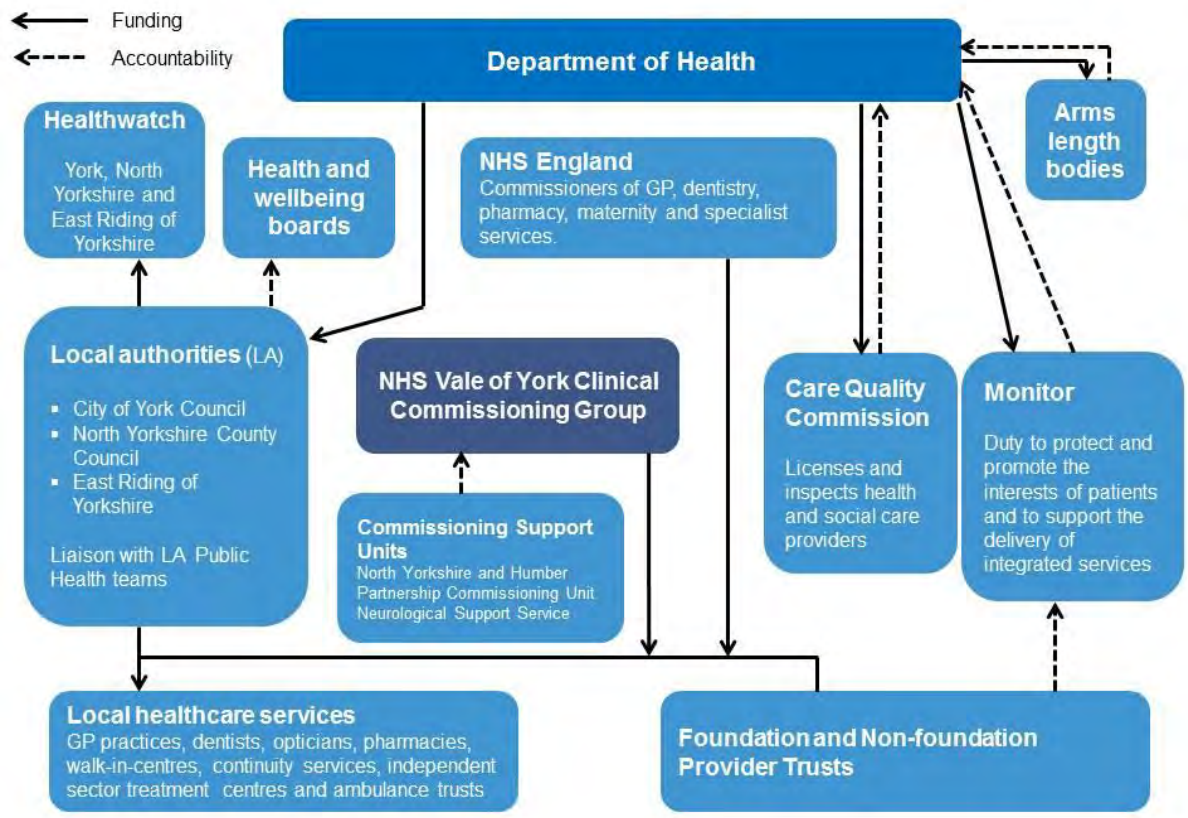


Fig 5 The CCG's external business environment

These wider standards, priorities and policy frameworks for service delivery are incorporated in the CCG's five year strategic vision for the Vale of York for 2014 to 2019.

CCGs are responsible for securing health care services that meet the needs of their population. The CCG will secure these services in the following ways:

- Through contracts with current providers and future contract variations.
- Through enabling patients, when they are referred to services, to choose from any qualified provider (AQP) that can provide the service.
- Through tendering for a new or replacement service.

As a public body the CCG will adhere to the legislation that governs the award of contracts which requires commissioners to ensure that they adhere to good practice in

relation to procurement, to not engage in anti-competitive behaviour and protect promote the right of patients to make choices about their healthcare.

2.3.3 Structure of the business – organisations the CCG commission services from

There is one main acute provider of hospital and community care - York Teaching Hospital Foundation Trust and one main provider of mental health services - Leeds and York Partnership Foundation Trust in the Vale of York area.

Specialist healthcare services are primarily provided by Leeds Teaching Hospitals for our local area. The population is also served by the Yorkshire Ambulance Service and a range of other public, private, voluntary and independent health care providers across the range of services as demonstrated in the table below.

Acute Providers	Mental Health Service Providers
York Teaching Hospital NHS Foundation Trust Yorkshire Ambulance Service NHS Trust Leeds Teaching Hospitals NHS Trust Hull and East Yorkshire Hospitals NHS Trust Harrogate and District NHS Foundation Trust Mid Yorkshire Hospitals NHS Trust South Tees Hospitals NHS Foundation Trust North Lincolnshire & Goole Hospitals NHS Trust Ramsay Healthcare UK – Clifton Park Hospital Nuffield Health - York Hospital Yorkshire Health Solutions (AQP) Sheffield Teaching Hospitals NHS Foundation Trust	Leeds and York Partnerships NHS Foundation Trust Humber NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust City Health Care Partnership (CIC)
Other Services	**Community Services**
Marie Curie Cancer Care Marie Stopes International British Pregnancy Advisory Service (BPAS) St Leonard's Hospice York St Catherine's Hospice Scarborough A range of local voluntary organisations	York Teaching Hospital NHS Foundation Trust York Teaching Hospital NHS Foundation Trust - MSK Harrogate and District NHS Foundation Trust Jorvik Podiatry Centre Humber NHS Foundation Trust

Table 2 CCG commissioning services

Examples in the North Yorkshire and Humber region of centralised services include major trauma, procedures relating to Primary Percutaneous Coronary Intervention and vascular interventions that are already commissioned through Specialist Commissioned Services.

2.3.4 Commissioning support

The CCG is supported by the North Yorkshire and Humber Commissioning Support Unit that provides a range of back office functions and clinical policy support to the CCG.

It also works in collaboration with neighbouring North Yorkshire CCGs and is supported by the Partnership Commissioning Unit in the commissioning of around Continuing Health Care, Mental Health and Learning Disabilities, Children's and Adult Safeguarding Services.

The CCG also commissioned Neurological Commissioning Support (NCS) to work with patients and other stakeholders to explore and co-produce new draft pathways for Motor Neurone Disease, Parkinson's, Multiple Sclerosis and Epilepsy. Prior to this work commencing, the CCG commissioned NCS to conduct a thorough audit of existing neurological services and request it to submit a findings report to the CCG.

2.4 The CCG's objectives

The Integrated Operational Plan 2013-14 set out the objectives for the CCG's first year. The Governing Body holds the CCG to account for delivery of the operational plan which is monitored on a regular basis by the Quality and Finance Committee (previously known as the Performance and Finance Committee).

In 2013-14, the CCG's objectives were underpinned by commitments within five core aims. These were to:

- improve health outcomes
- reduce health inequalities
- improve the quality and safety of commissioned services
- improve efficiency
- achieve financial balance

The actions in the 2013-14 Integrated Operational Plan were assigned to CCG departments to be incorporated into work plans and Quality, Improvement, Performance and Productivity (Quality, Improvement, Performance and Productivity) project plans.

Progress against Quality, Improvement, Performance and Productivity plans was monitored by the Quality and Performance Committee. This committee was superseded by the Performance and Finance Committee in December 2013. A mid-year review of progress was initiated in autumn 2013, with the findings being incorporated into the CCG's Governing Body workshop session in October 2013.

In response to the review, the CCG conducted a re-prioritisation of Quality, Improvement, Performance and Productivity schemes, revised the staffing capacity and identified key commissioning leads for priority programmes of work which would deliver the objectives within the plan.

Establishing clear leadership for each work programme, supported by a Clinical Lead and senior manager helped to deliver projects and progress plans and associated financial profiles in a monthly report to the Performance and Finance Committee (now

known as the Quality and Finance Committee). This information was also reported at regular intervals to the Governing Body.

The CCG aimed to ensure that services were not only sustainable, but enhanced and had a positive impact on people's lives. To address these challenges and respond to the community needs, the CCG set itself the following objectives for the next five years (2014-2019).

People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life.
People will have more opportunities to influence and choose the healthcare they receive and shape future services.
People will continue to have good access to safe and high quality healthcare services.
When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.
Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life.
When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.
A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.
High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.
A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.
Access to world class highly complex and specialist care provided through specialist centres across the country.
Opportunities for accessing and leading research to improve healthcare systems for all.

Table 3 The CCG's objectives for 2014-2019

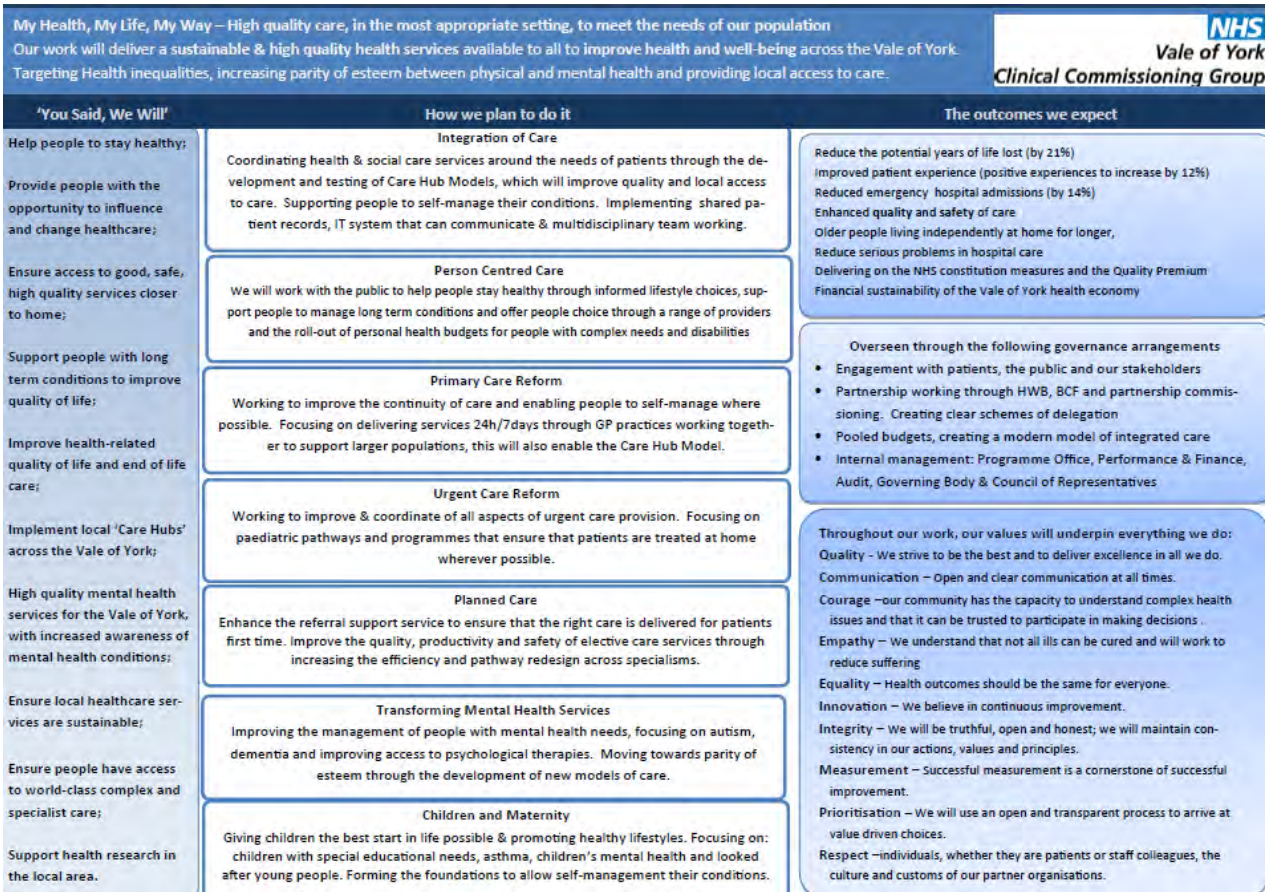
The CCG is committed to engage and involve the local community so they can have their say in the delivery of healthcare services. 'My Health, My Life, My Way' is giving local patients and members of the public their chance to shape future services that will deliver high quality care in the most appropriate setting, whilst it meets the needs of the local population.

In its work to deliver sustainable and high quality healthcare services to all, the CCG aims to improve health and wellbeing across the Vale of York area by:

- addressing health inequalities
- increasing parity of esteem between physical and mental health
- providing better access to health care services in a local setting.

The following table is an extract from the CCG's plan on a page and describes what the CCG aims to achieve, how it will do this and the monitoring processes that will take place to ensure successful outcomes.

Fig 6 The CCG's strategic plan on page



2.4.1 How we will know we are making a difference

To ensure that current services are sustainable, enhanced and have a positive impact on the community, the CCG has set itself the following ambitions for the next five years (2014-2019).

Table 4 Baselines and targets to measure the CCG's performance against its strategic plans

Ambition over the next five years	Baseline	Target
Reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 21%	1950.6	1545.8
Improve the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions to equal the best amongst our peers	76.73	77.95
Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.	1990.0	1712.9
Increase the proportion of older people living independently at home following discharge from hospital from a baseline of 76.7	76.7	
Increase the number of people with mental and physical health conditions having a positive experience of hospital care by 12%	123.8	108.6
Increase the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community by 12%	5.07	4.76
Make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	n/a	

2.4.2 Key Performance Indicators

The key performance indicators (KPIs) used by the CCG conform to the national definitions and standards set out by NHS England and the Health and Social Care Information Centre.

The CCG monitors its performance on a regular basis and provides reports to the Governing Body. The latest KPI report is available at: http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/3-april-2014/item-10-core-performance-dashboard.pdf

The full definitions and further context for these indicators are available in core documents produced by these organisations and are available at:

http://www.hscic.gov.uk/ccgois

http://www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

2.4.3 Monitoring

The strategic and associated operational plan was monitored on a monthly basis to assess the delivery against committed actions, performance and financial position. This ensured that any emerging risks were addressed in a timely manner and to avoid

slippage. For months 1 to 11, this process was led by the Performance and Finance Committee. In month 12 the committee name was changed to Quality and Finance Committee and will continue to be referred to the Quality and Finance Committee in 2014-15. Both reported to the Governing Body.

The Plan will be formally reviewed annually using both the financial and performance perspective, but also the 'you said, we did' framework and the results published to increase transparency for the public.

2.5 Development and performance of the CCG for the period under review and in the future

The CCG uses local Joint Strategic Needs Assessments; a range of performance information, quality outcomes, financial data and feedback from the local population, to understand the health needs and specific issues in the Vale of York. These are compared to other similar areas in the UK to help prioritise work and to drive improvements in health across the local area.

2.5.1 Successes and things working well

The CCG and local providers perform better than the national average on a range of services and outcomes. Compared to the average for England, the Vale of York community reports:

- a greater patient satisfaction with their GPs
- a higher quality of life for people with Long Term Conditions (LTC)
- that more people feel supported to manage their condition
- the health and wellbeing of children and young people is better than the England average.

Overall the Vale of York population is comparatively healthy, the CCG area scores significantly better than the England average on 18 out of the 32 national health indicators. None of the areas commissioned by the CCG perform significantly worse than the England average.

Compared to the England average, the particular areas of success for NHS Vale of York CCG show that there are:

- fewer emergency admissions for alcohol related liver disease
- fewer unplanned admissions for asthma, diabetes and epilepsy in under 19s
- fewer emergency re-admissions within 30 days.

Overall, performance is robust and stands up against the commitments in the NHS Constitution which include the national timescales for access to treatment and appropriate care.

The CCG has also seen significant organisational improvements in its first year of operation. Conditions and directives from authorisation were removed and the CCG anticipates a balanced budget after many years of deficit in the local area.

The CCG is leading a collaborative approach to service improvement and it has strong clinical engagement in all areas of work. It has grown its staffing capacity, including the number of apprenticeships for support staff and development opportunities for clinical staff.

2.5.2 Investing in services

The CCG has invested in a new Section 136 Health Based Place of Safety (HBPoS) with a full year effect of £440k and increased capacity within the Autism Assessment service, full year effect £88k. Both will be provided by Leeds and York Partnership Foundation Trust.

The lack of a HBPoS was a concern in North Yorkshire and York for a considerable length of time. The provision of a Section 136 suite was agreed to be a priority by the CCG, North Yorkshire Police, City of York Council, North Yorkshire County Council and local health service providers York Teaching Hospital Foundation Trust and Leeds and York Partnership Foundation Trust. In July 2013 the Governing Body agreed to commission a HBPoS as part of an overall crisis service from Leeds and York Partnership Foundation Trust and it was formally opened in February 2014.

The Autism Assessment investment recognised the lack of capacity within the existing service and the ability of Leeds and York Partnership Foundation Trust to deliver the service outcomes.

The ability to invest in 2013-14 was significantly reduced by the overall financial position. However, moving forward the CCG now has a stronger baseline and initial plans in place to invest in the following areas:

- £1.6m – Re-ablement
- £0.7m – Carers breaks
- £1.7m – Primary Care elderly funding
- £1.7m – Emergency admissions and re-admissions avoidance
- £2.2m – Better Care Fund preparatory schemes

These areas are made up of a number of individual schemes and the investments are fundamental to the financial sustainability of the organisation. Each will play a key role in managing the future demand for services, specifically moving activity out of an acute setting and into the community or primary care. Moreover, they will require the CCG to build on and maintain the strong partnerships it has developed between health and social care providers.

2.5.3 Areas for improvement

Despite the successes, there are some areas where we have lower outcomes than comparator and the national average. These areas are:

- higher mortality rate for those with cancer under 75 years of age
- worse patient reported outcome measures for groin hernia operations
- higher emergency admission for children with lower respiratory tract infections
- the Selby area scores significantly worse than the England average for adult obesity.
- higher than average spend on emergency admissions than comparators and national average
- higher than average growth in the number of emergency admissions than comparators and national average
- faster than average growth in the number of GP referrals to services than comparators and national average
- higher than average disease prevalence on Depression, Atrial Fibrillation, Dementia, Cancer, Hyperthyroidism, Stroke and Coronary Heart Failure
- top 20% of 55 Office of National Statistics comparators for spend on Circulation, Neurology.

The CCG recognises that there are areas where current performance against the NHS Constitution commitments could be improved, including:

- the prevalence of healthcare acquired infections (e.g. MRSA, C.Difficile)
- ambulance response and turnaround times
- accident and emergency waiting times
- access to mental health services

Services also create financial pressures. The cost of healthcare activity in-year can exceed the planned budget and the CCG needs to change this situation to ensure that services are sustainable.

2.6 Resources, principal risks and uncertainties and relationships that may effect the CCG's long term value

The CCG has two funding streams:

1. Programme Costs – a funding allocation based on a weighted capitation formula that takes into account population and demographics, deprivation levels and health needs and profile. This covers direct payments for the provision of healthcare or healthcare-related services.
2. Running Costs - money allocated to CCGs to pay for non-clinical management and administrative support, including commissioning support services.

2.6.1 Programme Costs

Allocation (£'000s) - £362,472 **Spend** (£'000s) - £360,416

An analysis of the Programme Cost expenditure is provided below.

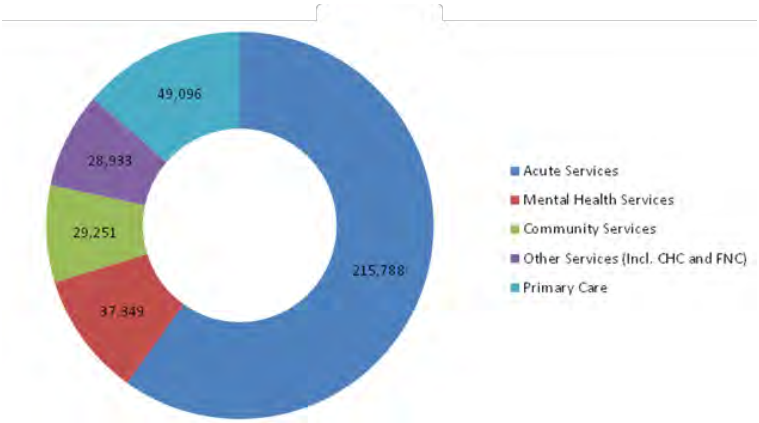


Fig 7 Analysis of the CCG's programme costs 2013-14

2.6.2 Running Costs

Allocation (£'000s) - £5,427 **Spend** (£'000s) - £5,427

An analysis of the Running Cost expenditure follows.

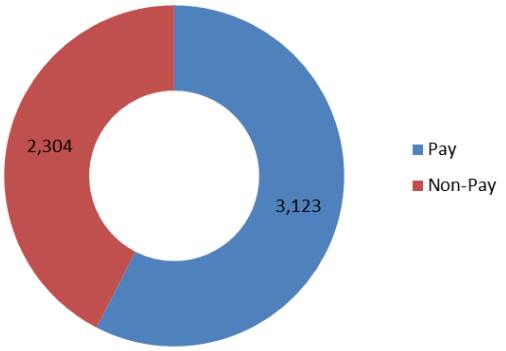


Fig 8 Analysis of the CCG's running costs 2013-14

The CCG agreed a series of Detailed Financial Policies in accordance with the Directions issued by the Secretary of State for Health under the provisions of the NHS Act 2006 as amended by the Health and Social Care Act 2012, with responsibilities set out under that and subsequent secondary legislation for the regulation of the conduct of the CCG in relation to all financial matters.

These policies detail the financial responsibilities, policies and procedures adopted by the CCG. They are designed to ensure that the CCG's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They are used in conjunction with the matters reserved to the Governing Body and the scheme of delegation.

2.7 Position of the business (including descriptions of capital structure, treasury policies and objectives and liquidity)

2.7.1 Financial Position

The CCG began the year planning for the national 1% surplus target, £3.6m, but it became clear that the challenging financial environment would make this difficult to achieve whilst maintaining the quality of services. The target was subsequently amended and the CCG delivered a revised surplus of £2.1m (0.57%).

A large part of the financial challenge was the CCG's share of the debt inherited from the legacy North Yorkshire & York PCT, £3.5m, which had to be paid back in full in 2013-14. The CCG has therefore relied upon a series of non-recurrent measures to off-set this, including two transfers of resources from Running Costs the first in June at £1.7m and the second in March at £1.2m.

2.7.2 Progress against agreed targets

The CCG uses a range of measures to assess financial performance during the year including those duties reported upon in the Annual Accounts. These duties fall into one of two categories, statutory or administrative. Whilst the organisation aims to achieve all targets it is the former that is of most concern, as the CCG should operate within its legal framework.

As the following table shows the CCG delivered on most of the statutory targets and; where this was not the case, had a strong performance.

Target	Category	Delivery	Plan	Actual
Revenue - Break-Even is achieved (£'000s)	Statutory		£362,472	£360,416
Revenue - 1% planned Surplus is achieved	Statutory		1%	0.57%
Quality, Improvement, Performance and Productivity - Savings delivered in line with plan (£'000s)	Administrative		£10,870	£4,673
Cash - Must be less than Maximum Cash Drawdown (£'000s)	Statutory		£353,939	£353,939
Cash - 95% of NHS Invoices by Value are Paid within 30 Days	Statutory		95%	99.6%
Cash - 95% of NHS Invoices by Number are Paid within 30 Days	Statutory		95%	94.6%
Cash - 95% of Non NHS Invoices by Value are Paid within 30 Days	Statutory		95%	97.2%
Cash - 95% of Non NHS Invoices by Number are Paid within 30 Days	Statutory		95%	91.3%
Cash - Period End Cash Balances are within 0.125% of Drawdown or < £250k	Statutory		<£250k	£38k

Table 5 Progress against agreed targets

The CCG aims to build on this position and is putting plans in place for 2014-15 to deliver these targets in full together with the following business rules as published in the planning guidance:

- Surplus 1% = £3.7m
- Contingency 0.5% = £1.8m
- NEL Threshold £3.8m
- Re-admissions £1.0m
- Non-Recurrent resources 2.5% = £9.2m

Excluding the effect of all non-recurrent elements in this year's position, the CCG has a significantly stronger financial position than at the start of 2013-14 with an underlying recurrent surplus of £2.0m moving into the new year. However, there are a number of factors that are likely to affect the financial position going forward.

2.7.3 Risks

2.7.3.1 Acute Services - Specialised commissioning

Issues relating to the correct distribution of resource relating to specialised services have continued through 2013-14. A complete re-base exercise has been agreed, but there remains a risk of a further recurrent allocation adjustment from the CCG.

2.7.3.2 Acute Services - Contract overtrade

The CCG has made a number of growth and activity assumptions that it considers reasonable, but there is a risk that activity exceeds this or issues arise in year that have not been planned for.

2.7.3.3 Acute Services - Difference in contract baselines with York Teaching Hospital Foundation Trust

The plan submitted included the CCG's proposed contractual position with the Trust in terms of growth, price and efficiency assumptions and was approved by the Governing Body. However, there exists a significant risk in this position as the Trust baseline offer is considerably greater and contracts have not yet been signed for 2014-15 as at the time of writing. It is envisaged that contracts will be agreed by the beginning of June 2014.

2.7.3.4 Prescribing - Prescribing overspend

Growth, pressure, NICE and price assumptions have been made in line with national and local Medicines Management advice but the risk remains of overspend due to actual prescribing being in excess of this or unforeseen pressures arising in year.

2.7.3.5 Quality, Improvement, Performance and Productivity – Under-delivery of schemes

Quality, Improvement, Performance and Productivity schemes are at differing stages of development and while some are well advanced and the risk to delivery is low, others are still being developed and there remains an element of unidentified Quality, Improvement, Performance and Productivity in the plan at this stage.

2.7.3.6 Continuing Care - Retrospective cases payments greater than risk pool

A risk pool has been created nationally through a top-slice of funding included in CCG allocations which is deemed sufficient to deal with payment of retrospective cases in 2014-15. The CCG, through the Partnership Commissioning Unit, has agreed a contract to undertake the assessment and payment of these cases during 2014-15 which accelerates the process for patients, families and carers. There is a risk that if the risk pool nationally is insufficient that CCGs will be asked to contribute further.

2.7.3.7 Mental Health - Costs in 2015-16 and beyond

The current contract with the main provider of mental health services has currently been extended to September 2015 so there remains a degree of uncertainty as to the costs of the service after that point depending on the procurement route undertaken.

2.7.3.8 Better Care Fund - Savings and outcomes not delivered as planned

The CCG will contribute to three funds across three local authority areas. The vision is clearly articulated and stakeholders are agreed but there remains significant risk that the savings and outcomes required are not realised. Investment will have been made in BCF schemes but activity continues to flow to current providers creating significant financial risk.

2.8 Annual Accounts

2.8.1 Preparation of the Annual Accounts

The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

2.8.2 Accounting Policies

The CCG prepares the accounts under International Financial Reporting Standards (IFRS) and in line with the HM Treasury Financial Reporting Manual, NHS England Annual Reporting Guidance and approved accounting policies. Additional detail in relation to provisions, critical judgements and sources of estimation uncertainty has been added as these are the ones where management has made specific decisions in applying the CCG's accounting policies that has had the most significant effect on the amounts recognised in the financial statements.

The Accounting Policies are set out in full in Note 1 to the Financial Statements.

2.8.3 Financing Transactions

There have been no major financing transactions undertaken by the CCG.

2.8.4 Cash

The CCG delivered against all of its cash targets in 2013-14 and plans to do so again in 2014-15.

The only special factor that has influenced cash flows in this financial year is with regards to the Payment by Results rules for maternity pathways that changed for 2013-14 whereby commissioners should make one payment per pregnancy for all antenatal care included in the scope. From the CCG's perspective therefore, this is a contractual payment in line with the terms of the pathway. It is considered that the benefit that is accruing to the CCG through its commissioning is the patient receiving 'treatment'.

Where this benefit accrues to the commissioner over the year end it is expected that the commissioner will reflect the economic substance of the transaction as a prepayment in

its accounts. This reflects the principles of International Accounting Standards (IAS) 18 that apply more directly to the income for the provider.

The value of this prepayment reflects the deferred income recorded in the York Teaching Hospital Foundation Trust accounts, who took the lead in providing an estimate of the 'work-in-progress' at the year end. This formed part of the accruals statement for agreement of balances.

2.9 Managing risk

The Governing Body has a duty to assure itself that the CCG has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact that they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- identifies risks to the achievement of its strategic objectives
- monitors these via the Assurance Framework
- ensures that there is a structure in place for the effective management of risk throughout the CCG
- approves and reviews strategies for risk management on an annual basis
- receives regular reports from the Quality and Finance Committee that identifies significant clinical risks
- receives regular updates and reports from the Management Team identifying significant risks and progress on mitigating actions
- demonstrates leadership, active involvement and support for risk management.

Management of the CCG's Risk Assurance Framework is critical to risk control and avoidance.

2.10 Better Payments Practice Code

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

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements.

Table 6 Better Payment Practice Code Summary Statements

NON-NHS						
NHS Vale of York CCG						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-13	51	51	100.00	985,004.11	985,004.11	100.00
May-13	134	130	97.01	1,070,938.59	1,059,594.12	98.94
Jun-13	183	161	87.98	2,068,827.98	2,014,689.84	97.38
Jul-13	199	175	87.94	2,184,748.40	2,099,333.95	96.09
Aug-13	353	297	84.14	2,339,380.37	2,172,621.20	92.87
Sep-13	182	161	88.46	1,099,704.39	1,004,410.15	91.33
Oct-13	360	323	89.72	2,664,110.57	2,622,927.86	98.45
Nov-13	298	265	88.93	2,447,241.22	2,382,550.48	97.36
Dec-13	281	258	91.81	2,097,461.00	2,016,198.00	96.13
Jan-14	311	299	96.14	2,092,479.85	2,062,408.10	98.56
Feb-14	246	238	96.75	1,891,508.68	1,887,069.21	99.77
Mar-14	296	284	95.95	2,942,043.85	2,903,535.02	98.69
	2894	**2642**	**91.29**	**23,883,449.01**	**23,210,342.04**	**97.18**
NHS						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-13	12	12	100.00	20,107,496.76	20,107,496.76	100.00
May-13	18	14	77.78	21,107,430.42	20,993,947.42	99.46
Jun-13	35	29	82.86	22,007,191.82	21,940,574.82	99.70
Jul-13	182	175	96.15	23,120,732.40	23,069,669.97	99.78
Aug-13	326	312	95.71	16,010,782.13	15,877,054.77	99.16
Sep-13	249	232	93.17	25,393,252.27	25,291,675.87	99.60
Oct-13	204	188	92.16	21,798,549.36	21,734,826.74	99.71
Nov-13	165	158	95.76	24,686,327.80	24,640,927.87	99.82
Dec-13	307	283	92.18	26,999,227.00	26,552,973.00	98.35
Jan-14	296	277	93.58	26,000,534.15	25,951,795.67	99.81
Feb-14	278	273	98.20	25,523,662.10	25,504,894.59	99.93
Mar-14	274	267	97.45	28,560,185.02	28,514,005.91	99.84
	2346	**2220**	**94.63**	**281,315,371.23**	**280,179,843.39**	**99.60**

2.11 Prompt Payment Code (PPC)

The CCG applied to sign up to the Code of Practice as soon as it became aware of the requirement to do so (1st April 2014) and it can report that its application was confirmed to be successful on the 8th May 2014.

The CCG had not signed up to the Code of Practice earlier as it was unaware of the formal process for signing up to the code until guidance was received from NHS England.

This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute. Approved signatories undertake to:

- pay suppliers on time
- give clear guidance to suppliers and resolve disputes as quickly as possible
- encourage suppliers and customers to sign up to the code.

2.12 Sustainability Report

The CCG is committed to shaping a more sustainable NHS by:

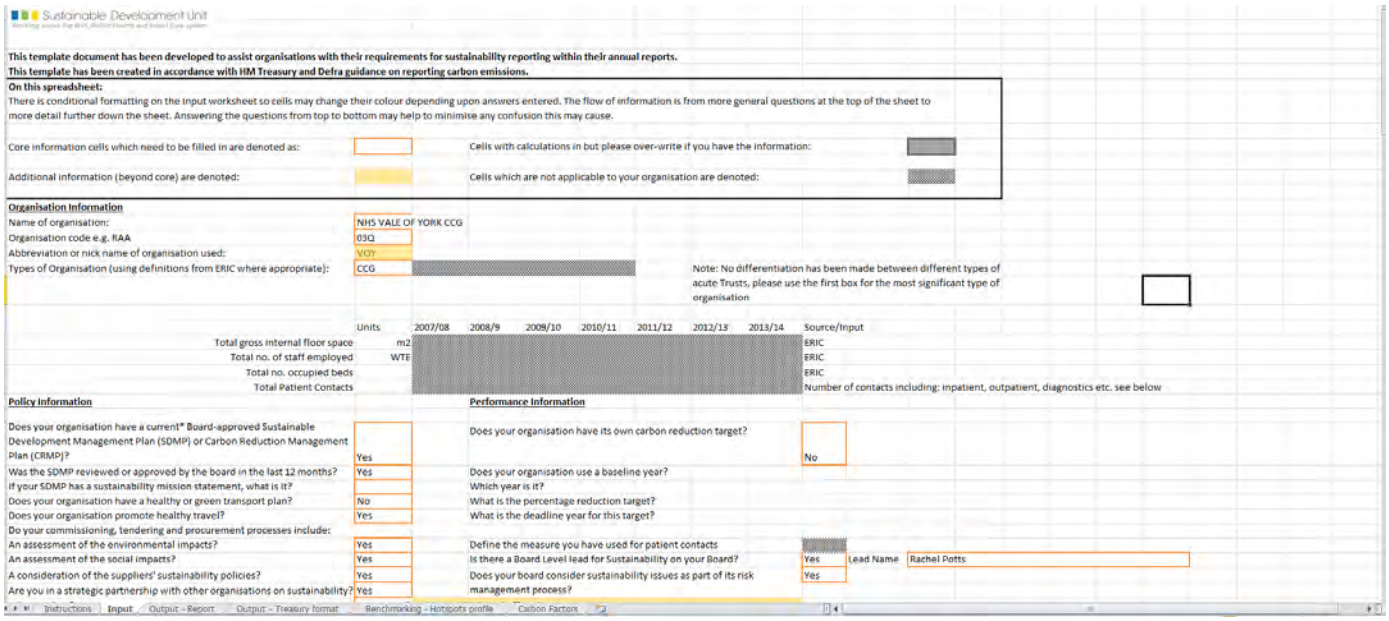
- developing a whole systems approach to commissioning;
- understanding its role in improving the sustainability of healthcare;
- using the commissioning cycle to increase sustainability and to implement the NHS Carbon Reduction Strategy.

The CCG is developing plans to assess risks, enhance performance and reduce impact through carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

2.12.1 Sustainability Strategy and Sustainable Development Management Plan

The CCG has committed to a Sustainable Development Management Plan (SDMP) that addresses the financial, environmental and social sustainability of the health care services it commissions.

The CCG continues to ensure that every policy and service improvement initiative is reviewed from a sustainability perspective at committee and Governing Body levels.


Sustainable Development Unit

This template document has been developed to assist organisations with their requirements for sustainability reporting within their annual reports.
This template has been created in accordance with HM Treasury and Defra guidance on reporting carbon emissions.

On this spreadsheet:
There is conditional formatting on the input worksheet so cells may change their colour depending upon answers entered. The flow of information is from more general questions at the top of the sheet to more detail further down the sheet. Answering the questions from top to bottom may help to minimise any confusion this may cause.

Core information cells which need to be filled in are denoted as:
Cells with calculations in but please over-write if you have the information:
Additional information (beyond core) are denoted:
Cells which are not applicable to your organisation are denoted:

Organisation Information

Name of organisation:	NHS VALE OF YORK CCG
Organisation code e.g. RAA	03Q
Abbreviation or nick name of organisation used:	VOY
Types of Organisation (using definitions from ERIC where appropriate):	CCG

Note: No differentiation has been made between different types of acute Trusts, please use the first box for the most significant type of organisation

	Units	2007/08	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	Source/Input
Total gross internal floor space	m2								ERIC
Total no. of staff employed	WTE								ERIC
Total no. occupied beds									ERIC
Total Patient Contacts									Number of contacts including: inpatient, outpatient, diagnostics etc. see below

Policy information

Does your organisation have a current* Board-approved Sustainable Development Management Plan (SDMP) or Carbon Reduction Management Plan (CRMP)?	Yes	Does your organisation have its own carbon reduction target?	No
Was the SDMP reviewed or approved by the board in the last 12 months?	Yes	Does your organisation use a baseline year?	
If your SDMP has a sustainability mission statement, what is it?		Which year is it?	
Does your organisation have a healthy or green transport plan?	No	What is the percentage reduction target?	
Does your organisation promote healthy travel?	Yes	What is the deadline year for this target?	
Do your commissioning, tendering and procurement processes include:			
An assessment of the environmental impacts?	Yes	Define the measure you have used for patient contacts	
An assessment of the social impacts?	Yes	Is there a Board Level lead for Sustainability on your Board?	Yes Lead Name: Rachel Potts
A consideration of the suppliers' sustainability policies?	Yes	Does your board consider sustainability issues as part of its risk management process?	Yes
Are you in a strategic partnership with other organisations on sustainability?	Yes		

Instructions | Input | Output - Report | Output - Treasury format | Benchmarking - Hotspots profile | Carbon Factors

Fig 9 An extract from the CCG's Sustainable Development Management Plan (SDMP)

The Governing Body's approval of the CCG's SDMP has ensured that the plans for a sustainable future are well known within the organisation and are clearly laid out.

In addition, the CCG has developed and implemented a Sustainability Impact Assessment (SIA) tool and guidance for its staff. This helps the team to identify the likely sustainability implications of either:

- the introduction of a new policy, project, or function or,
- the implementation of an existing policy, project, or function within the organisation.

Once sustainability implications are been identified, it is possible to initiate steps to amend proposed policies, projects or functions, or to amend how they are implemented ensuring they are inclusive and do not discriminate, either knowingly or inadvertently.

2.12.2 Sustainability Objectives

The CCG reviews its sustainability objectives annually and monitors progress through the Good Corporate Citizen Assessment Framework.

Domain	Actions
Governance	Embed sustainability within the CCG's policies and procedures and reinforcement of Board level commitment and responsibility. Raise awareness of sustainability across the workforce. Work in partnership with local groups (e.g. Health and Wellbeing Boards, Local Strategic Partnership) to support sustainable development and better prepare and adapt to the predicted effects of a future changing climate. Complete the Good Corporate Citizenship Self-Assessment Tool to set a baseline and identify opportunities for improvement. Review the plan on an annual basis and report on sustainability in the CCG Annual Report.
Travel	Identify opportunities to reduce car usage by staff and patients: encouraging active travel; promoting low carbon models of care; encouraging the use of remote communication in place of face to face meetings and encouraging home working.
Procurement	Commission health services which are environmentally, socially and economically sustainable. Through the contracting processes ensure that the providers of services commissioned by the CCG are complying with national and local requirements on sustainability, including carbon reduction.
Facilities Management	Minimising impacts on the environment (reduce energy and water demand, minimise waste) and supporting the local community and economy.
Workforce	Respond to local employment conditions and needs and proactively building a skilled local workforce, promoting the health and wellbeing of employees through our HR policies.
Community Engagement	Understanding the local community and involving its members in decision making and scrutiny, the planning and delivery of healthcare and supporting a strong and sustainable local economy. Identify innovative solutions from engagement.
Buildings	Consider all relevant sustainability issues in the design and operation of new or refurbished buildings to reduce waste, energy and resource use e.g. promoting active travel, expanding green and natural spaces.
Adaptation	Contribute to the development of strategic multi-agency plans for responding to emergencies in partnership with the Local Health Resilience Partnership (LHRP).
Models of Care	Collaborate with cross sector partners to prevent illness, promote health and develop sustainable joint service plans. Tailor healthcare so it is closer to home. Work with cross sector partners and individuals to reduce inequalities.

Table 7 Review of the CCG's sustainability objectives

2.12.3 The CCG's location

The CCG is based within the City of York Council headquarters at: West Offices, Station Rise, York YO1 6GA. The CCG has been based within this building throughout 2013-14 and occupies the equivalent space of 36 desks within a section of the three storey building of open plan office space.

In 2013-14 it has not been possible to apportion the emissions data for the building to the CCG's specific usage; however the building has been designed as a sustainable building that harvests rainwater, houses solar panels, uses bio fuels for heating and has natural daylight and ventilation.

The building has been awarded an energy performance certificate rating of B and an 'Excellent' building industry standard rating. Information about the West Offices site is available at:
http://www.york.gov.uk/info/200564/west_offices_building/168/west_offices_building

2.13 Equality Report

2.13.1 Promoting Equality

In in first year, the CCG was proud to introduce its first Equality, Diversity and Human Rights Strategy and Implementation Plan for 2013 - 2017. The strategy highlights and supports the CCG's guarantee to promote equality throughout the planning and development of service commissioning; whilst appreciating and respecting the diversity of the local community and CCG staff.

As a commissioner of health services in the area, the strategy supports the CCG's commitment to give everyone in the community the opportunity to be heard and give their opinions about local healthcare services. It also helps the CCG to continue to have open, honest and two-way conversations – at times and in ways that are appropriate for stakeholders.

To achieve this, the CCG works with other health care providers and contractors to ensure that valuing diversity and promoting fair access to services are core elements of care and that full consideration is given to all equalities issues when planning or redesigning services and assessing the health needs of the local population. In partnership with local communities and other local organisations in the health and social care sector, the CCG aims to reduce inequalities in health.

In line with the requirements of the Public Sector Equality Duty, the CCG published its draft plan and objectives in October 2013. Then, over a three month period it asked the community to comment on the draft document. After the consultation period the CCG published its final strategy.

2.13.2 Equality Objectives

The CCG's equality objectives are to:

- provide accessible and appropriate information to meet a wide range of communication styles and needs
- improve the reporting and use of equality data to inform equality analyses
- strengthen stakeholder engagement and partnership working
- be a great employer with a diverse, engaged and well supported workforce
- ensure leadership is inclusive and effective at promoting equality.

To achieve these, the CCG has put in place a number of key delivery actions in its Equality and Diversity Implementation Plan. Further information is available at: http://www.valeofyorkccg.nhs.uk/about-us/equality/

As an employer, the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. It actively works to remove any discriminatory practices, eliminates all forms of harassment and promotes equality of opportunity in all recruitment, training, performance management and development practices.

The CCG's Equal Opportunities Policy can be accessed at: http://www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/equaloppvers2-000.pdf

2.13.3 Supporting policies and processes

Policies and processes in place to support the CCG's equality objectives include:

- Managing Performance
- Disciplinary procedures / Conduct
- Grievance
- Staff Induction
- Bullying and Harassment
- Flexible working
- NHS Code of Conduct for Managers
- Job descriptions (including statements of equality and diversity expectations)
- Health policies
- Annual appraisals with staff
- Employment equality monitoring forms

The CCG actively encourages people with disabilities to apply for advertised positions. Applicants applying for roles within the CCG whilst declaring a disability will be eligible for a guaranteed interview. This is based upon meeting minimum criteria within the person specification of individual vacancies.

In its support to staff, the CCG offers Occupational Health Support and workplace adjustments to help them in the role in which they are employed. All policies and procedures that are developed for the CCG include advice on how to obtain the policies in different formats, e.g. in Braille.

The CCG provides mandatory Equality and Diversity training on a regular basis. As of the 31 March 2014 the completion rate for Equality and Diversity training was at 66%. Mandatory Equality and Diversity training is in addition to bespoke Equality Impact Analysis Training and an Equality Delivery System workshop which were delivered in September 2013. Enhanced training is also available and delivered as appropriate to individual staff roles.

For more information, and to read the CCG's full year end Equality Report, go to: http://www.valeofyorkccg.nhs.uk/about-us/equality/

2.13.4 Gender breakdown at the end of the financial year

The CCG can report the gender breakdown of its staff and partner colleagues in 2013-14 as:

CCG function	Male	Female
Council of Representatives	24	8
Governing Body (including Very Senior Managers)	13	5
Employees of the CCG	32	44

Table 8 Gender breakdown by CCG function

2.14 Environmental, Social and Community Issues

The CCG's commitment to sustainability is embedded in its strategic planning. Each Governing Body and committee paper requires a sustainability statement that refers to the items within the paper to enable scrutiny at each decision point.

Through this work, we will ensure the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

Sustainability is particularly embedded within the following business processes and procedures:

Area	Is sustainability covered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

Table 9 The CCG's sustainable processes and procedures

Dr Mark Hayes - Accountable Officer
2nd June 2014

3. Members' Report

3.1 Preparation of the Members' Report

The Members' Report has been prepared by the Governing Body.

3.2 Details of Member Practices

The list below provides the detail of the CCG's member practices in the Vale of York area. More detail about each practice can be found by clicking on the links to practice websites.

Table 10 NHS Vale of York CCG's member practices

GP Practice	Website
Beech Grove Medical Practice	www.beechgrovemedicalpractice.co.uk
Beech Tree Surgery	www.beechtreesurgery.co.uk
Clifton Medical Practice	www.cliftonhealthcentre.co.uk
Dalton Terrace Surgery	www.daltonterracesurgery.nhs.uk
East Parade Surgery	www.eastparademedical.co.uk
Elvington Medical Practice	http://elvingtonmedicalpractice.co.uk/wordpress
Escrick Surgery	www.escricksurgeryyork.co.uk
Front Street Surgery	www.frontstreet.gpsurgery.net
Gale Farm Surgery	www.galefarm-oldforgesurgery.nhs.uk
Gillygate Surgery	www.gillygatesurgery.co.uk
Haxby Group Practice	www.haxbygroup.co.uk
Helmsley Surgery	www.helmsleymedicalcentre.co.uk
Jorvik Medical Practice	www.jorvikmedicalpractice.co.uk
Kirkbymoorside Surgery	www.thekirkbymoorsidesurgery.nhs.uk
Millfield Surgery	www.millfieldsurgery.co.uk
Minster Health	http://minsterhealth.co.uk
MyHealth	www.myhealthgroup.co.uk
Old School Medical Practice	www.oldschoolmedical.gpsurgery.net
Petergate Surgery	www.petergatesurgery.co.uk
Pickering Medical Practice	www.pickeringmedicalpractice.co.uk
Pocklington Group Practice	www.pocklingtongps.nhs.uk
Posterngate Surgery	www.posterngatesurgery.nhs.uk
Priory Medical Group	www.priorymedical.com
Scott Road Medical Centre	www.scottroad.org.uk
Sherburn Group Practice	www.sherburnsurgery.nhs.uk
South Milford Surgery	www.southmilfordsurgery.co.uk
Stillington Surgery	stillingtonsurgery.co.uk
Tadcaster Medical Centre	www.tadcastermedicalcentre.co.uk
Terrington Surgery	http://terringtonsurgery.wordpress.com/
The Surgery at 32 Clifton	www.thesurgery32clifton.co.uk
Tollerton Surgery	www.tollertonsurgery.co.uk
Unity Health	www.unityhealth.info
York Medical Group	www.yorkmedicalgroup.nhs.uk

3.3 Names of NHS Vale of York Clinical Commissioning Group Chair and Accountable Officer

3.3.1 The NHS Vale of York Clinical Commissioning Group's Chairmanship

The Lay Chair for NHS Vale of York Clinical Commissioning Group is Professor Alan Maynard. Professor Maynard has held this position throughout 2013-14 and up until and including the date of signing the Annual Report and Accounts.

3.3.2 The NHS Vale of York Clinical Commissioning Group's Accountable Officer

The Accountable Officer is Dr Mark Hayes, the Chief Clinical Officer for NHS Vale of York Clinical Commissioning Group. Dr Hayes has held this position throughout 2013-14 and up until and including the date of signing the Annual Report and Accounts.

3.4 Details of Members of the Membership Body and the Governing Body

3.4.1 Composition of the Membership Body (Council of Representatives)

The Council of Representatives met on six occasions in 2013-14. The membership during this time is provided below along with the attendances per member.

Key: Y = attended, A = apologies, N = neither attended nor sent apologies, PM = Practice Manager represented the practice.

Table 11 Composition of the Council of Representatives (2013-14) and attendances per member

Practice	18 April 2013	16 May 2013	20 June 2013	18 July 2013	10 Oct 2013	23 Jan 2014
Beech Grove Medical Practice	Y	A	N	N	Y	Y
Beech Tree Surgery	Y	A	N	PM	A	N
Clifton Medical Practice	Y	A	N	Y	N	PM
The Surgery at 32 Clifton	Y	Y	A	Y	Y	N
Dalton Terrace Surgery	Y	Y	A	Y	Y	Y
East Parade Medical Practice	A	A	N	N	N	N
Elvington Medical Practice	Y	Y	N	N	N	Y
Escrick Surgery	Y	A	N	N	N	N
Front Street Surgery	Y	Y	Y	Y	Y	Y
Gale Farm Surgery	Y	Y	Y	N	Y	Y
Gillygate Surgery	Y	Y	Y	A	Y	A
Haxby Group Practice	Y	A and PM	Y	Y	Y	Y
Helmsley Surgery	Y	A	N	N	N	N
Jorvik Medical Practice	Y	Y	Y	Y	Y	N
Kirbymoorside Surgery	Y	Y	Y	Y	Y	Y
Millfield Surgery	Y	Y	Y	N	Y	Y
Minster Health Practice	Y	Y	Y	N	Y	Y
MyHealth	Y	Y	Y	N	Y	Y
Old School Medical Practice	Y	Y	Y	Y	Y	Y
Petergate Surgery	PM	Y	PM	PM	PM	PM
Pickering Medical Practice	Y	Y	A	Y	A	A
Pocklington Group Practice	Y	Y	Y	Y	N	Y
Posterngate Surgery	Y	A	N	Y	Y	Y
Priory Medical Group	Y	Y	Y	Y	Y	Y
Scott Road Medical Centre	Y	Y	Y	N	Y	Y
Sherburn Practice	Y	Y	Y	Y	Y	Y
South Milford Surgery	Y	Y	Y	Y	Y	Y
Stillington Surgery	Y	A	Y	Y	Y	Y
Tadcaster Medical Centre	Y	Y	Y	N	Y	Y
Terrington Surgery	*As Helmsley Surgery*					
Tollerton Surgery	Y	A	N	N	N	A
Unity Health	Y and PM	Y	Y	Y	Y	Y
Whitby Drive Medical Centre (to 30 September)	Y	Y	N	A		
York Medical Group	Y	Y	Y	Y	A	N

3.4.2 Composition of the Clinical Commissioning Group's Governing Body

The Governing Body met on 10 occasions in 2013-14. The membership during this time is provided below along with the attendances per member for its public meetings.

Governing Body Member	Governing Body Role	Attendance
Professor Alan Maynard	CCG Lay Chair of the Governing Body	10/10
Dr Louise Barker from 3 February 2014	GP Member	0/1
Mrs Wendy Barker from 15 July 2013 to 12 January 2014	Acting Executive Nurse	5/5
Miss Lucy Botting from 13 January 2014	Chief Nurse	1/1
Dr Emma Broughton	GP Member	8/10
Dr Chris Burgin from 4 November 2013	GP Member	0/3
Dr David Hartley from 16 May to 2 August 2013	Council of Representatives Member	2/3
Dr Mark Hayes	Chief Clinical Officer	8/10
Mr Kevin Howells from 1 July to 31 October 2013	Interim Chief Finance Officer	4/4
Dr Tim Hughes	GP Member to 31 May 2013 Council of Representatives Member from 16 May 2013	1/2
Dr Jonathan Lloyd from 6 March 2013	Council of Representatives Member	1/1
Dr Tim Maycock	GP Member	8/10
Mr John McEvoy from 4 July 2013	Practice Manager Member and Chair of Quality and Finance Committee	6/7
Dr Shaun O'Connell	GP Member	7/10
Dr Andrew Phillips	GP Member	7/10
Dr Guy Porter	Consultant Radiologist, Airedale Hospital NHS Foundation Trust Secondary Care Doctor member	9/10
Mrs Rachel Potts	Chief Operating Officer	7/10
Mrs Tracey Preece from 4 November 2013	Chief Finance Officer	3/3
Mr Keith Ramsay	Lay Member and Audit Committee Chair	7/10
Dr Cath Snape to 30 September 2013	GP Member	4/6
Mr Adrian Snarr to 30 June 2013	Chief Finance Officer	3/3
Dr Phil Underwood from 17 May to 7 November 2013	Council of Representatives Member	3/6
Mrs Caroline Wollerton to 15 July 2013	Executive Nurse	3/4

Co-opted Members	Governing Body Role	Attendance
Dr Paul Edmondson-Jones	Director of Public Health and Well-being, City of York Council	7/10
Ms Kersten England to 30 November 2013	Chief Executive, City of York Council	2/8
Dr Brian McGregor	Local Medical Committee Liaison Officer, Selby and York	4/10
Ms Helen Taylor to 30 November 2013	Corporate Director, Health and Adult Services, North Yorkshire County Council	3/8
Mr Richard Webb from 3 March 2013	Corporate Director, Health and Adult Services, North Yorkshire County Council	1/1

Table 12 Composition of the Governing Body (2013-14) and attendances per member at its public meetings.

3.4.3 Names of the Members of the Clinical Commissioning Group's Audit Committee

The Audit Committee is chaired by Keith Ramsay who is also a Lay Member of the CCG's Governing Body and has a lead role in governance. The other members are John McEvoy who is also a Practice Manager Member of the Governing Body and Chair of the Quality and Finance Committee and Dr Guy Porter, Consultant Radiologist from Airedale Hospital NHS Foundation Trust who is the Secondary Care Doctor Member of the Governing Body.

Keith Ramsay and Dr Guy Porter held positions on the Audit Committee throughout 2013-14 and up until and including the date of signing the Annual Report and Accounts. John McEvoy became a member of the Audit Committee in July 2013.

3.4.4 Details of Members of other Committees and Sub-Committees

Details of members of other committees and sub-committees are available in section 6.5.5 of the Governance Statement.

3.4.5 Relevant disclosures

Relevant disclosures of the Governing Body, Membership Body (Council of Representatives) and Senior Management Team members (not Governing Body members) are available in 4.15 of the Remuneration Report.

3.5 Other relevant disclosures

3.5.1 Political or charitable donations

The CCG has not made any political or charitable donations during the 2013-14 financial year.

3.5.2 Important events since the end of the 2013-14 financial year that affect the Clinical Commissioning Group

There have been no important events affecting the CCG since the end of the financial year.

3.5.3 Future developments at the Clinical Commissioning Group

Aside from the information provided in section 2.4.3, the CCG is not aware of any other developments.

3.5.4 Significant activities in the field of research and development

There have been no significant activities in the field of research and development. The CCG continues to support research and development, in particular funding NHS Treatment Costs as per the requirements set out under the guidance 'Attributing the cost of health and social care Research & Development (AcoRD)'.

3.5.5 Existence of branches outside the UK

The CCG does not have branches outside the UK.

3.6 Pension Liabilities

For Pension Liability information please refer to the CCG's Accounting Policy 1.9.2 and note 4.5 to the Annual Accounts.

3.7 Sickness and Absence Data

The CCG sets out it commitments as an Employer within its Constitution and has adopted a full range of HR policies during the past 12 months. The Absence Management Policy has been adopted and implemented by the CCG, which sets out the required process for managers to follow in the case of staff sickness.

The CCG is committed to supporting all of its employees. The Health and Safety Assessment and action plan for 2013-14 includes actions to manage stress and reduce ill-health. Performance management arrangements, including objective setting, appraisal

and personal development processes and staff team meetings are in place and staffing issues are a standing item on the Management Team agenda.

The CCG promote the wellbeing of staff through a series of office protocols, the implementation of flexible working and access to occupational health and staff support services.

The CCG's 2013-14 sickness absence level for directly employed staff is 0.24%. Staff sickness reporting was implemented from June 2013 following a re-allocation of team roles and the development of the 'Business Support Manager' function.

Guidance and forms were circulated to all managers and sickness submissions are managed through the Business Support Manager. The CCG recognises that for 2013-14 the levels of staff sickness may be under-reported due to the delay in Quarter 1 reporting.

Details of the total staff days lost due to sickness are included within Note 4.3 of the Financial Statements.

3.8 External Audit

The CCG's external auditor is Mazars. It was appointed by the Audit Commission. Auditors' and remuneration to Mazars for April 2013 to March 2014 totalled £97,600 (including VAT). This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and work to examine the CCG's use of resources and financial aspects of corporate governance).

The external auditor is required to comply with the Audit Commission's requirement in respect of independence and objectivity and with International Auditing Standard (UK & Ireland) 260: 'The auditor's communication with those charged with governance'.

The CCG's Audit Committee receives the external auditor's Annual Audit Letter and other external audit reports.

3.9 Disclosure of Serious Unavoidable Incidents

The CCG has implemented systems to ensure that information security or data protection incidents are reported via the CCG's incident reporting system. This is hosted by the North Yorkshire and Humber Commissioning Support Unit.

The established procedure requires that incidents logged through the CCG's incident reporting system are reviewed and investigated by the Commissioning Support Unit Information Governance Team. Serious incidents are notified to the CCG's Senior Information Risk Owner (SIRO) and Caldicott Guardian where applicable and reported

appropriately, including a report to the Audit Committee. Risks arising through the investigation are logged in the CCG's risk registers, along with a note of actions to be taken to minimise the chances of occurrence and reduce impact.

The CCG has experienced one minor information breach during the year. The assessed level of incident breach, measured by the North Yorkshire and Humber Information Governance Team was at Level 1 and as such did not require reporting to the Information Commissioner's Office (ICO). A summary of information incidents, as required by Annual Accounts reporting guidance is provided below.

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	0

Table 13 Summary of other personal data related incidents

In 2013-14 the CCG had no Serious Unavoidable Incidents relating to data security breaches, including any that were reported to the Information Commissioner.

3.10 Cost allocation and setting of charges for information

3.10.1 Clinical Commissioning Group Certification

The CCG certifies that it has complied with HM Treasury guidance on cost allocation and the setting of charges for information.

3.11 Principles for Remedy

The CCG endeavours to comply with the Parliamentary and Health Service Ombudsman's Principles for Remedy when considering complaints. The CCG works to meet the six principles as follows:

1. Getting it right – The CCG aims to acknowledge and put right cases of maladministration and poor service that have led to injustice and hardship by considering all the relevant factors, ensuring fairness to the complainant and any others who have suffered from the same maladministration or poor service.

2. Being customer focused – the CCG aims to deal with patient complaints professionally and sensitively, where appropriately apologising and explaining poor service and maladministration.

3. Being open and accountable – the CCG aims to explain clearly in its response to any complaint its findings and the reasons for upholding or not upholding the complaint and any associated remedy.

4. Acting fairly and proportionately – the CCG aims to treat all complaints without bias, unlawful discrimination or prejudice.

5. Putting things right – where a complaint is upheld, the CCG aims to offer an appropriate remedy including an apology, an explanation and details of any remedial action to be undertaken. The CCG will consider any remedy that returns the complainant to the position they would have been in and where that is not possible, compensation will be considered.

6. Seeking continuous improvement – the CCG learns from complaints and ensures that where identified, changes are made to policies, procedures and systems and any associated staff training is carried out.

3.12 Employee consultation

The CCG's internal communications and consultation strategy provides:

- clear, open, honest and two-way conversations
- accurate, regular and timely information to and from staff
- consistent messages across the whole organisation.

As a people-centred organisation that has pledged to meet its promise to value all stakeholders, the CCG is committed to maintain and continually improve its conversations with staff.

To ensure the CCG can fulfil its vision it needs to communicate effectively and openly with its staff and everyone in the organisation is part of the process.

2013-14 was the first year as a new organisation, however the CCG had a very clear vision and recognised that staff are key to the CCG's success. The expertise and skills of staff helped to deliver the organisation's objectives by creating and delivering positive outcomes for stakeholders. The CCG places a high value on the work and commitment of all staff members – whatever their role.

To ensure staff received feedback and important information about the organisation, the CCG's Internal Communications Strategy sets out clear objectives that:

- highlights the responsibilities of staff in the communications process
- provides new and novel ways to share ideas and opinions

- makes sure staff have the right information to do their job well and effectively
- ensures that staff have clarity on the priorities, goals and objectives of the organisation
- gives opportunities for staff to feedback to the Senior Management Team and to each other
- provide ways for staff to suggest improvements and offer good ideas.

3.12.1 High quality and regular staff communication and involvement

The CCG is committed to delivering high quality, two-way communications to staff through the appropriate tools that will keep them informed and involved at every opportunity, they include:

3.12.2 Clinical Commissioning Group's staff survey

Consultation and engagement has proved to be a vital tool that has enabled and supported the participation of staff in the CCG. The first staff survey took place in September 2013 and a second phase is scheduled for late spring 2014.

3.12.3 Clinical Commissioning Group's staff e-update

A fortnightly staff e-update (was weekly however staff requested to receive this every two weeks) provides an electronic communication to all staff that includes updates about project development, CCG performance and a range of other types of information.

3.12.4 Weekly staff 'huddle'

Promoting its culture that encourages two-way communication, the CCG's Senior Management Team takes a highly active role in staff communications and engagement. Once a week a member of the senior team calls for staff to 'huddle' and hear updates from the weekly Senior Management Team meeting. The meetings are informal and last approximately 10 minutes. Staff huddles are a platform for cascading information to staff whilst providing an opportunity for staff to share information with the rest of the team.

3.12.5 Clinical Commissioning Group's intranet site

The CCG's intranet site plays an important role in staff communication. It is a repository for important policies, updates and project information. GPs and practice staff also access the intranet which is viewed as the CCG's digital workplace and a space to exchange information.

3.13 Disabled employees

The CCG actively encourages people with disabilities to apply for positions in the organisation. Applicants applying for roles within the CCG, who declare a disability, will be eligible for a guaranteed interview, providing they meet the minimum criteria within the person specification for the particular vacancy.

The CCG also supports staff and offers Occupational Health Support and adjustments that may be required within the role in which they are employed. All policies and procedures that are developed for the CCG include advice on how to obtain the policies in different formats, e.g. in Braille.

As an employer, the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. It actively works to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in recruitment, training, performance management and development practices.

The policies and processes in place to support this include:

- Managing Performance
- Disciplinary / Conduct
- Grievance
- Staff Induction
- Bullying and Harassment
- Flexible working
- NHS Code of Conduct for Managers
- Job descriptions (with equality and diversity statements)
- Health policies
- Annual appraisals with staff
- Employment equality monitoring forms

The CCG has a number of key delivery actions in place in its implementation plan and a full update is available at www.valeofyorkccg.nhs.uk

3.14 Emergency preparedness, resilience and response

Under the Health and Social Care Act 2012, the Civil Contingencies Act 2004 (CCA 2004) and the NHS CB Emergency Preparedness Framework 2013, the CCG is required to develop sufficient plans that ensure the organisation and all commissioned services are well prepared to respond effectively to major incidents / emergencies so that they can mitigate the risk to public and patients and maintain a functioning health service.

The North Yorkshire and Humber Area Team has incident response plans in place that are compliant with the NHSCB Emergency Preparedness Framework 2013. The CCG is assured that the North Yorkshire and Humber Area Team regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan locally.

The CCG is a designated Category 2 responder under the CCA 2004 and its main role will be in support of Category 1 responders, under the direction of Public Health England (PHE) and NHS England (Area Team) and dependent on the nature of the major incident / emergency.

As a Category 2 Responder the CCG is required to have an up-to-date Business Continuity Plan. A Business Continuity Standard (BCS) for the CCG has been approved and is in place, along with the necessary capacity and appropriate control plans to manage incidents.

The BCS and its associated Planning Tool provides an overview of key functions, roles and responsibilities of the Emergency Preparedness, Resilience and Response (EPRR) system and the CCG's arrangements for EPRR response and Business Continuity. These documents provide assurance that the CCG has robust processes in place to meet its statutory duties and should be read in conjunction.

3.14.1 The Clinical Commissioning Group's Certification of Emergency Preparedness

The CCG's incident response plans are in place and fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013.

Regular reviews and improvements to the major incident plan through a programme for regular testing provides progress reports to the CCG's Governing Body.

3.15 Statement as to disclosure to auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's external auditor is unaware; and,
- The member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Dr Mark Hayes - Accountable Officer
2nd June 2014

4 Remuneration Report

4.1 Remuneration Committee Report

Chaired by the CCG Chairman, the Remuneration Committee has delegated authority from the Governing Body to determine pay and remuneration for CCG employees. This includes development pay, the use of Recruitment and Retention Premiums, annual salary awards where applicable, allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. The Committee also determines severance payments of employees and contractors, seeking Her Majesty's Treasury approval as appropriate in accordance with the guidance 'Managing Public Money'. It also receives and reviews new policies and instructions relating to remuneration.

The Committee met four times in 2013-14 and was quorate (the Chair and one other Lay member present) on each occasion.

4.2 Remuneration Committee performance / highlights

- Review of remuneration and terms of appointment for posts not on Agenda for Change
- Review of performance objectives for Very Senior Managers (VSMs).

4.3 Details of membership of Remuneration Committee

Name	Role	Membership from	Attendances
Professor Alan Maynard	CCG and Remuneration Committee Chair	April 2013	4/4
John McEvoy	Practice Manager Governing Body Member	July 2013	2/2
Keith Ramsay	Lay Member with a lead role in governance and Audit Committee Chair	April 2013	3/4

Table 14 Remuneration Committee members

4.4 Non Remuneration Committee member attendances

There were two people who provided advice to the Committee that materially assisted in their consideration of remuneration matters:

Amanda Wilcock, Director of Human Resources, North Yorkshire and Humber Commissioning Support Unit attended the Remuneration Committee on two occasions in the capacity of external advisor;

Sheila Duckett, HR Business Partner for North Yorkshire and Humber Commissioning Support Unit attended one meeting to represent Amanda Wilcock (in the capacity of external advisor).

Both Ms Wilcock and Ms Duckett also provided a range of general HR advice to the CCG during the 2013-14 financial year. They are employed by the Commissioning Support Unit who are contracted to provide a HR service to the CCG. The committee is satisfied that the advice received was objective and independent. There was no additional fee paid other than the contracted commitment to the Commissioning Support Unit through the Service Level Agreement (SLA).

There were no other attendances of non-members at the committee.

4.5 Policy on remuneration of senior managers

4.5.1 2013-14 Policy on remuneration of senior managers

Very senior managers pay rates are set taking into account guidance on the Pay Framework for Very Senior Managers in CCGs received from NHS England. For Very Senior Managers who transferred under the TUPE regulations the Very Senior Managers Pay Framework for PCTs would be followed.

Independent HR advice is provided to the Remuneration Committee from an HR Director contracted from North Yorkshire and Humber Commissioning Support Unit.

The Committee is fully constituted in accordance with relevant codes of practice for remuneration committees with robust terms of reference using the template for CCG Governing Body recommendations for Remuneration Committee Terms of Reference. Regular benchmarking reporting and pay intelligence background is presented to the committee including written recommendations for consideration.

Benchmarking data is collected locally and nationally from CCGs and other NHS bodies as required to inform the remuneration committee's decisions. Other senior managers are paid in accordance with Agenda for Change Terms and Conditions of service and fall outside of the remit of the Remuneration Committee.

4.5.2 2014-15 Policy on remuneration of senior managers

The CCG will continue to follow appropriate guidance on setting remuneration levels for Very Senior Managers and account taken of the prevailing financial position of the wider NHS and the need for pay restraint taking account of the ability to recruit and retain the

right calibre of staff. performance of Very Senior Managers will be monitored in line with the organisation's objective setting and appraisals processes.
The Remuneration Committee has considered the possibility of Performance related bonus and made a decision not to implement this for Very Senior managers. The Committee will continue to receive regular performance objective reports on all of the CCG's senior team.

4.6 Senior managers' performance related pay

There were no Performance Related Pay (PRP) payments made during 2013-14.

4.7 Policy on senior managers' contracts

Very Senior Managers are employed on substantive and permanent contracts. They are required to give and entitled to receive 3 months' notice. Any termination payments will be made in line with the individual's contract of employment and terms and conditions of service.

4.8 Senior managers' service contracts

Senior Manager service contracts have not been in place at the CCG.

4.9 Payments to past senior managers

There were no payments made to past senior managers.

4.10 Payments for Loss of Office

There have not been any payments made for loss of office in 2013-14.

4.11 Salaries and allowances

2013/14						
Name and Title	Salary & Fees	Taxable Benefits	Annual Performance Related Bonuses	Long-term Performance Related Bonuses	All Pension Related Benefits	Total
	(bands of £5,000) £000	(Rounded to the nearest £00) £00	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Professor A Maynard Chair	10-15	0	0	0	0	10-15
Mrs R Potts Chief Operating Officer	85-90	13	0	0	57.5-60	150-155
Dr M Hayes Chief Clinical Officer	180-185	0	0	0	25-27.5	210-215
Mr A Snarr Chief Finance Officer (to 30 June 2013) 0.6 WTE see (e)	15-20	10	0	0	32.5-35	60-65
Mr K Howells Chief Finance Officer (1 July 2013 to 3 November 2013) see (a)	30-35	0	0	0	0	30-35
Mrs T Preece Chief Finance Officer (from 4 November 2013)	35-40	0	0	0	32.5-35	70-75
Ms C Wollerton Executive Nurse (to 15 July 2013) 0.6 WTE see (e)	15-20	0	0	0	135-137.5	150-155
Mrs W Barker Executive Nurse (10 July 2013 to 12 January 2014)	25-30	0	0	0	22.5-25	50-55
Ms L Botting Chief Nurse (from 13 January 2014)	15-20	0	0	0	45-47.5	65-70
Dr S O'Connell GP Governing Body Member	95-100	0	0	0	17.5-20	115-120
Dr T Maycock GP Governing Body Member	30-35	0	0	0	5-7.5	40-45
Dr Emma Broughton GP Governing Body Member	30-35	0	0	0	7.5-10	40-45
Dr A Phillips GP Governing Body Member	45-50	0	0	0	2.5-5	45-50
Dr C Snape GP Governing Member (to 30 September 2013)	30-35	0	0	0	10-12.5	40-45
Dr L Barker GP Governing Body Member (from 3 February 2014)	10-15	0	0	0	35-37.5	45-50
Mr K Ramsay Audit Committee Chair and Lay Member	5-10	0	0	0	0	5-10
Dr C Burgin GP Governing Body Member (from 4 November 2013)	10-15	0	0	0	65-67.5	75-80
Dr G Porter Secondary Care Doctor see (b)	15-20	0	0	0	0	15-20
Mr J McEvoy Practice Manager Representative (from 4 July 2013) see (c)	10-15	0	0	0	0	10-15
Dr T Hughes GP Governing Body Member to 31 May 2013 and Chair of Council of Representatives from 16 May 2013 see (d)	10-15	0	0	0	0	10-15
Dr J Lloyd Council of Representatives Member (from 1 February 2014)	0-5	0	0	0	0	0-5
Dr P Edmondson-Jones Director of Public Health and Well Being (Co-opted) see (f)	0	0	0	0	0	0
Ms K England Local Authority Chief Executive (Co-opted) see (f)	0	0	0	0	0	0
Mr R Webb Local Authority Corporate Director Health and Adult Services (from 1 March 2014) (Co-opted) see (f)	0	0	0	0	0	0
Ms H Taylor Local Authority Representative (Co-opted) (to 30 November 2013) see (f)	0	0	0	0	0	0
Dr D Hartley Council of Representatives and Governing Body Member (16 May 2013 to 2 August 2013)	0	0	0	0	0	0
Dr B McGregor Local Medical Committee Representative	0	0	0	0	0	0
Dr P Underwood GP Council of Representatives Member (16 May to 7 November 2013)	0	0	0	0	0	0

NB all senior managers are continuing except where stated:

(a) Mr K Howells was employed through an agency. The salary & fees represents the overall cost to the CCG and not the amount paid to Mr K Howells by the agency.

(b) Dr G Porter is employed by Airedale NHS Foundation Trust and the CCG is invoiced by them directly for his time.

(c) Mr J McEvoy invoices the CCG as John McEvoy Ltd.

(d) Dr T Hughes remuneration relates to his role as a GP Governing Body member only.

(e) Mr A Snarr (Total salary band £000 = 107.5-110) and Ms C Wollerton (Total salary band £000 = 80-82.5) held shared posts between the CCG and Scarborough & Ryedale CCG hence their costs only represent the portion of their time attributable to the CCG, 0.6 Whole Time Equivalent (WTE).

(f) Co-opted members of the Governing Body do not receive remuneration direct from the CCG for their role.

"Taxable Benefits" relate to lease cars (the lease for the lease car of Mrs R Potts expired on 5 June 2013).

"All Pension Related Benefits" relate to those receiving pension contributions only. The amount comprises all pension related benefits in year, including the cash value of payments (cash or otherwise) in lieu of retirement benefits and all benefits from participating in pension schemes regardless of employing organisation, WTE or length of employment with the CCG.

4.12 Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued lump sum at age 60 at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Partnership Pension To nearest £100
Mrs R Potts Chief Operating Officer	2.5-5	35-40	7.5-10	105-110	647	564	71	0
Dr M Hayes Chief Clinical Officer	0-2.5	15-20	5-7.5	55-60	393	338	48	0
Mr A Snarr Chief Finance Officer (1 April 2013 to 30 June 2013)	0-2.5	35-40	5-7.5	115-120	631	572	46	0
Mrs T Preece Chief Finance Officer (from 4 November 2013)	0-2.5	10-15	2.5-5	40-45	197	167	27	0
Ms C Wollerton Executive Nurse (1 April 2013 to 15 July 2013)	5-7.5	20-25	17.5-20	65-70	394	245	144	0
Mrs W Barker Executive Nurse(15 July 2013 to 12 January 2014)	0-2.5	10-15	2.5-5	40-45	277	242	30	0
Ms L Botting Chief Nurse (from 13 January 2014)	0-2.5	15-20	5-7.5	50-55	274	229	40	0
Dr S O'Connell GP Governing Body Member	0-2.5	10-15	2.5-5	30-35	180	149	26	0
Dr Emma Broughton GP Governing Body Member	0-2.5	10-15	0-2.5	40-45	180	164	12	0
Dr A Phillips GP Governing Body Member	0-2.5	5-10	0-2.5	20-25	149	134	12	0
Dr C Snape GP Governing Member (to 30 September 2013)	0-2.5	10-15	0-2.5	30-35	219	195	20	0
Dr L Barker GP Mental Health Lead (from 3 February 2014)	0-2.5	0-5	2.5-5	5-10	36	17	18	0
Dr T Maycock GP Governing Body Member	0-2.5	5-10	0-2.5	25-30	130	117	11	0
Dr C Burgin GP LTC/Older Persons Lead (from 4 November 2013)	2.5-5	5-10	0	0	51	23	28	0

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 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 the 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 effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

4.13 Pay Multiples

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

The banded remuneration of the highest-paid member of the Governing Body of the Clinical Commissioning Group in the financial year 2013-14 was £180k - £185k. This was 4.35 times the median remuneration of the workforce, which was £43,133.

In 2013-14, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £0k - £5k to £180k - £185k (bands of £5,000).

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

4.14 Off Payroll Engagements

The Clinical Commissioning Group has not had any highly paid and/or senior off-payroll engagements as at 31 March 2014 that are for more than £220 per day and that lasted longer than six months.

4.15 Membership Body and Governing Body Profiles (as of 31 March 2014)

Professor Alan Maynard, Lay Chair of the Governing Body

Alan is a Professor of Health Economics in the Department of Health Sciences and Hull York Medical School. He has worked in the NHS for 30 years; and from 1997-2010 was Chair of York Hospitals NHS Foundation Trust.

Dr Mark Hayes, Chief Clinical Officer (Accountable Officer)

Dr Hayes has been a local GP since 1986. He has been involved in commissioning since 1998 and became Chairman of Selby Primary Care Group in 2000. He was a founder Board member of York Health Group and became Chairman in 2010. He was appointed Shadow Accountable Officer of NHS Vale of York Clinical Commissioning Group in August 2011.

Dr Louise Barker, GP Member

Louise is a GP at the Haxby Group Practice and is the CCG's GP Lead for Mental Health. Louise graduated from Liverpool Medical School and completed her GP training in Yorkshire. In her work at the Haxby Practice she is involved in offering women's health services, minor surgery procedures and Hull York Medical School (HYMS) teaching to medical students.

Lucy Botting, Chief Nurse

Lucy joined the CCG as Chief Nurse in January 2014. She brings a wealth of experience at national and local levels, having worked in Northern Ireland and England in both provider and commissioning organisations. She has also worked in senior positions within the Department Health and Royal College of Nursing as well as undertaking roles such as a Director of Clinical Commissioning, Director of Quality and Governance and Executive Nurse. When not in work Lucy continues to practice as a nurse practitioner in her local out of hours service keeping her front line skills credible and up to date. She is also a Trustee of a local palliative care charity, Chair of a village committee for the local development planning process and in May 2014 was elected as a local Councillor for Mole Valley District Council in Surrey.

Dr Emma Broughton, GP Member

Emma is a GP member of the CCG with responsibilities for Clinical Governance of the Referral Support Service and the Primary Care Programme. She is also the CCG's lead for women's health. Having graduated from Edinburgh Medical School in 1999, Emma undertook specialty training in Obstetrics and Gynaecology in both Edinburgh and Yorkshire prior to entering GP training in 2007. She is a GP partner at Priory Medical Group in Central York and has a specialist interest in substance misuse, working for Lifeline in York. She also provides contraceptive and minor surgery services in York.

Dr Chris Burgin, GP Member

Chris Burgin graduated from Sheffield Medical School in 2008 after completing a degree in Music and Education from the University of Leeds in 2001. Chris completed his GP training on the Harrogate scheme and is now a full time GP partner at Tadcaster Medical Centre with particular interests in medical education and elderly medicine. Within the CCG Chris is the Clinical Lead for older people and long term conditions programmes.

Dr Tim Hughes, CCG Council of Representatives member

Tim is a Principal GP at Kirkbymoorside Surgery with a specialist interest in musculoskeletal medicine and pain management as well as an interest in older person's medicine. His commissioning interest is in the delivery of community services. As well as his roles in practice and the Governing Body, Tim is also a GP trainer for the York GP Training Programme and Chair of the CCG's Council of Representatives.

Dr Jonathan Lloyd, CCG Council of Representatives member

Jonathan graduated from Edinburgh University in 1978 and has been a GP Partner in the Priory Medical Group in York since 1983. From 1984 – 2003 Jonathan worked as a Forensic Medical Examiner for North Yorkshire Police and since 1997 has worked as one of the Training Programme Directors of the York GP Vocational Training Scheme. Jonathan was a member of the Professional Executive Committee of Selby and York PCG/PCT from 1999 – 2003 with lead responsibility for IM&T and Education. Since then, Jonathan has become involved in the Hull York Medical School where currently a Director of Clinical Studies and Associate Clinical Dean for Students.

Dr Tim Maycock, GP Member

Tim graduated from Leeds University in 1994, completed the York GP training scheme in 1998 and took up a partnership in Pocklington where he is currently a full-time GP. He has special interests in medical education, information technology and risk stratification. Tim's current roles include representing NHS Vale of York CCG on the East Yorkshire Health and Wellbeing Board and acting as clinical lead for the Primary Care Programme.

John McEvoy, Practice Manager Member and Chair of the Quality and Finance Committee

John is the Managing Partner of Haxby Group, a large GP Practice and Pharmacy Group based in York and Hull. Following a full career in the military, John joined Haxby Group as a Practice Manager in 2002 and became a partner in 2005. His previous experience includes serving as vice-Chairman of the York Practice Based Commissioning Group from 2005 until 2009.

Dr Shaun O'Connell, GP Member

Dr O'Connell is the GP Lead for Prescribing, Planned Care, Quality and Performance. Having studied medicine at Southampton University he trained to be a GP in Dorset and Somerset. He was a founding member of the National Association of Non-Principals, (now renamed Sessional GPs). He has experienced general practice as a locum, a salaried doctor and a partner. He has been a GP trainer, GP appraiser and member of the Council of the Royal College of General Practitioners. He combines his role as a GP Governing Body member with his work as a salaried doctor at South Milford Surgery and a Selby representative member on North Yorkshire Local Medical Committee.

Dr Andrew Phillips, GP Member

Andrew qualified in 1999 from Leeds University Medical School. He has lived in North Yorkshire since 2001 and began training on The York General Practice Vocational Training Scheme at that time. Andrew has an interest in commissioning and primary care service design. He has been an active participant in Practice-based Commissioning since 2006 in east Yorkshire and Ryedale until being appointed to the CCG Governing Body in 2011. Andrew combines his role as a Ryedale practice GP with his role in Vale of York CCG. He has regularly provided Out of hours GP services for several years and has an interest in its future service design and integration in primary care in North Yorkshire.

Dr Guy Porter, Secondary Care Doctor Member

Consultant Radiologist, Airedale Hospital NHS Foundation Trust.

Rachel Potts, Chief Operating Officer

Rachel has 30 years of experience working in the NHS. This has included a variety of senior general management and leadership roles including strategic planning and performance within community, mental health and learning disability services. Rachel also played a lead role in establishing and developing a first wave PCT in Doncaster. Rachel came to North Yorkshire in 2003 as Associate Director of Contracting and Performance in Selby and York PCT. In October 2010 Rachel took on the role of Locality Director North Yorkshire and York Primary Care Trust (PCT) in which she played a lead role in the development of the Vale of York Clinical Commissioning Group. In addition to a number of health service management qualifications, Rachel also has a post graduate marketing diploma and Executive MBA in Health and Social Care.

Tracey Preece, Chief Finance Officer

Tracey studied at York University and joined the NHS through the NHS Financial Management Training Scheme, graduating in 2002. Tracey has over 14 years NHS finance experience and has held senior positions in acute provider organisations in Yorkshire and the North East, most recently as Deputy Director of Finance at Gateshead Health NHS Foundation Trust. Tracey is an Associate member of the Chartered Institute of Management Accountants.

Keith Ramsay, Lay Member and Chair of the Audit Committee

Keith has held several senior roles, both in and outside of the NHS. He has been accountable for the success of several organisations including taking a lead role in setting the strategic direction for health and welfare projects and the performance management of billions of pounds of public funding. His roles have included Non-Executive Director and NHS Yorkshire and the Humber Board member, Non-Executive lead for Social Enterprise, Non-Executive lead for Innovation, Chair of the NHS Regional Innovation Fund, Chair of the Advisory Board for the Big Lottery Fund and Trustee - Altogether Better England. In his work to reduce health inequalities across the Yorkshire and the Humber regions, Keith worked closely with Community Health Champions to empower communities to improve their health and wellbeing. Keith is the Chair of the CCG's Audit Committee, a member of its Remuneration Committee and Lay Member of the Governing Body.

4.16 Membership Body and Governing Body Disclosures for 2013-14

Name	Job Title	Nature of Interest
Lucy Botting	Chief Nurse *(from 13 January 2014)*	Trustee - Bridget Trust Palliative Care Charity; Advanced Nurse Practitioner – Harmoni (Care UK) Out of Hours Service. Local Councillor for Mole Valley District Council in Surrey.
Dr Emma Broughton	GP Governing Body Member	GP at Priory Medical Group (Non-Equity); Sessional GP at Lifeline; Yorkshire Skin Clinic – Sessional GP/Minor Operations; GP Reviewer for the Referral Support Service.
Dr David Hartley	Member of Council of Representatives and Governing Body *(16 May to 2 August 2013)*	Finance Lead within Jorvik Medical Practice; Shareholder in Invoy Health Ltd GP provider and advisory business; Elected representative on YORLMC. Jorvik Medical Practice conducts research funded via PCRN (Primary Care Research Network) and it is applying for commercial research opportunities.
Kevin Howells	Interim Chief Finance Officer *(from 1 July to 3 November 2013)*	Interim management consultancy at Leeds Teaching Hospitals NHS Foundation Trust
Dr Tim Hughes	GP Governing Body Member *(to 31 May 2013)* and Chair of Council of Representatives *(from 16 May 2013)*	Senior Partner in member practice
Dr Jonathan Lloyd	GP Governing Body Member representing the Council of Representatives (*from 1 February 2014)*	Director of Clinical Studies and Associate Clinical Dean for Students – Hull York Medical School. Training Programme Director York GP Vocational Training Scheme – Health Education England, Yorkshire and Humber
Dr Tim Maycock	GP Governing Body Member	GP Partner, Pocklington Group Practice. Wife is Deputy Retail Manager for St Leonard's Hospice shops.
Professor Alan Maynard	Chair	Former member of Dr Foster Ethics Committee; Former Chair / Non-Executive Director of Compass, York.
John McEvoy	Practice Manager Member and Chair	Managing Partner Haxby Group Practice; Co-owner, Director, Shareholder in: HBG

	of the Quality and Finance Committee *(from 4 July 2013)*	Ltd, Haxby Group Pharmacy Ltd, Market Weighton Pharmacy Ltd – all of which operate in healthcare and hold NHS contracts; Haxby Group Practice and HBG Ltd are part of the Primary Care Research Network and each are Research Ready Accredited with this scheme; Dr M Holmes, Business Partner and close friend, holds position with Harrogate Trust Out of Hours Care and Hull CCG.
Dr Shaun O'Connell	GP Governing Body Member	Employee at South Milford Surgery; Spouse is employee at York Teaching Hospital Foundation Trust; North Yorkshire Local Medical Committee member.
Dr Andrew Phillips	GP Governing Body Member	Partner at Pickering Medical Practice; Focus Medical Yorkshire Limited; Joint Director with spouse to undertake GP out of hours and locum duties by Dr Andrew Phillips.
Keith Ramsay	Audit Committee Chair and Lay Member	CIDA; Incommunities; Jigsaw Consultancy Ltd; Trustee, Altogether Better; Chair, Commercial Board Incommunities; Wife is also a Director of Jigsaw Consultancy Ltd.
Dr Cath Snape	GP Governing Body Member *(to 30 September 2013)*	GP; Gillygate Surgery Partnership; Practice may consider changes to out of hours services.
Adrian Snarr	Chief Finance Officer *(to 30 June 2013)*	Member of Joseph Rowntree Trust and Joseph Rowntree Housing Association Audit Committee; Although employed by NHS Vale of York CCG, also held a Joint Chief Finance Officer role within NHS Scarborough and Ryedale CCG.
Dr Philip Underwood	GP, Council of Representatives Member *(16 May to 7 November 2013)*	Partner at Scott Road Medical Centre, Selby. Business Partners hold shares in Invoy.
Caroline Wollerton	Executive Nurse *(to 15 July 2013)*	Holds an annually renewed contract with the Parliamentary and Health Service Ombudsman to provide ad hoc advice as External Professional Advisor on NHS Funded Continuing Healthcare cases.

Table 15 Disclosures from members of the Membership Body and Governing Body

4.16.1 Co-opted member profiles (as of 31 March 2014)

Dr Paul Edmondson-Jones MBE, Director of Public Health and Wellbeing, City of York Council

Dr Edmondson-Jones trained in Scotland and then spent 23 years as an Army Doctor, working worldwide supporting the Gurkha Rifles in the Falklands War of 1982 and commanding the British Medical Battalion with the United Nations in the Former Yugoslavia in 1993. He was awarded the MBE in the Gulf War Honours List in 1992.

Paul joined the NHS in 2000 as Director of Public Health (DPH) for Portsmouth City in 2001. He moved to York as DPH in August 2012 but now has a wider portfolio as Deputy Chief Executive which incorporates Director of Adult Social Services as well as the role of the DPH. He is Co-opted member of the Governing Body for NHS Vale of York CCG, Member of the Advisory Committee for Resource Allocation, Member of the Home Office's Partnership Advisory Group on Community Safety, Member of the Advisory Board for the Centre for Reviews and Dissemination, Secretary of the Association of Directors of Public Health.

Richard Webb, North Yorkshire County Council

Richard is the Corporate Director for Health and Adult Services at North Yorkshire County Council. A graduate of Durham University, Richard has worked in various roles across the NHS and in local government. He has been a statutory Director of Adult Social Services since 2005 and was the co-chair for the Association's Mental Health, Drugs and Alcohol Network. Richard is currently national Honorary Secretary for the Association of Directors of Adult Social Services (ADASS).

4.16.2 Governing Body Co-opted Member Disclosures for 2013-14

Name	Job Title	Nature of Interest
Dr Paul Edmondson-Jones	Director of Public Health and Well-being (Co-opted)	Director of Public Health and Well-being for the City of York Council; Paid employee on Senior Management Team of City of York Council.
Kersten England	Local Authority Chief Executive (Co-opted) *(to 30 November 2013)*	Director of Science City York; Trustee of National Endowment for Science Technology and the Arts (NESTA); Fellow of the Royal Society of Arts (RSA); Member of the Guild of Merchant Adventurers. Husband is Director of Creating Space 40; an Associate of Phoenix Consultants, who work in NHS; and Trustee of York CVS.
Dr Brian McGregor	Governing Body Member (Co-opted)	Director of YORLMC – Parent company of Local Medical Committee; Vice-Chair of North Yorkshire Branch of YORLMC; Out of Hours Salaried GP; GP with Special Interest in Addictions, Lifeline York.
Helen Taylor	Local Authority representative (Co-opted) *(to 30 November 2013)*	Corporate Director of North Yorkshire County Council; Statutory Director of Adult Services (NYCC).
Richard Webb	Local Authority representative (Co-opted) *(from 3 March 2014).*	Stephanie Carson (Wife), Darley Consulting, Yorkshire and Humber Lead on Personal Health Budgets.

Table 16 Disclosures from co-opted members of the Governing Body

4.16.3 Clinical Commissioning Group Senior Manager Profiles (not part of the Governing Body) as of 31 March 2014

4.16.3.1 Michael Ash-McMahon, Deputy Chief Finance Officer

Michael joined the NHS in 2001 through the NHS Financial Management Training Scheme, graduating in 2004. Since that point he has spent two years working within Ernst & Young's Healthcare consultancy team, working on large scale NHS projects with a range of organisations across the country.

Michael has built up over 13 years NHS finance experience and has held several positions in acute provider organisations in the North West, most recently as Assistant

Director of Finance for Business and Financial Planning at Southport and Ormskirk NHS Trust. Michael is a member of the Chartered Institute of Public and Finance and Accountancy.

4.16.3.2 Dr Wendy Barker, Deputy Chief Nurse

Wendy is a registered Nurse with over 34 years' experience working within the acute, primary and community care setting. She trained at Poole General Hospital in Dorset, but has spent the last 24 years working in the community across Hull and the East Riding of Yorkshire.

She is a qualified District Nurse who has worked as a Nurse Consultant (Older People and Adult Safeguarding) for nine years. Previously she was a member of the East Riding Clinical Executive Committee and a member of the Humber NHS Foundation Trust Governing Body.

She holds an MSc in advanced nursing practice and a PhD in nursing research. She is an Honorary Senior Lecturer at Hull University. She has published articles in leading nursing journals and has spoken at national and international conferences.

4.16.3.3 Fiona Bell, Deputy Chief Operating Officer

Fiona started her NHS career in 1992 after graduating from Loughborough University with a 1st class degree in Physical Education, Sports Science and Ecology BSc and an MSc in Sports Science.

Her first job in the NHS was as a Health Promotion Specialist with the responsibility for establishing a coronary heart disease prevention programme. Various health promotion roles culminated in Fiona becoming manager of the North Yorkshire Specialist Health Promotion service, before she moved into planning and commissioning roles in the newly formed PCGs.

Since then Fiona has held several senior planning, commissioning and health improvement roles and during recent years she has driven service improvement and redesign in provider (community and mental health, and foundation trust) and commissioner settings across the county.

Prior to joining the CCG, Fiona held the positions of Associate Director of Service Improvement and Performance for Community and Mental Health Services in North Yorkshire and most recently was Deputy Director of Service Improvement at Harrogate and District NHS Foundation Trust.

Trained as a lean practitioner in the Virginia Mason Lean Methodology, Fiona brings highly developed improvement and innovation skills with a particular focus on system change, partnership working and co-production. She currently leads the CCG's

Innovation and Improvement Team, working with partners on a range of improvement and transformation projects.

4.16.3.4 Janet Probert, Director of the Partnership Commissioning Unit

Janet began her career after completing her degree and qualifying as nurse and midwife. A range of senior clinical roles specialising in nursing, infection control and management followed; in England and abroad, and when she returned Janet combined her hands on experience with academia to gain a Masters in Business Administration (MBA).

This led to gaining strategic roles in the NHS including Director of Nursing, Managing Director of Community and Mental Health Services, Director at Harrogate District Foundation Trust and Janet's current position as Director of the Partnership Commissioning Unit - supporting the delivery of health and social care in North Yorkshire and York.

Outside of work Janet enjoys travelling and skiing with her husband and two teenage children and spending time with friends too. In her spare time Janet is also a governor at both Middleton Tyas Church of England Primary School and Henshaws College.

4.16.4 Relevant disclosures from the Clinical Commissioning Group's Senior Management Team members (not part of the Governing Body) for 2013-14

Name	Job Title	Nature of Interest
Michael Ash-McMahon *(from 1 August 2013)*	Deputy Chief Finance Officer. Member of the Quality and Finance Committee	Caroline Alexander, working for Attain into North Yorkshire and Humber Commissioning Support Unit, is a close friend
Fiona Bell *(from 1 June 2013)*	Deputy Chief Operating Officer/Innovation Lead. Member of the Quality and Finance Committee	Worked on honorary contract for Harrogate and District NHS Foundation Trust for two days a week for the month of June 2013, as well as NHS Vale of York CCG. Contract with Harrogate and District NHS Foundation Trust ended 19 July 2013
Janet Probert *(from 1 September 2013)*	Director of the Partnership Commissioning Unit.	Governor at Henshaw College

Table 17 Disclosures from members of the CCG's Senior Management Team

4.16.5 Governing Body Statement to External Auditors

The Governing Body is not aware of any relevant audit information that has been withheld from the Clinical Commissioning Group's external auditors. The CCG can confirm that members of the Governing Body take all necessary steps to ensure they are aware of relevant information and that this is passed to the external auditors where appropriate.

Dr Mark Hayes - Accountable Officer
2nd June 2014

5 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 Clinical Officer to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including 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) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health 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 *Manual for Accounts* issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Dr Mark Hayes - Accountable Officer
2nd June 2014

6 NHS Vale of York Clinical Commissioning Group Annual Governance Statement

6.1 Introduction and Context

The NHS Vale of York Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2013, the CCG was licensed with 9 conditions and 2 legal directions. These were:

Criteria	Condition	Support Level
1.3A	Arrangements in place for CCG to involve and seek advice from healthcare professionals from secondary, community, mental health, learning disabilities and social care.	II
1.3B	CCG governing body includes nurse and secondary care doctor.	I
3.1.1B	CCG has a clear and credible integrated plan, which includes an operating plan for 2012-13, draft commissioning intentions for 2013-14 and a high-level strategic plan until 2014-15.	IV
3.1.1C	CCG has detailed financial plan that delivers financial balance, sets out how it will manage within its management allowance, and any other requirements set by the NHSCB and is integrated with the commissioning plan.	IV
3.1.1D	Quality, Improvement, Performance and Productivity is integrated within all plans. Clear explanation of any changes to existing Quality, Improvement, Performance and Productivity plans	IV
4.3.1C	CCG can demonstrate how its proposed staff resource and any contracted commissioning support will provide capacity and capability to deliver its full range of responsibilities.	IV
5.3B	Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of the Local Safeguarding Children Board and the Safeguarding Adults Board.	I
5.3D	CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.	I
6.4G	Senior in-house management roles in CCG provide adequate capacity and capability to maintain strategic oversight with available resources.	I

Table 18 Conditions and legal directions upon licence of the CCG

The CCG was supported by the North Yorkshire and Humber Area Team during 2013-14 to work towards removal of the conditions. Rectification plans were put in place. These included:

- A revised and significantly enhanced staffing structure. At the point of authorisation in April 2013, the NHS Vale of York CCG structure had 39 substantive posts identified in the structure, with a vacancy rate of 30% and not all appointed staff in post. The team were supported by a small team of interim project managers dedicated to delivering the Quality, Improvement, Performance and Productivity programme. Of the 39 posts in the April structure, over 50% were joint posts with Scarborough and Ryedale CCG.
- The original structure had shared teams for finance and contracting, and quality and performance across the NHS Vale of York CCG and NHS Scarborough and Ryedale CCG. The CCG now has significantly expanded teams, with 6 dedicated clinical leadership posts, 49 substantive officer posts and dedicated finance and contracting and quality and performance functions and 5 dedicated delivery managers from the Commissioning Support Unit. The CCG now has a Chief Finance Officer and Chief Nurse in place and it continues to enhance the structure to ensure the CCG capacity is fit for purpose.
- A holistic review of the financial position and Quality, Improvement, Performance and Productivity plans. The financial plan was revised in August 2013 and the organisation was subject to a 'deep dive' financial review in Autumn 2013. Greater financial controls have been introduced through the detailed financial policies and supporting detailed scheme of financial and operational delegation. The Quality, Improvement, Performance and Productivity planning process has been revised to ensure robust financial modelling of efficiency plans and the contracting team has been significantly expanded.

The CCG was fully authorised in January 2014 at the fourth conditions review and the legal directions were revoked.

6.2 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

6.3 Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice.

For the financial year ended 31 March 2014, and up to the date of signing this statement, the CCG complied with the provisions set out in the Code, and applied the principles of the Code except in areas where the CCG is committed to working towards the UK Corporate Governance Code, as outlined below.

Leadership	The NHS Vale of York CCG is a membership organisation and is led by the Council of Representatives. This includes a representative from each member practice. The strategic and operational management of the CCG is led by the Governing Body. The Governing Body met 10 times during the past 12 months with regular attendance from Governing Body members. The Governing Body included an independent Chairman and Lay Member for governance, as well as the Executive team, Chief Nurse, Secondary Care doctor, six clinical leads, two Council of Representative members, directors from local authorities and a Practice Manager representative.
Effectiveness	The Governing Body had a broad skill mix, supported by officers within the CCG. This supporting capacity was expanded in 2013-14, with a dedicated Chief Finance Officer and Chief Nurse for the CCG. The tenure of the Chair is two years, and for the Lay Member three years. The Governing Body was supported by an Executive Assistant. The Governing Body members undertook statutory and mandatory training and induction as required with the Executive Team. Performance management arrangements were in place for the Chair, clinical leads and lay members led by the Chief Clinical Officer. The Constitution provided clear roles and responsibilities and procedures for replacing key roles. The CCG's supporting Organisational Development Plan embraced the 'Appreciative Inquiry' approach to organisational working.
Accountability	The CCG's Audit Committee was chaired by the Lay Member lead for finance and governance. The CCG put in place a series of financial controls, including the detailed financial policies and

	schemes of delegation. The Risk Management Framework was also in place, with risk, performance and financial issues being reported weekly to the Senior Management Team monthly to the Performance and Finance Committee and to each Governing Body meeting. The CCG had policies in place regarding conflicts of interest and business conduct, and published the declarations of interest for Governing Body members. The CCG instructed internal audits (NYAS) and External Auditors (Mazars) to report to Audit Committee.
Remuneration	The CCG worked within the guidance for Agenda for Change and NHS Commissioning Board guidance: '*.Remuneration guidance for Chief Officers (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers'* The Remuneration Committee was in place and set the policies for pay and expenses based upon the guidance above.
Relations with Stakeholders	The Chairman of the Governing Body was the lead for engagement within the CCG. There were robust arrangements for engaging with stakeholders and the public. The CCG linked to three Health and Wellbeing Boards (North Yorkshire, York and East Riding) and had Governing Body representation at each one. The Health and Wellbeing Boards were underpinned by key strategic partnerships, including children's trusts, integrated commissioning boards (leading on the integration of health and social care through the Better Care Fund). The CCG led the work of the Urgent Care Working Group. The CCG worked closely with neighbouring CCGs to help plan across the health system and manage co-commissioning arrangements. This was managed through the North Yorkshire Strategic Collaborative Commissioning Committee and the North Yorkshire and Humber CCG Collaborative. The CCG was committed to public engagement and had a Public and Patient Engagement (PPE) Steering Group, with strong links to Healthwatch and community groups. A number of engagement events were held during 2013-14 to inform commissioning decisions and strategic planning.

	The CCG had a quarterly programme of practice manager meetings and developed Board to Board arrangements with key providers. The CCG is scheduling an AGM and annual meeting of the Council of Representatives to be held later in the year (Late summer 2014)

6.4 The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The Governing Body works to the NHS Vale of York CCG Constitution to discharge its functions and apply the principles of good governance.

6.4.1 The Constitution

The NHS Vale of York CCG has set its vision of 'achieving the best health and wellbeing for everyone in our community'. To deliver this vision it is committed to developing a strong, transparent and effective organisation to deliver excellent local commissioning. The CCG's constitution provides the framework for the organisation. It is signed up to by all member practices and is embedded across the organisation. The constitution is available at: http://www.valeofyorkccg.nhs.uk/data/uploads/constitution-version-2_15-08-13.pdf

The constitution covers:

- CCG geographic area
- Membership
- Vision, Mission and Values
- Functions and General Duties
- The Governing Structure (decision-making)
- Roles and Responsibilities
- Standards of Business Conduct and Managing Conflicts of Interest
- The Group as Employer
- Transparency, Ways of Working and Standing Orders.

Supporting appendices include the financial policies, standing orders, NHS constitution, Nolan principles and Terms of Reference for Committees and the Council of Representatives.

The constitution sets the framework for decision making through the scheme of delegation, which sets out the split of responsibilities and decision making between the membership body (Council of Representatives), the Governing Body and the committees of the CCG. This was in place for authorisation and has been implemented throughout 2013-14. In November 2013, the Governing Body approved to delegate approval of Human Resources policies to the Senior Management Team.

The constitution is a living document and was updated during 2013 at the approved submission point in June 2013. This enhanced the whistle-blowing guidance, arrangements for Individual Funding Requests and amended the number of membership practices in line with practice mergers. The process is on-going with an annual review of the constitution embedded in the planning cycle.

During 2013-14 the Council of Representatives was fully established, with two members of the Council of Representatives represented at Governing Body. The first meeting was held in April 2013. The Council of Representatives held a session on its role, responsibilities and decision-making functions in June 2013. The corporate management support to the Council of Representatives was enhanced during the year, with practice visits from the Executive team to increase communication.

The constitution is supported by a range of underpinning documents, which were developed through 2013-14. These included the detailed financial policies and the detailed scheme of financial and operational delegation (approved September 2013), Equalities Strategy (approved November 2013) and Sustainability Management Plan (approved November 2013).

6.4.2 Governing Body and Committee Structure

At the CCG's inception, the organisation held monthly Governing Body meetings, quarterly Audit Committee meetings, ad-hoc Remuneration Committee meetings and weekly Senior Management Team meetings. The Governing Body was underpinned by three committees 'Finance and Contracting', 'Quality and Performance' and 'Business', that monitored progress and operational delivery of Quality, Improvement, Performance and Productivity schemes, financial and contracting arrangements and provider performance.

The CCG worked in collaboration with the three other 'North Yorkshire' CCGs (NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG) through the Partnership Commissioning Unit. This allowed the four CCGs to combine resources on areas of specialism, namely Continuing Health Care, adult safeguarding, children and maternity and vulnerable

adults. At the CCG's inception, what is now known as the Partnership Commissioning Unit was formerly named Vulnerable Adults and Children Commissioning Unit. Significant work took place during 2013-14 on the arrangements for the Partnership Commissioning Unit, including the appointment of a Director, a 'risk-share' arrangement across the four CCGs, revisions to the CCGs scheme of financial and operational delegation and a Service Level Agreement for the Partnership Commissioning Unit. Formal arrangements were finalised in April 2014.

A review of Committees took place in Autumn 2013 to ensure the arrangements were 'fit for purpose'. Further to report recommendations in November 2013, the Committee structure was revised to create an integrated 'Performance and Finance Committee.' The recommendations also directed revisions that aligned the scheme of financial delegation across Senior Management Team, Committee and Governing Body. The revised arrangements implemented new processes to enhance transparency and communications. The report can be found at: http://www.valeofyorkccg.nhs.uk/governing-body-meetings/7-november-2013/

6.4.3 Committee Structure

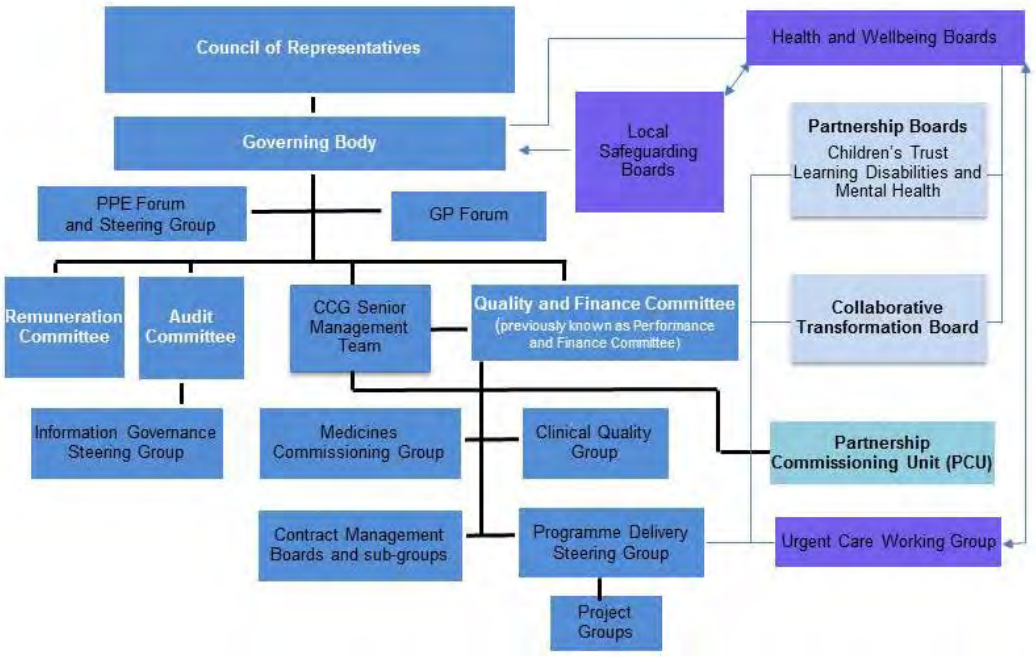


Fig 10 - The CCG's Committee Structure

6.4.4. Governing Body Meetings

The Governing Body met 10 times in public and was quorate on each occasion. Additionally four workshop sessions were held when members discussed the CCG's strategic and financial planning.

Governing Body Member	Governing Body Role	Attendance
Professor Alan Maynard	CCG Lay Chair of the Governing Body	10/10
Dr Louise Barker from 3 February 2014	GP Member	0/1
Mrs Wendy Barker from 15 July 2013 to 12 January 2014	Acting Executive Nurse	5/5
Miss Lucy Botting from 13 January 2014	Chief Nurse	1/1
Dr Emma Broughton	GP Member	8/10
Dr Chris Burgin from 4 November 2013	GP Member	0/3
Dr David Hartley from 16 May to 2 August 2013	Council of Representatives Member	2/3
Dr Mark Hayes	Chief Clinical Officer	8/10
Mr Kevin Howells from 1 July to 31 October 2013	Interim Chief Finance Officer	4/4
Dr Tim Hughes	GP Member to 31 May 2013 Council of Representatives Member from 16 May 2013	1/2
Dr Jonathan Lloyd from 6 March 2013	Council of Representatives Member	1/1
Dr Tim Maycock	GP Member	8/10
Mr John McEvoy from 4 July 2013	Practice Manager Member and Chair of Quality and Finance Committee	6/7
Dr Shaun O'Connell	GP Member	7/10
Dr Andrew Phillips	GP Member	7/10
Dr Guy Porter	Consultant Radiologist, Airedale Hospital NHS Foundation Trust Secondary Care Doctor member	9/10
Mrs Rachel Potts	Chief Operating Officer	7/10
Mrs Tracey Preece from 4 November 2013	Chief Finance Officer	3/3
Mr Keith Ramsay	Lay Member and Audit Committee Chair	7/10
Dr Cath Snape	GP Member	4/6

to 30 September 2013		
Mr Adrian Snarr to 30 June 2013	Chief Finance Officer	3/3
Dr Phil Underwood from 17 May to 7 November 2013	Council of Representatives Member	3/6
Mrs Caroline Wollerton to 15 July 2013	Executive Nurse	3/4
Co-opted Members	**Governing Body Role**	**Attendance**
Dr Paul Edmondson-Jones	Director of Public Health and Well-being, City of York Council	7/10
Ms Kersten England to 30 November 2013	Chief Executive, City of York Council	2/8
Dr Brian McGregor	Local Medical Committee Liaison Officer, Selby and York	4/10
Ms Helen Taylor to 30 November 2013	Corporate Director, Health and Adult Services, North Yorkshire County Council	3/8
Mr Richard Webb from 3 March 2014	Corporate Director, Health and Adult Services, North Yorkshire County Council	1/1

Table 19 Composition of the Governing Body (2013-14) and attendances per member at its public meetings.

6.4.5 Committee Roles and Attendances

The following table provides details of the role of each formal Committee. Attendance records in the form of apologies to meetings are maintained for each Committee to ensure quoracy and clinical representation. Performance highlights for each Committee are provided below.

Committee	Role and performance highlights
Strategic Committees:	
Audit Committee	Chaired by the Lay Member with the lead role in governance, the Audit Committee delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and security management, and financial reporting. The Committee met four times in 2013-14. There were initially two members, the Secondary Care Doctor Governing Body Member being

Committee	Role and performance highlights
	the second. The Practice Manager representative joined the CCG and the Committee from 1 July 2013. The first Committee meeting was not quorate (there was not the minimum of two members present). All meetings except the first were preceded by a private meeting of members with internal and external audit. Members: Keith Ramsay (Committee Chair), Lay Member with the lead role in governance John McEvoy - Practice Manager Governing Body Member (from July 2013) Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member Performance/Highlights: The Committee has scheduled to review its effectiveness at the September 2014 meeting and to revise its terms of reference in accordance with the recently published HFMA NHS Audit Committee Handbook. Review of Key Financial Policies and Procedures and Scheme of Delegation Review of Assurance Framework and Risk Register processes Review of Commissioning Support Unit assurance Review of Partnership Commissioning Unit assurance
Remuneration Committee	Chaired by the CCG Chairman, the Remuneration Committee had delegated authority from the Governing Body to determine pay and remuneration for employees of NHS Vale of York Clinical Commissioning Group including development pay, the use of Recruitment and Retention Premiums, annual salary awards where applicable, allowances under any pension scheme it might establish as an alternative to the NHS pension scheme, severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money', and receipt and review of new policies and instructions relating to remuneration. The Committee met four times in 2013-14 and was quorate (the Chair and one other Lay member present) on each occasion. Members: Professor Alan Maynard, CCG and Remuneration Committee Chair John McEvoy, Practice Manager Governing Body Member from July 2013 Keith Ramsay, Lay Member with the lead role in governance and Audit

Committee	Role and performance highlights
	Committee Chair Performance / highlights: Review of remuneration and terms of appointment for posts not on agenda for change Review of Performance Objectives for Very Senior Managers
Quality and Performance Committee	Chaired by the Lay Member/Audit Committee Chair for three meetings, the Secondary Care Doctor Governing Body Member for one meeting and the Practice Manager representative for three meetings, the Quality and Performance Committee met seven times from April to November 2013. The only meeting that was quorate (three members present) was the September meeting. From December 2013 the Quality and Performance Committee, Finance and Contracting Committee and Business Committee were amalgamated to form the Performance and Finance Committee. The overall objectives of the Quality and Performance Committee, which had delegated authority from the Governing Body with regard to all quality and performance issues, were to ensure that there was a detailed challenge and review of all aspects of the CCG's quality and performance and that remedial action plans were put in place in the event of any variation in quality and performance. Members: John McEvoy, Practice Manager Member of the Governing Body (Chair for three meetings) Dr Shaun O'Connell, Governing Body GP Clinical Lead for Quality and Performance Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member (Chair for one meeting) Keith Ramsay, Lay Member with the lead role in governance and Audit Committee Chair (Chair for three meetings) Performance / highlights: Review and development of Performance Dashboard Development and approval of Francis Report Action Plan Receipt of Safeguarding Adults and Children reports Quarterly Quality Report
Business Committee	Chaired by the Chief Clinical Officer the Business Committee met seven times from April to November 2013. All meetings were quorate (Chair and at least four Governing Body members two of whom were clinical). From December 2013 the Committee was amalgamated with

Committee	Role and performance highlights
	the Quality and Performance Committee and Finance and Contracting Committee to form the Performance and Finance Committee. The Business Committee had delegated authority from the Governing Body for the day to day business decisions of the CCG, in line with the scheme of delegation, standing orders and constitution, to drive through the delivery of the Integrated Commissioning Plan, monitor delivery, report progress and provide assurance of delivery against specific areas of the plan. Membership: Dr Mark Hayes, Chief Clinical Officer (Accountable Officer) (Committee Chair) Michael Ash-McMahon, Deputy Chief Finance Officer, from 1 August 2013 Wendy Barker, Acting Executive Nurse, from 15 July 2013 Fiona Bell, Deputy Chief Operating Officer, from 1 June 2013 Dr Emma Broughton, GP Governing Body Member Dr Paul Edmondson-Jones, Director of Public Health and Well-being, City of York Council Kevin Howells, Interim Chief Finance Officer, from 1 July to 31 October 2013 Dr Tim Hughes, GP Governing Body Member to 31 May 2013 Dr Tim Maycock. GP Governing Body Member Cheryl McKay, Interim Head of Delivery Dr Shaun O'Connell, GP Governing Body Member Dr Andrew Phillips, GP Governing Body Member Tracey Preece, Chief Finance Officer, from 4 November 2013 Rachel Potts, Chief Operating Officer Adrian Snarr, Chief Finance Officer to 30 June 2013 Dr Cath Snape, GP Governing Body Member, to 30 September 2013 Caroline Wollerton, Executive Nurse to 15 July 2013 Representatives of North Yorkshire and Humber Area Team, NHS England Performance / highlights: Quality, Innovation, Productivity and Prevention (Quality, Improvement, Performance and Productivity) Programme Reports Agreement of Referral Support Service Business Case and Pre-elective Smoking Cessation Quality, Improvement, Performance and Productivity Proposal Business Case for presentation to the Governing Body Consideration of Treatment Advisory Group recommendations Medicines commissioning decisions Approval of Community Dermatology Service Specification and

Committee	Role and performance highlights
	Evaluation Framework Consideration of Initial Viability Assessments, including relating to Emergency Care Practitioner Service, Patient Transport Service, Frequent Callers and Enhanced Primary Care, Care Homes Service Neurology Services Review commissioned from Neurological Support
Finance and Contracting Committee	Chaired by the CCG Chairman, the Finance and Contracting Committee met five times from May to September 2013 and was quorate on each occasion (three members present, at least one being a Governing Body member). This Committee's function was to drive through the delivery of the Integrated Commissioning Plan, monitor delivery, report progress and provide assurance of delivery against their specific area of the plan. The overall objectives of the Finance and Contracting Committee were to ensure a detailed review of all aspects of financial performance of the CCG and that, where there were any variations in performance, remedial action plans were put in place. From December 2013 the Committee was amalgamated with the Quality and Performance Committee and Business Committee to form the Performance and Finance Committee. <u>Members:</u> Professor Alan Maynard, CCG and Finance and Contracting Committee Chair Dr Mark Hayes, Chief Clinical Officer (Accountable Officer) Kevin Howells, Interim Chief Finance Officer, from 1 July to 31 October 2013 Keith Ramsay, Lay Member with the lead role in governance and Audit Committee Chair Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member Rachel Potts, Chief Operating Officer Tracey Preece, Chief Finance Officer, from 4 November 2013 Adrian Snarr, Chief Finance Officer, to 30 June 2013 <u>Performance / highlights</u>: Finance updates, Contracting updates, Detailed consideration of the Financial Plan
Performance and Finance Committee (now known as	The Performance and Finance Committee replaced the Business Committee, Quality and Performance Committee and Finance and Contracting Committee from December 2013. Chaired by the Practice Manager Governing Body Member the Committee met four times and

Committee	Role and performance highlights
the Quality and Finance Committee)	was quorate (four members present of which one was a Lay Member or Secondary Care Doctor and one was a clinician) for each meeting. The meetings alternate between a formal agenda and an agenda with the regular standing items followed by informal discussion of agreed items. Members: John McEvoy, Practice Manager Governing Body Member (Chair), from 1 July 2013 Michael Ash-McMahon, Deputy Chief Finance Officer, from 1 August 2013 Wendy Barker, Acting Executive Nurse, 15 July 2013 to 13 January 2014 Lucy Botting, Chief Nurse, from 13 January 2013 Dr Mark Hayes, Chief Clinical Officer Dr Tim Maycock, GP Governing Body Member, from 20 February 2013 Dr Shaun O'Connell, GP Governing Body Member Dr Andrew Phillips, GP Governing Body Member Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member Rachel Potts, Chief Operating Officer Tracey Preece, Chief Finance Officer, from 4 November 2013 Performance / highlights: Monthly detailed consideration of the Core Performance Dashboard and Financial and Quality, Improvement, Performance and Productivity Dashboards Regular Safeguarding reports Recommendations of the Francis and Winterbourne Reports Support for progressing a partnership approach to Diabetes Service Redesign MSK Procurement Case for Change

Table 20 Committee roles and highlights for 2013-14

6.5 The Clinical Commissioning Group Risk Management Framework

As a general principle the CCG seeks to eliminate or reduce all identifiable risk to the lowest practicable level and control all risks which have the potential to: harm its staff, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the CCG and/or its partner agencies; would have severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents.

The NHS Vale of York CCG has an agreed Risk Management Strategy, which was approved in April 2013. It sets out our definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management to which we adhere. The Governing Body held a risk workshop in April 2013 to establish the key risks to the organisation and create the Board Assurance Framework.

6.5.1 Risk Assessment

The CCG has adopted a risk assessment tool, which is based upon a 5 x 5 matrix. *(Used by Risk Management AS/NZS 4360:1999.)* Risks are measured according to the following formula:

Probability (Likelihood) x Severity (Consequences) = Risk

All risks need to be rated on 2 scales, probability and severity using the scales below.

Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5
Probability / **Severity**	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**

Fig 11 Risk Assessment Tool

6.5.2 Probability

Risks are first judged on the *probability* of events occurring so that the risk is realised. Enter a number (1-5) indicating the probability of the risk occurring. Please refer to the definition scale below.

		Broad descriptors of frequency	Time framed descriptors of frequency
1	Rare	This will probably never happen/recur	Not expected to occur for years
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	Expected to occur at least annually
3	Possible	Might happen or recur occasionally	Expected to occur at least monthly
4	Likely	Will probably happen/recur but it is not a persisting issue	Expected to occur at least weekly
5	Almost certain	Will undoubtedly happen/recur possibly frequently	Expected to occur at least daily

Table 21 Probability and Severity Scales

6.5.3 Severity

The Risk Management Strategy sets out the categories for 'severity'.

Table 22 Consequence score (severity levels) and examples of descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to

		standards Minor implications for patient safety if unresolved Reduced performanc e rating if unresolved	potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	performance rating Critical report	meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/k ey training	Uncertain delivery of key objective/servi ce due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performanc e rating if unresolved	Single breech in statutory duty Challenging external recommend ations/ improvemen t notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity / reputation	Rumours Potential for public concern / media interest Damage to an individual's reputation.	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a team's reputation	Local media coverage – long-term reduction in public confidence Damage to a services reputation	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence (NHS reputation)
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low eg files were encrypted	Serious potential breach and risk assessed high eg unencrypted clinical records. Up to 20 people affected	Serious breach of confidentiality eg up to 100 people affected	Serious breach with either particular sensitivity eg sexual health details or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

Based on the above judgments a risk assessment can be made of the potential future risk to stakeholders and the organisation as follows:

- Green – low risk
- Yellow – moderate risk
- Amber – high risk
- Red – significant risk

6.5.4 Risk Reduction

The CCG seeks to reduce the risks in the all aspects of its work. Each new policy, project or service improvement is required to complete an equalities impact assessment, sustainability impact assessment and a bribery impact assessment. The processes have been designed to reduce risks to service users, finances and organisational reputation through ensuring the appropriate safeguards are considered at the beginning of a process.

The CCG has approved policies on conflicts of interest and business standards, carried forward from the Primary Care Trust and whistleblowing (updated 5th September 2013) to encourage transparency and encourage reporting of incidents. The CCG works with NHS Protect and Internal Audit services (NYAS) to reduce the risks of fraud.

The CCG was operating under the predecessor PCT's policies for the early part of the year, including counter fraud, but the CCG specific policy was approved by the Audit Committee in April 2014. The CCG had 20 counter fraud days in its plan for 2013-14 which included an element of new organisation set-up. The Audit Committee recently approved the counter fraud plan for 2014-15 which, following discussion, includes an allowance for the CCG's contribution to counter fraud provision in the Partnership Commissioning Unit. The Local Counter Fraud Specialist provides updates to the Audit

Committee on counter fraud work, including updates on current and concluded fraud investigations and proactive counter fraud work undertaken.

The CCG has a robust approach to public and stakeholder engagement in both strategic and operational planning, and includes engagement as a critical factor within the Assurance Framework. The CCG is transparent about the risks it faces and publishes the Assurance Framework with the Governing Body papers.

6.6 The Clinical Commissioning Group Internal Control Framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the CCG's policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

6.6.1 Assurance Framework

The Governing Body held the annual risk management workshop in April 2013 to review the Risk Strategy and set the risk appetite. The CCG Assurance Framework was developed for approval in June 2013. The Assurance Framework assesses risk to the critical success factors for the organisation:

Critical Success Factor	
1	Improving health outcomes for the local population
2	Improve the quality and safety of commissioned services
3	Achieving Financial Balance
4	Collaborative working with stakeholders in service development and decision making
5	Ensuring the CCG has the capacity and processes to deliver its statutory duties

Table 23 Assurance Framework

Each risk on the Assurance Framework is embedded into the relevant departmental risk register. The Assurance Framework is reviewed and updated monthly and reported to each Governing Body on an exception basis (i.e. significant risks only), with the full Assurance Framework reported quarterly.

Each department (Quality and Performance, Corporate, Innovation and Improvement and Finance and Contracting) has a dedicated risk register. These are overseen by the Chief Officers for each department. Each identified risk is assessed against the Risk Management Strategy assessment process and entered on the risk register, listing the controls in place and actions to mitigate the risk. This process was established in June 2013 and is monitored through the Integrated Governance team.

The risk registers are reviewed monthly by each department and reported monthly to the Performance and Finance Committee. In addition the corporate risk register is reported to the Senior Management Team. The significant risks within each register (score over 15) are also included on the Assurance Framework as appropriate and reported to the Governing Body. Audit Committee receives bi-annual reports on risk management and assurance processes and receives reports of incidents and breaches of standing orders as required.

The process has been enhanced during the past 12 months with additional capacity secured through the Policy and Assurance post in November 2013, increased reporting to Committees and Governing Body through the inclusion of a standing item on risk on each agenda and the procurement of an integrated risk system, covering both risk and project management. The system is expected to be fully implemented by June 2014.

Risk management is embedded across the organisation through these processes, but also through assessment of specific risks including information security, business continuity planning and emergency preparedness. There is a clear mechanism for reporting incidents and sharing findings. There have been no reported incidents to the Information Commissioners Office during 2013-14 and low level incidents have been reported to Audit Committee.

6.7 Information Governance

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

assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

The CCG has implemented systems to ensure that information security or data protection incidents are reported via the CCG's incident reporting system. This is hosted by the Commissioning Support Unit. Established procedure requires that incidents logged per the CCG's incident reporting system are reviewed and investigated by the Commissioning Support Unit Information Governance Team. Serious Incidents are notified to the CCG's Senior Information Risk Owner (SIRO) and Caldicott Guardian where applicable and reported appropriately, including a report to Audit Committee. Risks arising through the investigation are logged in the CCG's risk registers, along with a note of actions to be taken to minimise the chances of occurrence and reduce impact.

The CCG has experienced one minor information breach during the year. The assessed level of incident breach, as assessed by North Yorkshire and Humber Information Governance Team, was level 1 and as such did not require reporting to the Information Commissioner's Office (ICO). A summary of information incidents, as required by Annual Accounts reporting guidance is provided below.

Summary of other personal data related incidents		
Category	**Nature of Incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	0

Table 24 Summary of other personal data related incidents

The CCG has processes in place for ensuring compliance with the Freedom of Information Act 2000, (FOIA). It has published a Freedom of Information Act Publication Scheme on the CCG's website along with details provided to requestors under FOIA applications.

The CCG acknowledges the importance of safeguarding the information it holds and uses and in December 2013 established an Information Governance Steering Group

which is chaired by the Chief Operating Officer (SIRO). The group receives updates on the work under way to put in better Information Governance arrangements as well as receiving details regarding information incidents. The CCG's Information Governance Framework is led by the North Yorkshire and Humber Commissioning Support Unit Information Governance Team which provides guidance and support to the CCG on Information Governance matters. The emerging Information Governance work plan continues to be developed to build upon our current Information Governance compliance.

The CCG has implemented an Information Governance Framework as defined in the CCG's Information Governance Strategy. Supporting this framework is a number of information governance policies. These were refreshed in January and February 2013 and are as follows:

- Data Protection and Confidentiality Policy
- Confidentiality Audit Policy
- Records Management Policy
- Internet, Email and Acceptable Use Policy
- Information Security Policy
- Information Risk Policy
- Mobile Working Policy
- Freedom of Information Policy
- Subject Access Request Policy
- Safe Haven Policy

To further enhance data security a number of controls have been employed including: encryption of portable devices, authenticated remote access, access controls via passwords, and physical controls to control access to the hosting data centre. Information and publicity about the above policies is provided by way of the CCG's website and inclusion of Information Governance matters in the CCG's newsletter and intranet.

All staff working for the CCG are required to undertake training on Information Governance standards. During 2013-14 we were compliant with the requirement to have 95% staff working for the CCG having received Information Governance training. Guidance and reminders on information governance have also been sent out through the staff bulletin throughout the year.

The Audit Committee is responsible for providing the Governing Body with assurance regarding Information Governance systems, including the management of information risk.

The CCG has achieved compliance at Level 2 with the NHS Information Governance toolkit. This achievement has been independently audited and validated. The CCG's Internal Auditor's opinion provided "significant assurance" regarding the adequacy and quality of evidence supporting Information Governance toolkit compliance.

6.8 Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

6.9 Equality, Diversity and Human Rights Obligations

Control measures are in place to ensure that the Clinical Commissioning Group complies with the required public sector equality duty set out in the Equality Act 2010. The CCG's strategic lead for equalities is the Chief Operating Officer.

The CCG agreed the Equality Strategy and Implementation Plan 2013-17 in November 2013 and following consultation to January 2014, has set equality objectives which are:

- to provide accessible and appropriate information to meet a wide range of communication styles and needs;
- to improve the reporting and use of equality data to inform equality analyses;
- to strengthen stakeholder engagement and partnership working;
- to be a great employer with a diverse, engaged and well supported workforce;
- ensure leadership is inclusive and effective at promoting equality.

The equality objectives are embedded in the CCG's strategic plan. Each policy is required to have an equalities impact assessment and all Governing Body and committee papers require a statement on equalities impact of the items within the paper, enabling scrutiny at each decision point.

6.10 Sustainable Development Obligations

The CCG is committed to shaping a more sustainable NHS by:

- developing a "whole systems" approach to commissioning;
- understanding our role in improving the sustainability of healthcare;
- using the commissioning cycle to increase sustainability;
- to implement the NHS Carbon Reduction Strategy.

The CCG is developing plans to assess risks, enhance performance and reduce its impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

The CCG's Governing Body approved the organisation's Sustainability Development Management Plan in November 2013. Plans for a sustainable future are well known within the organisation and clearly laid out. The CCG is also setting out its commitment as a socially responsible employer.

In addition, the CCG has developed and implemented a Sustainability Impact Assessment tool and guidance for use by staff to help identify the likely sustainability implications of either:

- the introduction of a new policy, project, or function or,
- the implementation of an existing policy, project, or function within the organisation.

Once sustainability implications have been identified, steps are taken to amend the proposed policy, project or function or amend the way in which it is currently implemented to ensure it is inclusive and does not discriminate (either deliberately or accidentally). Our commitment to sustainability is embedded in our strategic planning. Each Governing Body and committee paper requires a statement on sustainability in relation to the items within the paper to enable scrutiny at each decision point.

Through this work, the CCG will ensure it complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

6.11 Risk Assessment in Relation to Governance, Risk Management and Internal Control

The CCG's current significant risks can be found at:
http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/3-april-2014/item-6-ccg-assurance-framework1.pdf

Each risk has a strategic and operational lead. The operational lead is responsible for delivering the identified mitigating actions and reporting the strategic lead on changes to the risk level. These are reviewed monthly and reported at each Governing Body meeting.

A specific Quality Strategy is in development to address the significant quality risks that have been identified in-year and the realisation of the risk on hospital acquired infection rates. The review of service specifications with the Commissioning Support Unit is targeted at reducing risks relating to accessing performance information, prescribing costs through medicines management and IT resilience.

The internal audit plan is aligned to areas of identified risk, and during 2013-14 internal audits have been conducted on the CCG's governance arrangements, management of the Commissioning Support Unit Service Level Agreement, financial arrangements, payroll verification, the securing of quality improvements and commissioning process. The findings from the audit report have been incorporated into mitigating action plans. The internal audit found that the governance arrangements provided significant assurance. A governance plan is in place for 2014-15 to enhance the CCG's arrangements and its communication with our Membership practices.

The CCG has actively monitored the financial risks to the organisation through 2013-14, including the delivery of the Quality, Improvement, Performance and Productivity programmes, continuing healthcare costs, prescribing costs and management of the provider contracts. The staffing capacity within the Finance and Contracting Team has been significantly increased, providing a dedicated team for the CCG which has been in place from September 2014. The CCG completed a fundamental review of the financial plan during the summer 2013, which was approved by the Governing Body in August 2013.

The Governing Body have raised the issue of data quality in the CCG performance reports at Governing Body meetings, and the availability of timely and high quality data has been included as an organisational risk. During quarter 1 there were issues with accessing performance data through changes to the national information governance requirements and through 2013-14 significant progress has been made on accessing data and the development of a revised performance dashboard for the CCG, agreed in Autumn 2013. This work will continue during 2014-15.

During 2013-14 it was identified that the processes used to track and escalate risk could be improved, and approval was sought and given by the Senior Management Team and Audit Committee to implement supporting risk management software to enhance risk recording and consistency. This is scheduled to be implemented by June 2014.

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

During 2013-14 the CCG's overall financial performance was monitored and managed on a regular basis by the Senior Management Team and by a formal committee of the Governing Body. This was initially the Finance and Contracting Committee which, following a review of Governance arrangements in November 2013 became the Performance and Finance Committee for the remainder of 2013-14. The Governing Body also receives a finance report at each public meeting and continues which covers all aspects of key financial performance. This report has evolved through the financial year from a basic report to encompass greater Quality, Improvement, Performance and Productivity reporting, a range of key indicators in addition to performance against the plan, enhanced risk and mitigating action reporting and sensitivity analysis. The format of the report was changed considerably following improved internal processes to ensure better reader understanding.

The opening financial plan was not considered clear and credible and the CCG was authorised with conditions. A detailed and fundamental review was undertaken of the financial plan in summer 2013, with the support of the Area Team, which resulted in a reduced surplus, lower Quality, Improvement, Performance and Productivity target, identification of running cost underspend to support the programme position and a number of further mitigating actions required to deliver the plan. This was a considerably more robust plan and was approved by the Governing Body in August 2013.

The CCG has delivered the revised planned surplus and has undertaken a detailed piece of work, as part of the planning for 2014-15 to 2018-19 to understand the underlying financial position, given the level of non-recurrent actions taken in 2013-14. The Governing Body considered and approved the financial plan in April 2014 which outlined a moderate underlying surplus position, based on a number of assumptions around contract positions and with a level of risk reported transparently alongside. There are considerable risks in the coming years for the CCG but the Governing Body has received assurance that the underlying financial position is significantly stronger than at the start of 2013-14.

The Quality, Improvement, Performance and Productivity target in the opening financial plan was £10.9m which was revised to £6.8m following the fundamental review of the plan and 'confirm and challenge' exercise conducted on the original Quality, Improvement, Performance and Productivity plans. Of this, £4.7m was delivered which demonstrates a commitment to the delivery of efficiency savings in the first year of the CCG's operation. There remains significant risk in the delivery of recurrent savings in

order to meet the CCG's part of the national £20bn funding gap outlined in 'A Call to Action' published in July 2013. The CCG's 5-year financial plan outlines how this will be achieved but there remains an element of unidentified Quality, Improvement, Performance and Productivity in each year of the plan and therefore a degree on continued delivery risk. The CCG is responding to this challenge by enhancing the focus on delivery and associated reporting and monitoring internally.

The CCG has significantly increased the finance and contracting resource during the year, making the decision, jointly with Scarborough & Ryedale CCG, to split the shared team in place at the start of the year. A new Chief Finance Officer and Deputy Chief Finance Officer were appointed in November 2013 and August 2013 respectively and an increased contracting team recruited to between October 2013 and February 2014. This has had a significant effect on achieving the financial position at the end of 2013-14 due to the greater analysis that has been undertaken.

There is also a material on-going effect into establishing contract baselines for 2014-15 where the substantial additional knowledge and analytical time available has identified a large number of areas for resolution and negotiation in addition to opportunities for efficiency, both in the CCG and in provider organisations. This will provide much greater assurance to the Governing Body in 2014-15 and beyond of the quality of the information that the CCG bases its contracts and payments on.

The Audit Committee has developed during 2013-14 and has an annual work plan in place in line with the Audit Committee handbook enhanced by specific local requirements. The committee has requested reports in person from the Commissioning Support Unit and Partnership Commissioning Unit in order to gain assurance on the operation of those bodies and follow up attendances are scheduled during the early part of 2014-15. The committee also considered its membership and representation at its meeting in January 2014 as part of the consultation about proposed constitutional requirements for NHS Trusts and CCGs and has made the decision in its April meeting to appoint an additional member in the early part of 2014-15. This has also been discussed and supported at the Governing Body.

6.13 Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group.

6.14 Capacity to Handle Risk

The CCG's capacity to handle risk has been enhanced during the past 12 months through significant internal changes in the staffing structure. The Commissioning Support Unit has provided risk management advice and expertise to the CCG through 2013-14. There are clear roles and responsibilities in relation to risk management:

6.14.1 Roles and Responsibilities

6.14.1.1 NHS Vale of York Clinical Commissioning Group Governing Body

The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows:

- identifies risks to the achievement of its strategic objectives
- monitors these via the Assurance Framework
- ensures that there is a structure in place for the effective management of risk throughout the CCG
- approves and reviews strategies for risk management on an annual basis
- receives regular reports from the Performance and Finance Committee and Audit Committee identifying significant clinical risks
- receives regular updates and reports from the Management Team identifying significant risks and progress on mitigating actions
- demonstrates leadership, active involvement and support for risk management.

6.14.1.2 The Chief Operating Officer

The Chief Operating Officer has overall accountability for the management of risk and is responsible for:

- continually promoting risk management and demonstrating leadership, involvement and support;
- ensuring an appropriate committee structure is in place, with regular reports to the Governing Body;
- ensuring that chief officers and senior managers are appointed with managerial responsibility for risk management;
- ensuring appropriate Policies, Procedures and Guidelines are in place and operating throughout the CCG;
- ensuring risk management systems are in place throughout the CCG;
- ensuring the Assurance Framework is regularly reviewed and updated;

- ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body;
- Overseeing the management of risks as determined by the Executive Team;
- ensuring risk action plans are put in place, regularly monitored and implemented.

6.14.1.3 Senior Managers

Senior Managers should incorporate risk management within all aspects of their work and are responsible for directing the implementation of the CCG Risk Management Policy by:

- demonstrating personal involvement and support for the promotion of risk management;
- ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility;
- setting personal objectives for risk management and monitoring their achievement
- ensuring risks are identified and managed and mitigating actions implemented in functions for which they are accountable;
- ensuring action plans for risks relating to their respective areas are prepared and reviewed on a regular basis;
- ensuring a risk register is established and maintained that relates to their area of responsibility and to involve staff in this process to promote ownership of the risks identified;
- ensuring risks are escalated where they are of a strategic nature.

6.14.1.4 Head of Integrated Governance

The Head of Integrated Governance has responsibility for:

- ensuring that a risk register and Assurance Framework are developed and maintained and reviewed by the Senior Management Team;
- ensuring that Senior Management Team have the opportunity to review risks jointly;
- providing advice on the risk management process;
- ensuring that the CCG Assurance Framework and risk register is up to date for the Governing Body and all of its sub committees;
- working collaboratively with Internal Audit.

6.14.1.5 All Staff

All staff working for the CCG are responsible for:

- being aware that they have a duty under legislation to take reasonable care of their own safety and the safety of others who may be affected by the CCG's business and to comply with appropriate CCG rules, regulations, instructions, policies, procedures and guidelines.
- taking action to protect themselves and others from risks
- identifying and reporting risks to their line manager using the CCG risk processes and documentation
- Ensuring incidents, claims and complaints are reported using the appropriate procedures and channels of communication
- Co-operating with others in the management of the CCG's risks
- Attending mandatory and statutory training as determined by the CCG or their Line Manager
- Being aware of emergency procedures relating to their particular department locations.
- Being aware of the CCG's Risk Management Policy and complying with the procedures

Guidance, workshops and staff briefings have been provided by the Risk Management Team within the Commissioning Support Unit. An additional post 'Policy and Assurance Manager' was approved and in post in November 2013 to add additional capacity to the Clinical Commissioning Group's Integrated Governance Team to monitor and report on risks to the organisation.

6.15 Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, Audit Committee and the Quality

and Performance Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control has been actively reviewed during 2013-14, with initial work in April 2013, the Board Assurance process approved in June 2013 and enhanced in the review of committees in November 2013. From December 2013 the Governing Body have received and discussed the significant risks at each meeting.

The Audit Committee has received reports on the Assurance Framework and risk management process and has endorsed proposed enhancements through additional capacity and the risk management software.
The CCG has also been subject to a series of Assurance Checkpoint meetings with the Area Team during 2013-14 to review progress against the conditions and directions placed on the CCG during authorisation, and in particular a focus on the action taken to address the significant financial risks to the organisation. Through 2013-14 the conditions and directions have been removed, as detailed within the introduction to this statement. The financial risks to the organisation are monitored weekly through the Senior Management Team, monthly through the Performance and Finance Committee and to each Governing Body meeting.

Internal Audit provided a report of 'Significant Assurance' for governance, securing improvements in quality, financial controls, payroll verification (revised from limited to significant), information governance and the management of the Commissioning Support Unit Service Level Agreement.

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of Internal Audit is provided below.

6.16 Head of Internal Audit opinion on the effectiveness of the system of internal control at NHS Vale of York Clinical Commissioning Group for the year ended 31 March 2014

Roles and responsibilities

On behalf of the Clinical Commissioning Group the Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for

putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Governance Statement (GS) is an annual statement by the Accountable Officer, on behalf of the Clinical Commissioning Group and the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the GS requirements.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. As such, it is one component that the Clinical Commissioning Group and Governing Body take into account in making its GS.

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer, the Commissioning Clinical Group and Governing Body which underpins the assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the organisation in the completion of its GS.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary.

My **overall opinion** is that

- ***Significant assurance*** **can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.**

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; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within the internal audit risk-based plan, 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.

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes.

In preparation for and since authorisation on 1 April 2013 the Clinical Commissioning Group's (CCG) arrangements for risk and assurance have continued to evolve and become further embedded. In providing the opinion above it is recognised that the CCG has not reached the end of this journey but that it has made sufficient progress in putting arrangements in place to ensure that the Governing Body is alerted to the significant risks to objectives and the controls and actions in place to manage these.

One of the first actions of the Governing Body was to review the transfer of outstanding risks from NHS North Yorkshire and York on its dissolution. Where appropriate these were incorporated into the CCG's own risk framework. This was supplemented by the adoption of outstanding audit recommendations from NHS North Yorkshire and York that have continued to be routinely tracked and reported to the Audit Committee.

The Governing Body has agreed an Assurance Framework that is aligned to its own strategic objectives. The Audit Committee has been delegated with the responsibility to oversee the development of the framework and its on-going effectiveness. During the year the Governing Body has received and reviewed the Assurance Framework on three separate occasions. Going forwards it is planned to supplement this review with reports

at each meeting on significant risks so that the Governing Body is regularly updated to any changes to the risk profile of the organisation.

The Governing Body has approved a Risk Management Strategy. This is currently under review in order to reflect developments in the risk management framework during the year and changes to the governance structure.

The Assurance Framework is underpinned by a portfolio of committee and programme risk registers. The committee structure was reviewed during the year and the risk registers were reviewed and aligned to this new structure. The review of risks at committee level has gradually become more embedded and is now a standing item on the agenda. This underpins the process for escalating risks to the Governing Body.

Internal Audit undertook a review of the CCG's evolving governance arrangements during the year. This incorporated its risk management, assurance and reporting processes. An overall opinion of Significant Assurance was awarded to the progress being made by the CCG in embedding these arrangements. A number of recommendations were made to further embed and strengthen risk management and assurance processes. Management accepted the recommendations and has made good progress in addressing them.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

The 2013-14 Internal Audit Operational Plan was approved by the Audit Committee on 19 April 2013. The primary focus of the plan for the first year of operation as an authorised body was to evaluate the progress being made in designing, implementing and embedding core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

- Governance (incorporating assurance and risk management)
- Securing Improvements in Quality
- Commissioning and Contract Management
- Financial Governance
- Information Governance.

Following the completion of an audit an audit report is issued and an assurance level awarded. The following assurance levels are used:

HIGH	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to meet the organisation's objectives.
SIGNIFICANT	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to meet the organisation's objectives and that this is operating in the majority of core areas
LIMITED	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in its design and/or operation in core areas to effectively meet the organisation's objectives
LOW	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the organisation's objectives.

An action plan is agreed with management. In order to ensure significant progress is being made in the implementation of agreed actions an Audit Recommendations Status Report is presented to every Audit Committee.

The outcome of the audit reports presented to the CCG from the 2013/2014 audit plan are summarised below.

Audit	Assurance Level
Governance	Significant
Management of the Service Level Agreement with the Commissioning Support Unit	Significant
Securing Improvements in Quality	Significant
Delivery of Commissioning Priorities (including Quality, Improvement, Performance and Productivity)	Limited
Contract Management	Significant
Interim Assessment of Financial Controls Follow Up to Interim Assessment of Financial Controls	Significant Significant
Payroll Verification	Limited Revised to Significant
Information Governance Toolkit	Significant
Partnership Commissioning Unit – Financial Reporting Processes*	Limited

* Note: The Partnership Commissioning Unit is a hosted organisation established by the CCGs in North Yorkshire to undertake commissioning activities on behalf of all four organisations. This includes Continuing Health Care, Children Services Commissioning, Mental Health Commissioning and Adult Safeguarding. As part of each internal audit plan a number of audit days are allocated to the audit of

systems and controls at the Partnership Commissioning Unit in order to provide assurance to all four CCGS. All four CCGs requested assurance on the processes for reporting the financial position. A detailed audit plan for the Partnership Commissioning Unit for 2014/2015 has been agreed to provide assurance in relation to the commissioning activities undertaken on behalf of the CCGs.

Taking into account the internal audit work completed, all of my findings and the CCG's actions in response to my recommendations to date, I believe the following areas of material risk remain:

- The CCG Governing Body agreed a Commissioning Plan and Quality, Innovation, Improvement and Prevention programme (Quality, Improvement, Performance and Productivity) for 2013/2014. The two are heavily interdependent. The two plans together form the programme of work for transforming services commissioned by the CCG and for ensuring on-going financial balance. There has been slippage in the achievement of the Quality, Improvement, Performance and Productivity programme during the year with a revision to the overall target in August 2013. There has been further slippage against the revised target. Internal audit conducted a piece of work to provide assurance on the arrangements the CCG has in place to support the implementation of both plans. This identified a number of areas where these arrangements could be improved. The CCG has developed a Programme Management Framework. However, the audit identified that there are inconsistencies in how effectively this has been implemented. This audit report was issued at the end of the audit year which has meant that the CCG has not been in a position to fully respond to all the recommendations. It should be noted that the CCG had already recognised many of the issues contained in the report and had instigated improvements that had not had the time to take full effect in time for the audit.

- The CCG inherited a number of recommendations from the outgoing NHS North Yorkshire and York relating to the management of Continuing Health Care commissioning. The CCGs in North Yorkshire have established a unit to manage this process on their behalf. The outstanding high priority recommendations relate to the processes and information for providing assurance on the achievement of the key deliverables of the service. Progress has been made in terms of implementing a system to support this process but at the time of reporting this work was not complete and the CCG was not receiving adequate management information and reports on the service. Implementation of the new system is imminent.

6.17 Audit Reports

6.17.1 Internal Audit Reports

During the year the Internal Audit issued the following audit reports with a conclusion of limited assurance:

- Draft Report 'Delivery of Commissioning Priorities';
- Payroll verification (later revised to significant assurance);
- Partnership Commissioning Unit – Financial Reporting Processes.

During 2013-14, Internal Audit issued no audit reports with a conclusion of no assurance. In that year, the following significant risks materialised:

- Provider quality risks related to healthcare acquired Infections, (breach of 2013-14 target);
- high incidence of falls within the hospital environment;
- breach of wait times related to cancer and the RTT pathway;
- breach in red category 1-2 ambulance times (8 minute);
- quality governance;
- workforce and estate issues in relation to the CCG's mental health provider.

These risks were:

- placed on the CCG's risk register;
- on the Board Assurance Framework;
- escalated to the Quality and Finance Committee;
- escalated to the Governing Body.

The CCG's Quality and Performance team worked closely with its three main providers to understand the root causes of these risks and to mitigate patient harm, worked to resolve risks and put in place action plans where appropriate.

The team also worked with external assurance partners at the Care Quality Commission (CQC), Monitor and the NHS England Area Team to identify ways to collaborate and resolve issues.

6.17.2 Third Party Assurances

Third Party Assurances have been received for 2013-14 for:

- ESR / McKessons (Payroll and HR system);
- NHS Shared Business Services (Financial ledger).

There are no issues to report in relation to these. Third Party Assurances reports have also been received for:

- North Yorkshire and Humber Commissioning Support Unit - Services provided under the SLA.

These reports provide an overall opinion of reasonable assurance that the specified control objectives would be achieved if the described control operated effectively throughout the defined period. There are a number of exceptions identified which require further action by the Commissioning Support Unit. These will be monitored through the existing SLA contract management arrangements to ensure future compliance.

6.17.3 Achievement of the anticipated financial savings forecast through the Quality, Improvement, Performance and Productivity Schemes

During 2013-14 some of the CCG's Quality, Improvement, Performance and Productivity schemes experienced slippage in implementation and others failed to realise the expected savings once further explorative work had been carried out. Enhancements in the CCG's Innovation and Improvement Team provided additional capacity for programmes of work with a review of systems and processes for programme management underway. The terms of reference for a Programme Delivery Steering Group were approved to monitor Quality, Improvement, Performance and Productivity programmes for 2014-15.

6.18 Data Quality

Data Quality was a significant problem in 2013-14 and it is identified on the CCG's risk register and Board Assurance Framework. The main risks were escalated to the Governing Body.

The Commissioning Support Unit; providers to the CCG via a service level agreement to deliver performance, quality, activity, contracting and finance based business intelligence information experienced major problems with historic servers and systems. Capacity issues also created problems, leading to the CCG receiving information that was 2-3 months out of date. Delays in receipt and inadequacies in the depth of information along with limitations in quality and patient experience information posed significant intelligence risks to the CCG in its first year.

In January 2014, the CCG began to work closely with the Commissioning Support Unit to manage and rectify problems. Outcomes and actions included:

- the development of a core quality and performance dashboard that identifies performance, quality and patient experience information that the CCG requires for its business intelligence
- a higher level strategy which includes a Commissioning Support Unit Alliance Framework i.e. partnership between Commissioning Support Units to enable the use of better information systems.

In its first year the CCG enhanced its own in-house risk and intelligence systems. This included the implementation of risk management system and project management (Quality, Improvement, Performance and Productivity) dashboards. In May 2014 this information will be used to inform a refresh of the Commissioning Support Unit's specification for Business Intelligence.

Following this, the CCG will continue to closely monitor the Commissioning Support Unit's performance and strategically manage potential risks linked to data quality, taking immediate remedial action when required.

6.19 Business Critical Models

The CCG receives modelling advice and support from the Commissioning Support Unit that includes multi-disciplinary expertise for finance, business intelligence, workforce and service re-design services. Quality assurance is delivered internally to the CCG through peer reviews and the Commissioning Support Unit's own internal audit programme. The CCG also gains assurance through the involvement of its own staff in the specification and testing of models, often against real life scenarios e.g. through the involvement of clinicians and hospital managers, and through its own internal audit mechanisms too.

6.20 Data Security

The CCG has submitted a satisfactory level of compliance with the information governance toolkit assessment.

The CCG has no Serious Untoward Incidents relating to data security breaches, including any that were reported to the Information Commissioner.

6.21 Discharge of Statutory Functions

To ensure compliance with relevant legislation, during its establishment the CCG corporate governance arrangements were developed with in-line with advice from external experts that also informed the matters reserved for Membership Body and Governing Body decision and scheme of delegation.

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred to it by the National Health Service Act 2006 (as amended) and other associated legislative 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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

6.22 Conclusion

During 2013-14 the CCG identified the following internal control issues and took remedial action as detailed in the body of the Governance Statement:

- availability and quality of performance data and management information;
- financial risks and the delivery of planned Quality, Improvement, Performance and Productivity schemes;
- Partnership Commissioning Unit financial reporting processes and continuing health care;
- risk reporting processes;
- provider quality for healthcare acquired infections, high incidence of falls within the hospital environment, breach of wait times related to cancer and the RTT pathway, breach in red category 1-2 ambulance times (8 minute), quality governance, workforce and estate issues in relation to our mental health provider.

Dr Mark Hayes - Accountable Officer
2nd June 2014

7. Additional Information

7.1 Freedom of Information

During the period 1 April 2013 to 31 March 2014, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000:

	2013-14
Number of FOI requests processed	219
Percentage of requests responded to within 20 working days	99%
Average time taken to respond to an FOI request	14.5 days

Table 25 The CCG's FOI detail for 2013-14

The CCG's target response time for FOI requests is 20 days. 99% of requests met this target, with the average response time being 14.5 days.

Two requests took longer to comply with, in agreement with the requester, due to their complex nature.

The CCG's publication scheme contains documents that are routinely published. Information about this is available at http://www.valeofyorkccg.nhs.uk/publications/freedom-of-information-new/

NHS
Vale of York
Clinical Commissioning Group

Section B

Annual Accounts 2013-14

The best health and wellbeing for everyone.

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR NHS VALE OF YORK CCG

We have audited the financial statements of NHS Vale of York CCG for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements 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 the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers [and related narrative notes] on page 59;
- the table of pension benefits of senior managers [and related narrative notes] on page 60; and
- the table of pay multiples [and related narrative notes] on page 61.

This report is made solely to the Accountable Officer for NHS Vale of York CCG in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of the Accountable Officer and auditors

As explained more fully in the Statement of Responsibilities in respect of the accounts, the Accountable Officer is responsible for overseeing the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the clinical commissioning group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the clinical commissioning group; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Vale of York CCG as at 31 March 2014 and of its net operating costs for the year then ended; and

Certificate

We certify that we have completed the audit of the accounts of NHS Vale of York CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Mark Kirkham
on behalf of Mazars LLP

4 June 2014

CONTENTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4.1.1	**4,110**
Other costs	5	**365,874**
Other operating revenue	2	**(4,141)**
Net operating costs before interest		**365,843**
Other operating revenue	7	**-**
Other (gains)/losses	9	**-**
Finance costs	10	**-**
Net operating costs for the financial year		**365,843**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**365,843**
Of which:		
Administration Costs		
Gross employee benefits	4.1.1	**3,123**
Other costs	5	**3,059**
Other operating revenue	2	**(755)**
Net administration costs before interest		**5,427**
Programme Expenditure		
Gross employee benefits	4.1.1	**987**
Other costs	5	**362,815**
Other operating revenue	2	**(3,386)**
Net programme expenditure before interest		**360,416**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**365,843**

Reconciliation of Cash Drawings to Parliamentary Funding	
Total cash received from DH (Gross)	**319,082**
Less Trade revenue from DH	**-**
(Less)/ plus movement in DH working balances	**(1,060)**
Sub total : net advances	**318,022**
(Less)/ plus transfers (to) from other resource account bodies	**-**
Plus cost of Dentistry (central charge to cash limits)	**-**
Plus drugs reimbursement (central charge to cash limits)	**34,614**
Parliamentary funding credited to General Fund	**352,636**

The notes on pages 5 to 52 form part of these statements

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	13	680
Intangible assets	14	-
Investment property	15	-
Trade and other receivables		-
Other financial assets		-
Total non-current assets		680
Current assets:		
Inventories	16	-
Trade and other receivables	17	3,755
Other financial assets	18	-
Other current assets	19	-
Cash and cash equivalents	20	38
Total current assets		3,793
Non-current assets held for sale	21	-
Total current assets		3,793
Total assets		4,473
Current liabilities		
Trade and other payables	23	16,639
Other financial liabilities	24	-
Other liabilities	25	-
Borrowings	26	-
Provisions	30	280
Total current liabilities		16,919
Total Assets less Current Liabilities		(12,446)
Non-current liabilities		
Trade and other payables		-
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions		-
Total non-current liabilities		-
Total Assets Employed		(12,446)
Financed by Taxpayers' Equity		
General fund		(12,446)
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		(12,446)

The financial statements on pages 1 to 52 were approved by the Audit Committee, under delegated authority from the Governing Body, on Monday 2nd June 2014 and signed on its behalf by:

Dr Mark Hayes
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		-	-	-	-
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	**13**	761	-	-	761
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**761**	-	-	**761**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year		(365,843)	-	-	**(365,843)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	-
Net gain/(loss) on revaluation of intangible assets		-	-	-	-
Net gain/(loss) on revaluation of financial assets		-	-	-	-
Total revaluations against revaluation reserve		-	-	-	-
Net gain (loss) on available for sale financial assets		-	-	-	-
Net gain (loss) on revaluation of assets held for sale		-	-	-	-
Impairments and reversals		-	-	-	-
Net actuarial gain (loss) on pensions		-	-	-	-
Movements in other reserves		-	-	-	-
Transfers between reserves		-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-	-	-
Transfers by absorption to (from) other bodies		-	-	-	-
Transfer between reserves in respect of assets transferred under absorption		-	-	-	-
Reserves eliminated on dissolution		-	-	-	-
Net Recognised CCG Expenditure for the Financial Year		(365,082)	-	-	**(365,082)**
Net funding		352,636	-	-	**352,636**
Balance at 31 March 2014		**(12,446)**	**-**	**-**	**(12,446)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(365,843)**
Depreciation and amortisation	**13**	**81**
Impairments and reversals		**-**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables		**(3,755)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables		**16,639**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions		**280**
Net Cash Inflow (Outflow) from Operating Activities		**(352,598)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(352,598)**
Cash Flows from Financing Activities		
Net funding received		**352,636**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**352,636**
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**38**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**38**

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 *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* 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 *Manual for Accounts* 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.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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 Acquisitions & Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

Notes to the financial statements

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Secondary Care Activity

Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the CCG with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as block contract arrangements. Although the counting and coding of secondary care is not finalised, this only potentially affects those organisations where there is no year-end agreement in place: Leeds Teaching Hospitals NHS Trust, Mid Yorkshire Hospitals NHS Trust, Harrogate and District NHS Foundation Trust and South Tees Foundation Trust. This equates to approximately £800,000 in totality. The outturn position for Yorkshire Ambulance Service NHS Trust has not been finalised by Harrogate and Rural District CCG on behalf of the four North Yorkshire CCG's. The forecast overtrade was £1.2 million, of which the CCG share would be 42.84%.Of this £104,000 has been disputed, which is less than the CCG's share of what Harrogate and Rural District CCG offered.

Notes to the financial statements

- Gross/Net Accounting Arrangements for Hosted Services

Scarborough & Ryedale Clinical Commissioning Group (SRCCG) host a Partnership Commissioning Unit (PCU) for the provision of Continuing Healthcare services and the commissioning of Mental Health, Adult Safeguarding and Children's services, on behalf of Scarborough & Ryedale CCG, Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG and Vale of York CCG. All payments relating to these services are transacted through the SRCCG ledger and expenditure is recharged to the other CCG parties on a risk share basis, the terms of which are defined in the Partnership Commissioning Unit Service Level Agreement.

The costs of PCU hosted services are apportioned between the CCG's as follows:

Continuing Healthcare/Funded Nursing Care
Hambleton, Richmondshire & Whitby CCG 20.23% £12,875,572
Harrogate & Rural District CCG 24.46% £15,568,463
Vale of York CCG 34.64% £22,045,444
Scarborough & Ryedale CCG 20.66% £13,147,926

Mental Health Out of Contract Placements
Hambleton, Richmondshire & Whitby CCG 17.78% £1,641,820
Harrogate & Rural District CCG 20.99% £1,937,775
Vale of York CCG 41.42% £3,824,160
Scarborough & Ryedale CCG 19.82% £1,829,920

The Partnership Commissioning Unit staff are employed by SRCCG. The costs of these staff are apportioned between the CCG's on a weighted capitation basis, as follows:

Hambleton, Richmondshire & Whitby CCG 18.97% £548,109
Harrogate & Rural District CCG 20.39% £588,996
Vale of York CCG 45.45% £1,312,831
Scarborough & Ryedale CCG 15.19% £438,861

SRCCG also hosts Children's Safeguarding and Specialist Neurological Rehab. services on behalf of the CCGs and the costs of these hosted services are apportioned as follows:

Children's Safeguarding
Hambleton, Richmondshire & Whitby CCG 18.97% £54,073
Harrogate & Rural District CCG 20.39% £58,106
Vale of York CCG 45.45% £129,515
Scarborough & Ryedale CCG 15.19% £42,305

Specialist Neurological Rehab
Hambleton, Richmondshire & Whitby CCG 5.00% £90,088
Harrogate & Rural District CCG 25.00% £450,441
Vale of York CCG 50.00% £900,881
Scarborough & Ryedale CCG 20.00% £360,353

IAS 18 determines that the nature of these hosted arrangements constitutes an agency relationship, and therefore 'net' accounting principles are applicable. Therefore only Vale of York Clinical Commissioning Group's share of costs and staff numbers are represented in these accounts.

1.7.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Notes to the financial statements

- Accruals

There are a number of estimated figures within the accounts. The main areas where estimates are included are:

• Prescribing - The full year figure is estimated on the spend for the first 10 months of the year,
• Purchase of Healthcare - The full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner.

The CCG has achieved the following level of accuracy in estimation :
Prescribing > 95%
Purchase of Healthcare >96%

- Provisions

A number of key assumptions have been included within the accounts concerning the future:

• Bad Debt Provision-there is no bad debt provision.
• Continuing Care Provision-The CCG has reflected the PCU estimation of the Continuing Healthcare provision wholly.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.10 Other Expenses

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

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Valuation

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

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the financial statements

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 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.

1.17.1 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.

1.17.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

Notes to the financial statements

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Notes to the financial statements

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 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.

1.21 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:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 13 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements.

1.22 Clinical Negligence Costs

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

1.23 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 Litigation Authority 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.

Notes to the financial statements

1.24 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.26 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 fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.26.1 Financial Assets 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 assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

The clinical commissioning group does not have any financial assets to disclose.

1.26.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.26.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

The clinical commissioning group does not have any financial assets to disclose.

Notes to the financial statements

1.26.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The clinical commissioning group does not have any loans or receivables to disclose.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.27 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.27.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.27.2 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 to disclose.

1.27.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements

1.28 Value Added Tax

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.29 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.30 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.31 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).

1.32 Subsidiaries

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 Associates

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.36 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.37 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2 Other Operating Revenue

	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	£000	£000
Recoveries in respect of employee benefits	-	-	-
Patient transport services	-	-	-
Prescription fees and charges	67	-	67
Dental fees and charges	-	-	-
Education, training and research	-	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	-
Receipt of donations for capital acquisitions: NHS Charity	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-
Non-patient care services to other bodies	3,737	736	3,001
Income generation	-	-	-
Rental revenue from finance leases	-	-	-
Rental revenue from operating leases	-	-	-
Other revenue	337	19	318
Total other operating revenue	**4,141**	**755**	**3,386**

Other operating revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note includes cash received from NHS England of £1,067,638. This was not drawn down directly into the bank account of the CCG but invoiced directly to NHS England.

3 Revenue

	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	£000	£000
From rendering of services	4,141	755	3,386
From sale of goods	-	-	-
Total	**4,141**	**755**	**3,386**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**3,547**	2,959	588	**2,708**	2,164	544	**839**	795	44
Social security costs	**228**	228	-	**171**	171	-	**57**	57	-
Employer Contributions to NHS Pension scheme	**328**	328	-	**244**	244	-	**84**	84	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**7**	7	-	**-**	-	-	**7**	7	-
Gross employee benefits expenditure	**4,110**	**3,522**	**588**	**3,123**	**2,579**	**544**	**987**	**943**	**44**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**4,110**	**3,522**	**588**	**3,123**	**2,579**	**544**	**987**	**943**	**44**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**4,110**	**3,522**	**588**	**3,123**	**2,579**	**544**	**987**	**943**	**44**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	-	-	-
Social security costs	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**-**	**-**	**-**

All staffing information in Note 4 includes staff directly employed by the CCG and the Vale Of York CCG's proportion of staff employed by the PCU.

4.2 Average number of people employed

2013-14	Total Number	Permanently employed Number	Other Number
Total	**59**	59	-
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	741
Total Staff Years	59
Average working Days Lost	13

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	6,881	1	1,744	**2**	**8,625**
£10,001 to £25,000	-	-	-	-	**-**	**-**
£25,001 to £50,000	-	-	-	-	**-**	**-**
£50,001 to £100,000	-	-	-	-	**-**	**-**
£100,001 to £150,000	-	-	-	-	**-**	**-**
£150,001 to £200,000	-	-	-	-	**-**	**-**
Over £200,001	-	-	-	-	**-**	**-**
Total	**1**	**6,881**	**1**	**1,744**	**2**	**8,625**

	Departures where special payments have been made	
	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	1	1,744
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval #	-	-
Total *	**1**	**1,744**

Includes any non-contractual severance payments made following judicial mediation, and none relating to non-contractual payments in lieu of notice.

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

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of section 16 of the NHS Terms and Conditions of Service Handbook(Agenda for Change) for compulsory redundancies.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is 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 Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

4.5 Pension costs

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as "pension commutation";

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	3,214	2,227	987
Executive governing body members	896	896	-
Total gross employee benefits	**4,110**	**3,123**	**987**
Other costs			
Services from other CCGs and NHS England	**5,254**	2,159	3,095
Services from foundation trusts	**239,367**	-	239,367
Services from other NHS trusts	**26,925**	-	26,925
Services from other NHS bodies	**529**	4	525
Purchase of healthcare from non-NHS bodies	**37,916**	15	37,901
Chair and lay membership body and governing body members	**-**	-	-
Supplies and services – clinical	**-**	-	-
Supplies and services – general	**5,027**	16	5,011
Consultancy services	**101**	84	17
Establishment	**223**	137	86
Transport	**12**	9	3
Premises	**847**	343	504
Impairments and reversals of receivables	**-**	-	-
Inventories written down	**-**	-	-
Depreciation	**81**	81	-
Amortisation	**-**	-	-
Impairments and reversals of property, plant and equipment	**-**	-	-
Impairments and reversals of intangible assets	**-**	-	-
Impairments and reversals of financial assets	**-**	-	-
· Assets carried at amortised cost	**-**	-	-
· Assets carried at cost	**-**	-	-
· Available for sale financial assets	**-**	-	-
Impairments and reversals of non-current assets held for sale	**-**	-	-
Impairments and reversals of investment properties	**-**	-	-
Audit fees	**98**	98	-
Other auditor's remuneration			
· Internal audit services	**46**	46	-
· Other services	**-**	-	-
General dental services and personal dental services	**-**	-	-
Prescribing costs	**47,873**	-	47,873
Pharmaceutical services	**-**	-	-
General opthalmic services	**145**	-	145
GPMS/APMS and PCTMS	**1,082**	-	1,082
Other professional fees excl. audit	**33**	25	8
Grants to other public bodies	**-**	-	-
Clinical negligence	**8**	8	-
Research and development (excluding staff costs)	**-**	-	-
Education and training	**35**	34	1
Change in discount rate	**-**	-	-
Other expenditure	**272**	-	272
Total other costs	**365,874**	**3,059**	**362,815**
Total operating expenses	**369,984**	**6,182**	**363,802**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Audit fees are shown net of an £8,000 refund of a premium payment for additional costs associated with carrying out Clinical Commissioning Group audits for the first time.

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	2,894	23,883
Total Non-NHS Trade Invoices paid within target	2,642	23,210
Percentage of Non-NHS Trade invoices paid within target	91.29%	97.18%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,346	281,315
Total NHS Trade Invoices Paid within target	2,220	280,180
Percentage of NHS Trade Invoices paid within target	94.63%	99.60%

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income Generation Activites

The clinical commissioning group does not undertake any income generation activities.

8. Investment revenue

	2013-14 £000
Rental Revenue	
PFI finance lease revenue (planned)	-
PFI finance lease revenue (contingent)	-
Other finance lease revenue	-
Total rental revenue	-
	-
Interest Revenue	-
LIFT: equity dividends receivable	-
LIFT: loan interest receivable	-
Bank interest	-
Other loans and receivables	-
Impaired financial assets	-
Other financial assets	-
Total interest revenue	-
	-
Total investment revenue	-

9. Other gains and losses

	2013-14 £000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-
Gain/(loss) on disposal of intangible assets other than by sale	-
Gain/(loss) on disposal of financial assets other than held for sale	-
Gain/(loss) on disposal of assets held for sale	-
Gain/(loss) on foreign exchange	-
Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure	-
Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure	-
Change in fair value of investment property	-
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	-
Total	-

10. Finance costs

	2013-14 £000
Interest	
Interest on loans and overdrafts	-
Interest on obligations under finance leases	-
Interest on obligations under PFI contracts:	
· Main finance cost	-
· Contingent finance cost	-
Interest on obligations under LIFT contracts:	
· Main finance cost	-
· Contingent finance cost	-
Interest on late payment of commercial debt	-
Other interest expense	-
Total interest	-
Other finance costs	-
Provisions: unwinding of discount	-
Total finance costs	-

11. Net gain/(loss) on transfer by absorption

There is no net gain/loss on transfer by absorption.

12. Operating Leases

12.1 As lessee

NHS Property Services, on behalf of Vale of York CCG, is finalising a tenancy agreement with the City of York Council for space within West Offices, Station Rise, York. The proposed agreement is for a period of six years, with a four year break, commencing 1st April 2013. The lease will be held by NHS Property Services but the clinical commissioning group will be recharged the full cost under a separate agreement from 2014/15.

For 2013/14 only, NHS Property Services costs have been calculated and invoiced to CCGs based on the allocation for each CCG which was ring-fenced for the year. Costs have not been charged on buildings occupied for 2013/14 and the charge for each CCG matches the amount of funding provided within the allocations.
The basis for these charges have been agreed with the National Audit Office and Audit Commission.
For 2013/14 this equated to a charge of £735,000 for the CCG. For 2014/15 NHS Property Services will be moving to invoicing based on actual premises being used by all parties.

12.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2013-14 Total £000
Payments recognised as an expense				
Minimum lease payments	-	735	8	**743**
Contingent rents	-	-	-	**-**
Sub-lease payments	-	-	-	**-**
Total	**-**	**735**	**8**	**743**

12.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2013-14 Total £000
Payable:				
No later than one year	-	276	-	**276**
Between one and five years	-	1,103	-	**1,103**
After five years	-	-	-	**-**
Total	**-**	**1,379**	**-**	**1,379**

12.2 As lessor

12.2.1 Rental revenue

	2013-14 £000
Recognised as income	
Rent	**-**
Contingent rents	**-**
Total	**-**

12.2.2 Future minimum rental value

	2013-14 £000
Receivable:	
No later than one year	**-**
Between one and five years	**-**
After five years	**-**
Total	**-**

13 Property, plant and equipment

2013-14

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	756	-	5	-	761
Adjusted Cost or valuation at 1 April 2013	-	-	-	-	756	-	5	-	761
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	756	-	5	-	761
Depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Adjusted depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	76	-	5	-	81
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	76	-	5	-	81
Net Book Value at 31 March 2014	-	-	-	-	680	-	-	-	680
Purchased	-	-	-	-	680	-	-	-	680
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	680	-	-	-	680
Asset financing:									
Owned	-	-	-	-	680	-	-	-	680
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total PFI & LIFT assets	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	680	-	-	-	680

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-	-	-

Assets transferred from closed NHS bodies as a result of the 1 April 2013 transition relate to ISTC Equipment transferred from North Yorkshire and York PCT.

13.1 Additions to assets under construction

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	-
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	**-**

13.2 Donated assets

The clinical commissioning group has not had any assets donated in 2013-14.

13.3 Government granted assets

The clinical commissioning group has not had any government granted assets in 2013-14.

13.4 Property revaluation

There have been no property revaluations performed in 2013-14.

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

The clinical commissioning group has not received any compensation from third parties for assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure.

13.6 Write downs to recoverable amount

The clinical commissioning group has had no assets written down to recoverable amounts and no reversals of previous write-downs.

13.7 Temporarily idle assets

The clinical commissioning group had no temporarily idle assets as at 31 March 2014.

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	680
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	**680**

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	10	10
Transport equipment	-	-
Information technology	-	-
Furniture & fittings	-	-

14 Intangible non-current assets

2013-14	Computer Software: Purchased £000	Computer Software: Internally Generated £000	Licences & Trademarks £000	Patents £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2013	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-
Adjusted Cost or valuation at 1 April 2013	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-
Additions internally generated	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	-
At 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Amortisation 1 April 2013	-	-	-	-	-	-
Adjusted amortisation 1 April 2013	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	-
At 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Net Book Value at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-
Donated	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-
Total at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £000's	Computer Software: Internally Generated £000's	Licences & Trademarks £000's	Patents £000's	Development Expenditure (internally generated) £000's	Total £000's
Balance at 1 April 2013	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-
Impairments	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-
Other movements	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-

The clinical commissioning group has no intangible non-current assets that meet the recognition criteria of IAS 38.

14 Intangible non-current assets cont'd

14.1 Donated assets

The clinical commissioning group has not had any donated intangible assets in 2013-14.

14.2 Government granted assets

The clinical commissioning group has not had any government granted intangible assets in 2013-14.

14.3 Revaluation

There have been no intangible non-current assets revaluations in 2013-14.

14 Intangible non-current assets cont'd

14.4 Compensation from third parties

The clinical commissioning group has not received any compensation from third parties for intangible assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure.

14.5 Write downs to recoverable amount

The clinical commissioning group has had no intangible assets written down to recoverable amounts and no reversals of previous write-downs.

14.6 Non-capitalised assets

The clinical commissioning group purchased licences and support for specific software during 2013-14. These are under the control of the clinical commissioning group during the period the licence is purchased for but do not meet the recognition criteria of IAS38 for capitalisation as an intangible asset as the licences are annual and do not allow for the probable flow of future economic benefits.

14.7 Temporarily idle assets

The clinical commissioning group had no temporarily idle assets as at 31 March 2014.

14.8 Cost or valuation of fully amortised assets

The clinical commissioning group had no fully amortised assets still in use as at 31 March 2014.

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	-
Computer software: internally generated	-	-
Licences & trademarks	-	-
Patents	-	-
Development expenditure (internally generated)	-	-

15 Investment property

The clinical commissioning group had no investment property as at 31 March 2014.

16 Inventories

The clinical commissioning group had no inventories as at 31 March 2014.

17 Trade and other receivables	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	2,274	-
NHS receivables: Capital	-	-
NHS prepayments and accrued income	876	-
Non-NHS receivables: Revenue	578	-
Non-NHS receivables: Capital	-	-
Non-NHS prepayments and accrued income	25	-
Provision for the impairment of receivables	-	-
VAT	2	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables	-	-
Total	**3,755**	**-**
Total current and non current	**3,755**	
Included above:		
Prepaid pensions contributions	**-**	

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 of them is considered necessary.

17.1 Receivables past their due date but not impaired	2013-14 £000
By up to three months	98
By three to six months	-
By more than six months	-
Total	**98**

£0 of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables	2013-14 £000
Balance at 1 April 2013	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjusted balance at 1 April 2013	**-**
Amounts written off during the year	-
Amounts recovered during the year	-
(Increase) decrease in receivables impaired	-
Transfer (to) from other public sector body	-
Balance at 31 March 2014	**-**

	2013-14 £000
Receivables are provided against at the following rates:	
NHS debt	-

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2014.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	-
Net change in year	38
Balance at 31 March 2014	**38**
Made up of:	
Cash with the Government Banking Service	38
Cash with Commercial banks	-
Cash in hand	0
Current investments	-
Cash and cash equivalents as in statement of financial position	**38**
Bank overdraft: Government Banking Service	**-**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**-**
Balance at 31 March 2014	**38**
Patients' money held by the clinical commissioning group, not included above	**-**

21 Non-current assets held for sale

The clinical commissioning group had no non-current assets held for sale as at 31 March 2014.

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure during 2013-14.

23 Trade and other payables	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	7,605	-
NHS payables: capital	-	-
NHS accruals and deferred income	-	-
Non-NHS payables: revenue	1,388	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	7,527	-
Social security costs	26	-
VAT	-	-
Tax	38	-
Payments received on account	-	-
Other payables	55	-
Total	**16,639**	**-**
Total payables (current and non-current)	**16,639**	

Other payables include £41,988 outstanding pension contributions at 31 March 2014.

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2014.

25 Other liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2014.

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2014.

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2014.

28 Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2014.

29 Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 31 March 2014.

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	7	-
Continuing care	273	-
Other	-	-
Total	280	-
Total current and non-current	280	

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	7	273	-	280
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	7	273	-	280
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	7	273	-	280
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**	**7**	**273**	**-**	**280**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £3,934,000.

31 Contingencies

	2013-14 £000
Contingent liabilities	
NHS Litigation Authority	2
Net value of contingent liabilities	2

Contingent assets

The clinical commissioning group had no contingent assets as at 31 March 2014.

32 Commitments

32.1 Capital commitments

The clinical commissioning group had no capital commitments not otherwise included in the financial statements as at 31 March 2014.

32.2 Other financial commitments

The clinical commissioning group and consolidated group had entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2013-14 £000
In not more than one year *	35
In more than one year but not more than five years	-
In more than five years	-
Total	35

*This relates to a contract for risk management and project management software with Covalent Ltd.

33 Financial instruments

33.1 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 the 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 clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the clinical commissioning group's revenue comes parliamentary funding, the 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.

33.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	2,274	-	**2,274**
· Non-NHS	-	578	-	**578**
Cash at bank and in hand	-	38	-	**38**
Other financial assets	-	-	-	**-**
Total at 31 March 2014	**-**	**2,890**	**-**	**2,890**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	**-**
· NHS	-	7,605	**7,605**
· Non-NHS	-	8,915	**8,915**
Private finance initiative, LIFT and finance lease obligations	-	-	**-**
Other borrowings	-	-	**-**
Other financial liabilities	-	-	**-**
Total at 31 March 2014	**-**	**16,520**	**16,520**

34 Operating segments

The clinical commissioning group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2013-14 £'000
Total net expenditure reported for operating segments	
Reconciling items:	
Commissioned Services	365,843
Total net expenditure per the Statement of Comprehensive Net Expenditure	**365,843**

34.2 Reconciliation between Operating Segments and SoFP

	2013-14 £'000
Total net assets reported for operating segments	
Reconciling items:	
Commissioned Services	4,473
Total net assets per Statement of Financial Position	**4,473**

	2013-14 £'000
Total liabilities reported for operating segments	
Reconciling items:	
Commissioned Services	16,919
Total liabilities per Statement of Financial Position	**16,919**

35 Pooled budgets

The clinical commissioning group was not party to any pooled budget arrangements during 2013-14.

36 NHS Lift investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2014.

37 Intra-government and other balances

	Current Receivables	Non-current Receivables	Current Payables	Non-current Payables
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Balances with:				
· Other Central Government bodies	-	-	-	-
· Local Authorities	554	-	107	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	881	-	3,050	-
· NHS Trusts and Foundation Trusts	2,269	-	4,555	-
Total of balances with NHS bodies:	3,150	-	7,605	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	51	-	8,927	-
Total balances at 31 March 2014	**3,755**	**-**	**16,639**	**-**

38 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Dr Andrew Phillips Governing body member - partner Pickering Medical Practice	336	0	0	0
Dr Andrew Phillips Governing body member - joint Director of Focus Medical Yorkshire Ltd which sub contracts with Primecare	260	0	22	0
Dr Cath Snape Governing body member - partner Gillygate Surgery Partnership	28	0	0	0
Dr Emma Broughton Governing body member - GP at Priory Medical Group(non equity)	353	0	0	0
Dr Shaun O'Connell Governing body member - employee at South Milford Surgery	485	0	0	0
Dr Shaun O'Connell Governing body member - spouse employee at York Teaching Hospital NHS Foundation Trust	191,930	0	2,688	841
Dr Tim Maycock Governing body member - Pocklington Group Practice	691	0	0	0
Dr Tim Maycock Governing body member - spouse Deputy Retail Manager St Leonards Hospice	1,066	0	0	0
John McEvoy Practice Manager Representative (from 4 July 2013) - Managing Partner Haxby Group Practice	329	0	0	0
Dr Louise Barker GP Mental Health Lead (from 3 February 2014) - Salaried GP Haxby Group Practice	329	0	0	0
Dr Louise Barker GP Mental Health Lead (from 3 February 2014) - spouse employee at Tees Esk Wear Valleys Foundation Trust	1,399	0	5	0
Kevin Howells Interim Chief Finance Officer (from 1 July 2013 to 3 November 2013) - Management Consultant Leeds Teaching Hospitals NHS Trust	7,554	0	0	405
Dr David Hartley Member of Council of Representatives and Governing body 16 May to 2 August 2013 - Finance lead with Jorvik Medical Practice	103	0	0	0
Dr Paul Edmondson Jones Director Of Public Health co opted - Director of Public Health City of York Council	1,554	398	106	398
Kersten England Local Authoriy Chief Executive Co opted - Director of Science City of York Council	1,554	398	106	398
Dr Philip Underwood GP Council of Representatives member 17 May to 7 November 2013 - partner at Scott Road Medical Centre	59	0	0	0
Dr Tim Hughes GP Governing Governing Body Member to 31 May 2013 and Chair of Council of Representatives wef from 16 May 2013 - Senior Partner Kirbymoorside Surgery	56	0	0	0
Richard Webb Governing Body Associate from 1 March 2014 - Corporate Director North Yorkshire County Council	3837	141	1	141
Helen Taylor Local Authority Representative on Governing Body to 30 November 2013-Corporate Director North Yorkshire County Council	3837	141	1	141
Adrian Snarr Chief Finance Officer to 30 June 2013-Joint Finance Officer with Scarborough and Ryedale CCG	1169	786	2791	151

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are listed below:

- NHS England;
- NHS Hambleton Richmondshire and Whitby CCG
- NHS Harrogate and Rural District CCG
- NHS Scarborough and Ryedale CCG
- NHS North Yorkshire and Humber CSU
- York Teaching Hospital NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust
- North Lincolnshire and Goole NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS 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. Most of these transactions have been with City of York Council and North Yorkshire County Council.

39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

40 Losses and special payments

The clinical commissioning group had no losses and special payments during 2013-14.

41 Third party assets

The clinical commissioning group had no third party assets as at 31 March 2014.

42 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).
The clinical commissioning group's performance against those duties was as follows:

National Health Service Act Section	Duty	2013-14 Maximum £'000	Performance £'000	Duty Achieved?
223H(1)	Expenditure not to exceed income	367,899	365,843	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	-	-	Yes
223I(3)	Revenue resource use does not exceed the amount	367,899	365,843	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	362,472	360,416	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	5,427	5,427	Yes

Note: For the purposes of 223H(1);expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year:and,income is defined as the aggregate of the notified maximum revenue resource,notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources,and included here on a gross basis).

43 Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2013-14 financial year.