NHS
Vale of York
Clinical Commissioning Group

Annual Report and Accounts 2016-17

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Issue date:	12-06-17
Document number:	ARA 2016-17
Prepared by:	NHS Vale of York Clinical Commissioning Group Governing Body

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Annual Report and Accounts 2016-17

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 2016 and 31 March 2017.

The report is made up of three parts. The first section contains details of the organisation's performance for 2016-17, with the second section covering details of governance and risk. The third is the financial accounts for the year 2016-17.

As a publicly accountable body, the CCG is committed to being open and transparent with its stakeholders.

In 2016-17 the Governing Body met eight times and the CCG hosted a number of engagement events that involved local patients and other stakeholders. Details of these meetings and events are published on the CCG's website at www.valeofyorkccg.nhs.uk.

An electronic copy of this report is also available on the CCG's website. Information contained in this report can also be requested in other languages. If you need this or if would like additional copies of this report, please contact the CCG.


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Performance

1.1 Report of the CCG's Lay Chair and Accountable Officer

Phil Mettam, Accountable Officer

Keith Ramsay, Lay Chair

Along with our NHS partners, we have a statutory duty to deliver services that are in line with the NHS Mandate and NHS Constitutional targets. Financial and workforce pressures in our local system have meant that these targets were not consistently delivered in 2016-17.

The financial situation worsened in 2016-17 and the Vale of York moves into 2017-18 with a deficit of £23.8m; money that needs to be recovered. The financial gap has provided the basis to begin work that uses our precious resources in a completely new way, so they drive improvement and help to achieve better value for money. We need to ensure our patients get the most benefit from healthcare services and that we help the community to take responsibility for their own health and to do this, the way that local people access healthcare services needs to change.

Looking ahead, we are moving to a new phase of delivering health and care services and collaboration, transparency and engagement are our watchwords throughout 2017-19. Our plan is to work with our partners as a system so we can ensure we recover the delivery of targets and that we do this in a sustainably and by managing the demand on services and putting prevention at the forefront of much of our work.

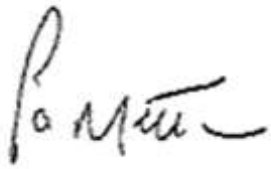
Transforming services as part of the wider Humber, Coast and Vale Sustainability Transformation Plan; and more importantly, driving transformation based on population need, it is critical to reposition the local system and remove the complexities within it.

To do this and align planning with all of our partners will be challenging but a focus on population and 'place' will allow us to plan together and challenge where things do not work as well as they could for patients.

This is why we are planning a system based on the needs of our population in each locality within the Vale of York through the development of a local Accountable Care System. This will help to ensure that:

- population and place needs are always put first;
- respectful alliances with a common purpose can be built;
- we can work with patients, the public, our workforce, carers and elected members as equal partners;
- there is shared accountability and rapid, effective joint decision-making;
- we can do things once – analyse, plan, make decisions, develop contracts and deliver; and
- we can share our scarce resources.

We are looking forward to working in a new way with our partners in 2017-18 to drive a cost reduction programme to reduce inefficiencies, duplication and unnecessary variation and deliver the services that patients need the most, within the allocation we receive.



Phil Mettam
Accountable Officer

Keith Ramsay
Lay Chair

1.2 Report of the Chair of the Council of Representatives

Dr Paula Evans
Chair of the Council of Representatives

2016-17 has been a challenging year. An enormous financial hole appeared; something that has happened to other CCGs across the country too.

In spite of the distraction and pressure this has caused, a lot of planning and hard work has carried on in the background. These plans have been embedded and we are now in action mode. We are engaging more widely than ever with our system partners to ensure they are heavily involved in this work.

The role of Primary Care has been given prominence in the CCG's operational plan for 2017-19 and I'm glad to report that working closely with our system partners has formed a very creative and lively environment, allowing councils, the voluntary sector and our secondary care partners to share and innovate with us.

The development of the Humber, Coast and Vale Sustainable Transformation Plan and our work to explore what an Accountable Care System might look like means that the relationships with our partners will move even closer.

The financial deficit position in the Vale of York has clearly been the most significant challenge for our CCG and it was the main factor for the issue of Legal Directions by NHS England in September 2016. Distasteful as it might feel, as a nation we need to discuss how our health and social care system can work more effectively so it provides the best value from the precious resources available.

To do this, and get it right, is the most challenging but ultimately the most satisfying work for us to do in the coming year. The CCG has prioritised its engagement strategy, and is now putting it into action. We are all very conscious of how we engage meaningfully and communicate effectively with

the public. Please do get involved in the discussion and make it a two way conversation.

Annual evaluation of Membership Body effectiveness

The Membership Body is pleased to report that the CCG has continued with its robust evaluation and governance measures throughout 2016-17.

In addition to the on-going evaluation of effectiveness from external sources, internal governance functions drive the delivery of the CCG's Five Year Integrated Operational Plan 2017-19, the monitoring of its delivery, the reporting on progress and providing of assurance.

The CCG's internal governance and assurance measures include:

Accountable Officer - 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 the delivery of financial balance and compliance with standing financial instructions;

NHS England Area Team - NHS England's Yorkshire and Humber Area Team reviews the CCG on a quarterly basis. The 2016-17 quality and assurance reviews have been very positive and have strengthened the commissioning relationship with NHS England.

Dr Paula Evans
Chair of the Council of Representatives

1.3 About the CCG

The CCG is an NHS organisation. It is led by local GPs and other clinicians that treat patients every day and understand the needs of the community and the impact that local services have on patients' health.

The CCG is responsible for commissioning the following healthcare services in the Vale of York:

- planned hospital care;
- urgent and emergency care;
- community health services;
- mental health and learning disability services;
- services that tackle inequality, including children's health and wellbeing.

1.3.1 CCG footprint

The CCG serves towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of around 350,000 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 2016-17, the CCG had 26 member GP practices in its operating area and an annual commissioning budget of £441.1m. The budget is set by central government and is based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

Fig 1 The NHS Vale of York CCG footprint

The CCG's footprint, the area that it commissions services for, includes urban, semi-urban and rural areas. It shares administrative boundaries with three local authorities, City of York Council, parts of North Yorkshire County Council and a part of the East Riding of Yorkshire Council boundary.

1.3.2 Accountability

The CCG is accountable to its Governing Body, its member practices, local patients and the Vale of York community. It is overseen by NHS England, a public body that is part of the Department of Health.

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

1.3.3 Location of the CCG

The CCG is co-located with City of York Council at their headquarters at West Offices, Station Rise, York YO1 6GA.

1.3.4 The CCG's vision

Ensuring that there is clinical input in its commissioning work and its plans that involve stakeholders and strategic partners, the CCG's vision is:

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

1.3.5 The CCG's mission

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

Table 1 – The CCG's mission

1.3.6 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.
Measurement	Successful measurement is a cornerstone of successful improvement.
Prioritisation	We will use an open and transparent process to arrive at value driven choices.
Quality	We strive to be the best that we can be and to deliver excellence in everything we do.
Respect	We have respect for individuals, whether they are patients or staff colleagues; we respect the culture and customs of our partner organisations

Table 2 – The CCG's values

1.4 Performance in 2016-17

1.4.1 NHS Constitution Targets

The NHS Constitution for England sets out the core values, principles and commitments of the NHS. It states what patients, the public, partners and staff can expect from the NHS and details a number of rights, responsibilities and key pledges.

The key measures that the CCG work to uphold are detailed in the tables and descriptions below, along with a view of the CCG's performance against each target.

Throughout this document, green, amber and red ratings are applied based on the following standard unless otherwise indicated.

Green		At or above target
Amber		Up to 5% away from meeting target
Red		More than 5% away from meeting target

Table 3 – Performance ratings green, amber and red

1.4.2 A challenged system

We have ended the year with a rapid recovery after the winter period in our Emergency and Urgent Care system.

Like many systems nationally, the Vale of York local health system has been severely challenged in 2016-17 and performance in delivering national Constitutional targets for patients has not been met consistently throughout the year.

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
4 hour performance	< 95%	86.8%	87.9%	87.2%	92.7%	90.6%	91.0%
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		85.5%	81.9%	81.2%	78.3%	81.5%	89.4%

Table 4 – 4 hour performance ratings

Demand for elective care has outstripped local and regional capacity in some specialties and the unprecedented demands on the Emergency and Urgent Care System over the winter period have impacted further on the capacity to deliver elective care. This has created a reduction in the associated performance targets for Referral to Treatment within 18 weeks.

This is despite the fact that there has been a drive through the CCG to further extend the support we provide to manage referrals through the Referral Support Service and extend the clinical thresholds for elective surgery. The CCG also developed one-stop Urology and Breast clinics and further

expanded skin referrals from Primary Care by utilising dermatoscopes that were provided by the CCG's partners at York Against Cancer. Referrals have subsequently reduced by 3.5% on average per month for the last five months of 2016-17 and this has reduced the pressure on some of the non-admitted pathways for elective care to our providers.

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Incomplete pathways seen < 18 weeks from referral	< 92%	92.4%	92.9%	92.4%	91.8%	91.5%	91.6%
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		91.5%	90.8%	90.6%	90.3%	90.5%	90.6%

Table 5 – Performance rating: Incomplete pathways seen < 18 weeks from referral

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients waiting less than 6 weeks for Diagnostic attendances	> 99%	98.6%	99.2%	99.0%	98.7%	98.6%	99.1%
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		98.7%	98.8%	98.3%	98.2%	98.0%	97.9%

Table 6 – Performance rating: Patients waiting less than 6 weeks for Diagnostic attendances

Likewise, the intensive system work undertaken via the A&E Delivery Board to establish Emergency Department Front Door initiatives that deliver early triage and streaming of patients by GPs, has resulted in a reduction in A&E attendances compared to 2015-16. This has meant locally we have already implemented national best practice as requested by NHS England and NHS Improvement.

Delays in Transfers of Care are at their lowest level for many years following improvements in the processes and access to community beds and care, and the CCG is now working with partners to improve the access to community beds for our elderly patients with mental illness, for example, dementia.

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Delayed transfers of care (York Unitary Authority Only)	-	*	*	998	972	935	982
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		1,000	1,121	996	610	572	850

*data excluded as incomplete

Table 7 – Performance rating: Delayed transfers of care (York Unitary Authority Only)

Despite these improvements in demand on the hospital, fluctuations in performance delivery, often on a daily basis, have reinforced we are a system which has limited resilience to deliver performance targets across all our pathways and specialities in a sustainable way.

At the centre of our system is a local hospital which has delivered urgent and planned care services throughout 2016-17 with an average bed occupancy of 92%, increasing to 95% over the winter period. There have been a high number of stranded patients (patients in hospital beds over seven days) and

elderly patients being cared for in hospital beds when they could be cared for at home or in the community if out of hospital services were delivered in a different way.

Small changes in workforce capacity through illness and the inability to fill vacancies, as well as theatre, outpatient and bed closures have a significant impact on both unplanned care and planned care performance. This is the baseline from which we must transform our out of hospital and in-hospital services as a system from 2017-18 and forms the basis of our improvement plans with our partner organisations.

1.4.3 A system response

The demand and capacity pressures outlined above have resulted in a strong collaborative response from all local organisations that are referring or delivering services to our patients to address performance improvement by working as a system during 2016-17. This has been supported by NHS England and NHS Improvement; the assurance bodies for NHS Clinical Commissioners and NHS Providers respectively. Additional local investment has also been made available to manage a backlog of patients that have waited more than 18 weeks for their elective care.

Our main acute provider, York Teaching Hospital NHS Foundation Trust has worked hard to implement an internal rapid recovery programme to support a return to normal operational standards after the winter period.

Similarly the local system's A&E Delivery Board has implemented all recommendations to stream patients to the most appropriate care at the front door of their Emergency Department and this has resulted in a reduction in non-admitted A&E four hour breaches. Additionally work that focused on ambulance handovers has seen performance improve since February 2017.

1.4.4 A sustainable recovery

As we transition into 2017-18 and work to deliver the national performance targets included in the new NHS Mandate, the ongoing performance challenges remain and there is a joint commitment from all partners to drive recovery that will ensure our patients receive high quality care in a timely manner.

The CCG enters 2017-18 with a strong platform for system working with all partners to drive performance improvement, both locally as part of our refreshed A&E Delivery Board and Planned Care System Recovery Group but also through our focus on local need through an Accountable Care System, our work as part of the local Sustainable Transformation Plan and with the support of Cancer Alliances via our Yorkshire and Humber region networks.

1.4.5 Understanding, managing and delivering for local demand

Whilst it works with providers to manage demand on the system, the CCG wants to continue its work to enable and support providers to have the capacity that is required across all specialties and for these to deliver services that meet the needs of the local population.

Together we will work as a system to refresh and remodel services to marry demand and capacity that will allow the system to deliver its key performance targets. The CCG is now working with York Teaching Hospital NHS Foundation Trust to systematically review all planned care pathways including managing demand on services through further improvements in referral support, clinical advice and guidance and transforming outpatient care. This will support pressures on elective care Referral to Treatment performance, cancer pathways and performance, make space available for delivering outpatient clinics and ensure the capacity planned for theatres and in-hospital beds are used effectively.

1.4.6 Bringing additional resource to support service delivery

Through the Humber, Coast and Vale Sustainable Transformation Plan, the system is successfully progressing bids for additional capacity to help manage demand on the Emergency Department through the expansion of a 24 hour psychiatric liaison, capacity for diabetes care in the community and cancer resources to support improved risk identification and early diagnosis.

1.4.7 Transforming out of hospital care and alleviating pressure on our acute hospital beds

The local system has commissioned and received recommendations from the Northwest Academic and Health Science Network's review of our local acute hospitals. This review has identified a number of areas where the system can focus on improving bed occupancy, flow and transforming the out of hospital care model to reduce the local dependency on acute beds. The NHS Mandate clearly articulates the need for our system to prioritise access to urgent and emergency care. This work will be aligned with the priorities identified by our three Accountable Care System localities so local populations can access the most appropriate out of hospital care to meet their needs.

1.4.8 Maintaining elective care performance delivery

While the 2017-18 NHS Mandate no longer requires the delivery of national performance for Referral to Treatment at the 2016-17 target, the local system will continue to work as part of the Planned Care Recovery Group to address the underlying issues locally and at Humber, Coast and Vale Sustainable Transformation Plan level in relation to elective care, diagnostics and cancer across all pathways.

The Planned Care Recovery Group will agree a refreshed trajectory through 2017-18 for Referral to Treatment performance and will continue to manage the existing backlog of admitted patients who have waited longer than 18 weeks for their surgery. Currently the backlog consists of approximately 950 patients with two of these patients having waited longer than 52 weeks for their surgery.

The aim is to continue to manage growth in demand for elective care alongside a reduction in the admitted backlog and work on each pathway to address the key drivers affecting under-performance. The pathways experiencing the greatest pressures currently include rheumatology, respiratory medicine and gastroenterology. Work has started to review these pathways as part of the CCG's and York Teaching Hospital NHS Foundation Trust's collaborative planned care programme. It also forms part of work to explore pathways identified by the national Right Care programme that offer opportunities to deliver improved clinical outcomes and value for money.

1.4.9 Delivering improvements in Cancer 62 day performance across all tumour sites and across our STP

Whilst the CCG was identified as one of the top seven performing CCGs in relation to commissioned cancer services, performance dipped below the national performance target level in all three measures during 2016-17. There has however been a rapid recovery around the 14 day urgent and 31 day cancer targets since February 2017.

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Patients seen < 62 days to first definitive treatment following urgent referral for suspected Cancer (including 31 day rare cancers)	85%	85.6%	89.6%	86.0%	84.9%	91.3%	71.8%
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		75.0%	77.3%	81.7%	82.4%	74.0%	78.7%

Table 8 – Performance rating: Patients seen < 62 days to first definitive treatment following urgent referral for suspected Cancer (including 31 day rare cancers)

In order to consistently deliver the 62 day target across all tumour sites, with all providers, there are some challenging and complex issues to be addressed. The CCG recognises that continued local work alone to address local breaches on specific pathways cannot deliver sustained performance delivery.

The CCG is therefore working with two Cancer Alliances to drive improvements at a Humber, Coast and Vale Sustainable Transformation Plan level and regionally as required, to augment improvement at a Humber, Coast and Vale and CCG footprint level through local primary care demand management initiatives, and by addressing diagnostic testing capacity, workforce pressures and technology challenges.

Radiology and pathology diagnostics remain a critical enabler to the delivery of elective care and most significantly cancer performance targets. This is particularly important for patients with vague symptoms who may currently experience delays as they undergo multiple testing and a transfer of care between different providers. Transfers of care are typically based on the provision of specific diagnostic testing, access to equipment and the need for investment.

There are capacity issues in magnetic resonance imaging (MRI) and computerised tomography (CT) at York Hospital and Hull Hospital. This is resulting in longer waiting times of above six weeks for some patients and delays in some cancer pathways.

Areas of focus for 2017-18, where referrals for suspected cancer are increasing, include colorectal, lung and gynaecology specialties. Locally, there are long-established capacity issues in relation to the local dermatology workforce, and at a regional level, NHS England's specialised commissioned maxillo-facial specialty is also experiencing capacity issues.

During 2017-18, work will continue with the oncology and chemotherapy teams at York District Hospital to fund a mobile chemotherapy service for the Vale of York. This service is expected to go live during Summer 2017.

Macmillan Cancer Support has funded the development of a pilot cancer care co-ordination service for the residents of Easingwold for a period of two years. The pilot will be based at Millfield Surgery in Easingwold Village.

Macmillan Cancer Support has also funded a joint project for three years that focuses on the recovery and survivorship of people with cancer.

1.4.10 Palliative and end of life care

The CCG and its partners are managing issues relating to the provision of fast track continuing health care that has significantly reduced due to the extra demand created by several providers in the system.

This will continue to be monitored through 2017-18 as the place based localities develop. CCGs in the Vale of York and Scarborough and Ryedale decided to focus on the two localities and this led to the re-establishment of the Palliative and End of Life Care Programme Board in February 2017. Work that focuses on the two localities will continue on a quarterly basis through 2017-18.

St Leonard's Hospice and Marie Curie have continued to deliver specialist care to people across the Vale of York and this has contributed to a high proportion of people being able to be at home or in the place of their choice at the end stage of their life.

1.4.11 Mental health and learning disabilities

The first full year of the contract with Tees, Esk and Wear Valleys NHS Foundation Trust has seen a number of changes to improve the estates and facilities to deliver care for our population.

The CCG led an extensive consultation exercise for a new mental health hospital for the Vale of York and the report from the consultation was endorsed by the Governing Body in February 2017. Over the coming year the CCG expects that Tees, Esk and Wear Valleys NHS Foundation Trust will continue to develop its plans for a new hospital and share these with the Governing Body. Tees, Esk and Wear Valleys NHS Foundation Trust was asked to evidence how it is building on the recommendations from the consultation report. The new facility is planned to open during 2019.

1.4.12 Dementia

With support from the local clinical network, the CCG was working to increase levels of dementia coding in primary care. In 2016-17 there have been minor fluctuations in what have been static levels of coding. The level of coding remains lower than the national expectation of 67% and the CCG requested further assistance from NHS England's Intensive Support Team.

To ensure specialist care is available and improve the quality of life for some of the most vulnerable people in society the CCG made plans to work with the provider to make pathway changes for assessment, timely diagnosis and support by improving access to local memory clinics, improving community personal support services, working with care homes and local hospitals.

The CCG work in 2016-17 with Dementia Forward is to continue to ensure earlier diagnoses and help people to maintain independence for as long as possible.

Measure	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Estimated diagnosis for people with Dementia	66.70%	51.1%	50.8%	53.1%	54.2%	52.7%	54.7%
		Oct-16	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
		55.3%	55.7%	55.1%	55.2%	55.1%	To follow

Table 9 – Performance rating: Estimated diagnosis for people with Dementia

1.4.13 Children's and young people's mental health

In 2016-17, the Future in Mind fund supported mental health projects in the Vale of York. This included a Community Eating Disorder Service and a Schools Wellbeing Workers Service schools in the city of York.

After a successful procurement in 2016-17, the Schools Wellbeing Workers Service was commissioned for North Yorkshire. The service starts in May 2017.

Tees, Esk and Wear Valleys NHS Foundation Trust's Single Point of Access service became operational in January 2017 and early indications proved this work to be successful in the improvement of clinical capacity.

In partnership with City of York Council, the CCG continued to fund the work of the Family Intervention Rapid Service Team that has helped families with complex needs.

The CCG worked closely with Tees, Esk and Wear Valleys NHS Foundation Trust to tackle the number of assessments and the length of time to access Children and Young Adults Mental Health Service and the Autism Assessment Service in the Vale of York.

The Children and Young Adults Mental Health Service Local Transformation Plan was refreshed in 2016-17 and this set the direction for partnership working and funding priorities with multiple stakeholders.

1.4.14 Community and voluntary sector partners

The community and voluntary sector has supported the CCG's work to ensure that the most vulnerable members of the population have timely and personal support. Dementia Forward and the School Wellbeing Service Project in York have each been rolled out across the city of York and there has been some very positive feedback. During 2017-18 the CCG expects to see the development of more responsive community services across the adults and children's teams in TEWV.

The CCG would like to sincerely thank all of its voluntary sector partners for assisting in the ongoing transformation and development of services to better meet the needs of the Vale of York population. With the development of an Accountable Care System and three place-based localities the CCG expects that voluntary sector partners will take a very significant role as all transformation and improvement projects and initiatives are developed and mobilised collaboratively.

1.5 Financial performance - Our year-end financial position

1.5.1 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). The NHS Commissioning Board is now known as NHS England.

1.5.2 Accounting policies

The CCG prepares the accounts under International Financial Reporting Standards (IFRS) and in line with the HM Treasury Financial Reporting Manual and approved accounting policies.

Additional detail in relation to provisions, critical judgements and sources of estimation of uncertainty has been added. These occur when management has made specific decisions in applying the CCG's accounting policies and where these have 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.

1.5.3 Financing transactions

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

1.5.4 Cash

The CCG delivered against all of its cash targets in 2016-17 and plans to do so again in 2017-18.

1.5.5 Summary of expenditure

The CCG has two funding streams. These are Programme costs and Running costs.

1.5.5.1 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.

1.5.5.2 Running costs

Payment allocated to CCGs based on £22.07 per head of ONS population to pay for non-clinical management and administrative support, including commissioning support services.

1.5.5.3 Analysis of the Programme costs expenditure

Allocation (£'000s) £433,581 **Spend (£'000s)** £457,688

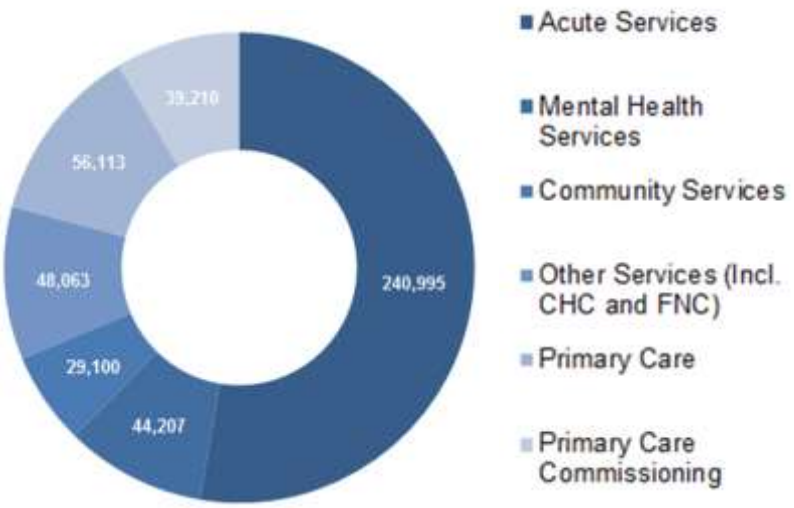


Fig 2 - Analysis of the CCG's programme costs 2016-17

1.5.5.4 Analysis of the Running Costs expenditure

Allocation (£'000s) £7,556 **Spend (£'000s)** £7,208

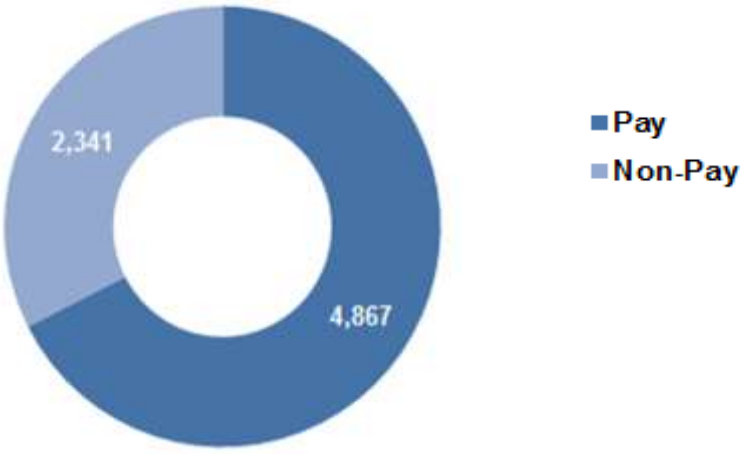


Fig 3 - Analysis of the CCG's running costs 2016-17

1.5.6 Underlying recurrent position

Excluding the effect of all non-recurrent elements in in the 2016-17 position, the CCG has an underlying recurrent deficit of £21.2m as it moves into 2017-18.

1.5.7 Quality, Innovation, Performance and Productivity

The CCG has been unable to deliver against all of its planned Quality, Innovation, Performance and Productivity (QIPP) schemes identified at the start of 2016-17.

This has been recognised by the CCG and in a number of external reviews as part of the CCG's financial recovery plan and having been placed under Legal Directions. In response the CCG has now addressed the underlying causes of financial deficit and identifies a path to sustainability.

It is this plan that has informed the 2017-18 QIPP programme that has been subject to confirmation and challenge with members of the CCG's Executive Team and members of the senior finance team at NHS England Yorkshire and Humber. Although the CCG has progressed QIPP schemes further than in previous years, delivery still remains key. The QIPP included in plan is £14.4m.

1.5.8 Longer term expenditure trend analysis

As part of the development of its Medium Term Financial Strategy the CCG has undertaken a longer term expenditure trend analysis to understand the direction of travel of the baseline spend prior to any intervention and to clearly identify the scale of the challenge faced by the organisation.

The detailed analysis has been carried out on a line by line basis using the best available information to identify future growth, inflationary and other pressures that may arise. Wherever possible published information has been used, in particular for 2017-18 and 2018-19, with a greater degree of informed estimation used for the years beyond that up until 2020-21. The graphs below summarise the CCG's in-year and cumulative financial position showing the impact of any proposed savings on the baseline spend with no interventions.

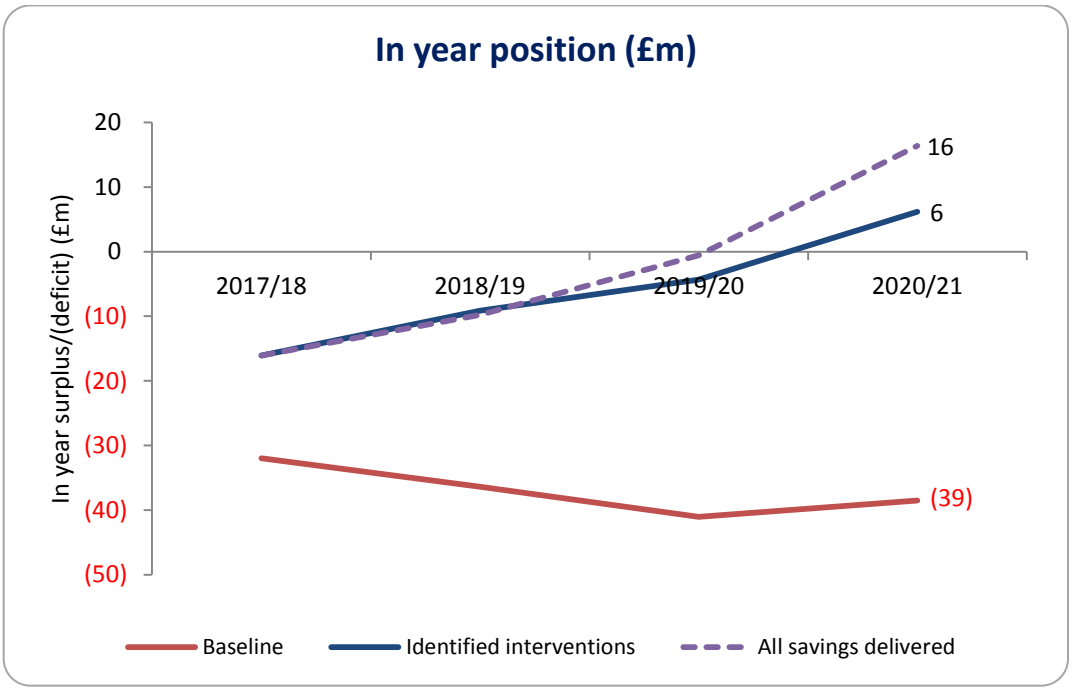


Fig 4 – In year position (£m)

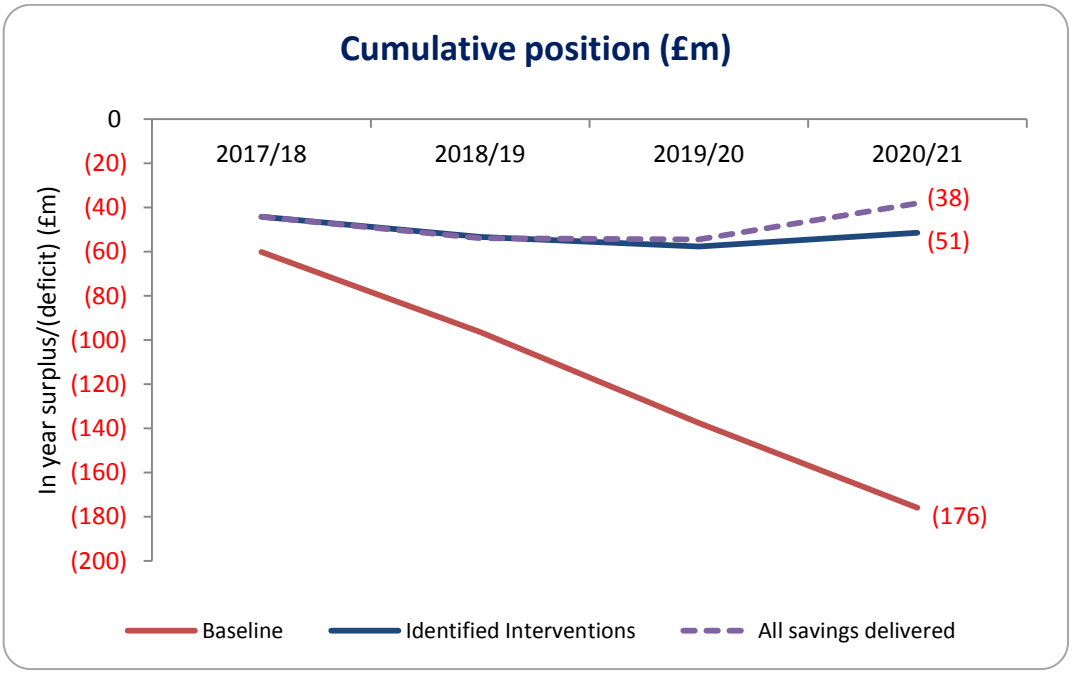


Fig 5 – Cumulative position (£m)

Without making any QIPP savings, the in-year deficit would be £39m by 2020-21, with a cumulative deficit of £176m (The “do-nothing” scenario).

If the specific interventions and schemes identified through the Medium Term Financial Strategy were achieved in full, the CCG would reach in-year surplus by 2019-20 but would still have a cumulative deficit of £51m at 2020-21.

The CCG is developing a further pipeline of schemes and opportunities which do not yet have savings quantified. These pipeline savings schemes are reflected in the plan as unidentified savings in 2019-20 and 2020-21. If these unidentified savings were developed into specific interventions and schemes and were delivered in full then the CCG would reach in-year financial balance by 2019-20 but would still have a cumulative deficit of £38m at 2020-21.

1.5.9 Statement of Going Concern

The CCG's accounts have been prepared on a Going Concern basis, The CCG's external auditors, Mazars, have written a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014 for the breach of financial duties in respect of the CCG's requirement to not have expenditure exceeding income. This is noted in 'Note 1.1 Going Concern' of the CCG's Accounting Policies, but does not affect the CCG preparing the accounts on a Going Concern basis.

Public sector bodies are assumed to have a Going Concern status where the continued and future provision of services is anticipated, as evidenced by inclusion of financial provision for that service in published comments. An NHS body will only have concerns about its Going Concern status if there is the prospect of services ceasing altogether in the future, either by itself or by another public sector entity.

1.5.9 Data quality

The CCG received a business intelligence service the commissioning support team at eMBED Health Consortium. This team checked and validated data internally. The Governing Body and the CCG's committees were reviewed during 2016-17 and no concerns were raised regarding the quality of data supplied by eMBED Health Consortium. The format of reporting at the Finance and Performance Committee was altered to increase the amount of data presented to the committee to provide added detail of system pressures.

1.5.10 Better Payments Practice Code

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. 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 and are summarised below for 2016-17.

Table 10 - Non-NHS invoices in 2016-17

Non-NHS						
Month	Total Paid	Invoices Paid on Time	% Paid Within Target	£ Total Paid	£ Value Paid on Time	% Paid Within Target
Apr-16	369	355	96.21%	8,097,055	8,003,581	98.85%
May-16	396	391	98.74%	12,556,193	12,543,695	99.90%
Jun-16	381	371	97.38%	7,003,219	6,995,463	99.89%
Jul-16	397	389	97.98%	6,489,799	6,445,640	99.32%
Aug-16	392	384	97.96%	5,893,332	5,878,690	99.75%
Sep-16	373	363	97.32%	6,496,327	6,482,830	99.79%
Oct-16	336	331	98.51%	5,281,634	5,248,002	99.36%
Nov-16	375	369	98.40%	6,104,788	6,097,625	99.88%
Dec-16	383	380	99.22%	7,335,026	7,330,192	99.93%
Jan-17	345	334	96.81%	5,820,513	5,793,929	99.54%
Feb-17	387	382	98.71%	7,707,499	7,691,038	99.79%
Mar-17	402	398	99.00%	6,402,629	6,397,996	99.93%
Totals	**4,536**	**4,447**	**98.04%**	**85,188,013**	**84,908,683**	**99.67%**

Table 11 - NHS invoices in 2016-17

NHS						
Month	Total Paid	Invoices Paid on Time	% Paid Within Target	£ Total Paid	£ Value Paid on Time	% Paid Within Target
Apr-16	321	315	98.13%	33,445,968	33,431,515	99.96%
May-16	301	298	99.00%	26,704,102	26,694,587	99.96%
Jun-16	297	297	100.00%	26,283,052	26,283,052	100.00%
Jul-16	254	254	100.00%	29,721,749	29,721,749	100.00%
Aug-16	357	356	99.72%	36,271,384	36,270,390	100.00%
Sep-16	271	268	98.89%	30,004,126	29,990,457	99.95%
Oct-16	265	264	99.62%	30,132,317	30,131,553	100.00%
Nov-16	288	286	99.31%	30,235,929	29,941,623	99.03%
Dec-16	272	271	99.63%	32,713,246	32,710,045	99.99%
Jan-17	268	268	100.00%	31,117,108	31,117,108	100.00%
Feb-17	314	312	99.36%	10,088,884	10,068,533	99.80%
Mar-17	345	345	100.00%	20,007,753	20,007,753	100.00%
Totals	**3,553**	**3,534**	**99.47%**	**336,725,619**	**336,368,365**	**99.89%**

1.6 Patient engagement

1.6.1 The CCG's commitment to involve its stakeholders

The CCG is committed to ensuring that patients' needs are at the heart of everything it does. In order to ensure that it reflects the needs of the local population it aims to have effective patient, carer and public involvement embedded in its work and planning processes.

The CCG's engagement strategy 'Involving Local Communities 2016-19' sets out its intention to involve stakeholders. Engagement is a vital to help achieve the organisation's strategic initiatives and deliver the best health and wellbeing within the resources available.

People in the Vale of York are living longer and more of the population have complex and long-term conditions. In order to meet these needs, within a context of financial constraint, collaboration with the community and other stakeholders is essential. By offering opportunities to help shape local healthcare in a transparent and open way, the CCG believes it can achieve the best health and well-being outcomes for localities in the Vale of York.

1.6.2 The CCG's duty to engage

Under the Health and Social Care Act 2012 (section 14Z2) the CCG has a legal duty to involve the public in the commissioning of services for NHS patients, and in the decisions about services that will be provided to them.

1.6.3 Partnerships, networks and events

The CCG operates in partnership with a wide range of stakeholders to share plans and involve them in our work. Examples include:

- member practices;
- local authority partners
- public health teams;
- local practice based Patient Participation Groups;
- the community and voluntary sector, including Healthwatch teams;
- local providers;
- local Health and Wellbeing Boards;
- local clinical networks.

1.6.4 How the CCG engages and involves its stakeholders

The CCG engages and involves its stakeholders in a variety of ways.

- Focus groups
- Informal discussions
- Formal consultations
- Public meetings
- Newsletters
- Social media
- Surveys
- Meetings with voluntary groups

1.6.5 Communication and engagement activity 2016-17

Throughout 2016-17 the CCG continued with its work to embed engagement throughout the organisation to capture patient, carer and public involvement conversations at all levels of its work. The CCG publishes the feedback it receives from patients and the public on its website. Some examples of engagement activities in 2016-17 include:

- consultation for a new mental health hospital in the Vale of York;
- improving patient choice and prescribing methods for gluten free foods;
- procuring new community equipment and wheelchair services;
- Vale of York Clinical Summit

More details about this work are available at www.valeofyorkccg.nhs.uk/getinvolved

In December 2016 the CCG recruited to a new role to work across the Vale of York to deliver effective and appropriate consultation and engagement.

1.7 Quality and patient experience

1.7.1 Quality and Patient Experience Committee

Quality is a key enabler and it is the foundation for the CCG's plans and programmes of work. The CCG has a dedicated Quality and Patient Experience Team which is led by the Executive Director of Quality and Nursing.

The Quality and Patient Experience Committee meets bi-monthly, its first meeting being in December 2016 when the committee's Terms of Reference were agreed. The committee's role is to ensure that commissioned services are safe, effective, provide good patient experience and ensure continuous improvement that is in line with the NHS Constitution (2011) and is underpinned by the CCG Quality Assurance Strategy.

1.7.2 12 hour trolley waits

12 hour trolley waits in the Emergency Departments York and Scarborough Hospitals have continued to be a serious concern, particularly during periods of extreme pressure over winter. These are due to a range of complex internal and external factors. There were a total of 63 trolley wait cases across both sites between 31 December 2016 and 20 February 2017. Eight of these cases were related to Vale of York patients.

Whilst no Vale of York patients came to any direct harm as a result of the wait, it is accepted by York Teaching Hospital NHS Foundation Trust, and by the CCG, that this can adversely affect patient experience and the CCG continues to work closely with York Teaching Hospital NHS Foundation Trust as part of a number of initiatives to improve patient flow both inside and outside the hospital.

Seeking assurance relating to potential patient harm, resulting in a serious incident being reported, requires an investigation to be completed within 48 hours. Given the timeframe, the existing investigation process requests information relating to harm and quality at a level of detail, which can be difficult for York Teaching Hospital NHS Foundation Trust to provide. Productive discussions took place in 2016-17 to gain separate information about quality assurance and the determination of harm, whilst appreciating there is a very close link between the subjects. An options appraisal for an alternative means of seeking assurance is a key work stream for 2017-18.

1.7.3 Healthcare associated infections

Healthcare associated infections remain a major cause of avoidable patient harm. The CCG is committed to a reduction of these infections and a robust, collaborative approach exists to review cases and establish pathways for learning.

As commissioners of local healthcare services, the CCG has the responsibility for working across organisational boundaries and taking a whole health economy view to ensure that the delivery of infection prevention and control is prioritised. The CCG ensures that provider organisations have appropriately trained and competent staff in place and that the principles of infection prevention and control are fully embedded. The CCG also ensured that patient education and awareness information was available and that individual patient needs were considered when it worked to reduce the risk healthcare associated infections.

On the 18 November 2016 the Secretary of State announced a requirement for a reduction in the number of E.coli Bacteraemia across the whole healthcare economy. Going forward, it is expected that this will entail a fifty percent reduction in the number of E.coli blood stream infections over three years based on 2015-16 figure.

The CCG's Head of Quality Assurance continued to attend provider post infection reviews of MRSA and C- Difficile cases to gain valuable insight into organisational progress in infection prevention and control practices and the issues that influenced or impacted on this.

York Teaching Hospital NHS Foundation Trust faced some significant challenges in relation to healthcare acquired infections over the last 12 months but it continues to make quality improvements. The figures below show the number of In terms of healthcare associated infections in 2016-17. Please note the numbers relate to Vale of York patients as a whole, not by commissioned service.

Healthcare acquired infection	2016-17 period
MRSA	9 cases
C-Difficile	56 cases

Table 12: Healthcare acquired infections in 2016-17

The CCG was involved in Post Infection Reviews of all cases of MRSA bacteraemia where the care was comprehensively reviewed using medical records and patient journey information which was mapped against the recommended processes. Themes from reviews were identified and incorporated into action plans.

C-Difficile infection continued to be a challenge however the picture improved on 2015-16 data with numbers being within trajectory. The CCG supported lapses in care process in line with national guidance, attended meetings with York Teaching Hospital NHS Foundation Trust clinicians on a regular basis. To support the embedding of good infection prevention processes, the CCG identified learning opportunities whether or not there were lapses in care.

York Teaching Hospital NHS Foundation Trust experienced Norovirus outbreaks during November and December 2016 at its Scarborough and Bridlington sites. The outbreaks resulted in a significant number of bed closures. The resultant negative impact for patients on patient flow throughout York Teaching Hospital NHS Foundation Trust, the impact on the hospital's emergency department and ambulance turnaround times was substantial.

In 2016, partners at NHS Scarborough and Ryedale CCG led a look back exercise that included round-table multi-agency discussions. This led to the development of an action plan and a multi-agency pathway for viral gastroenteritis that detailed a number of triggers to alert in and out of hospital services in the local system to viral gastroenteritis. The pathway can trigger the community and hospital Infection Prevention and Control teams to attend weekly 'Partner Calls' so any emerging issues in the hospital or in the community can be communicated. This aided effective communication between the public and partners with good practice being widely shared. Representatives from York Teaching Hospital NHS Foundation Trust, primary care and two nursing homes are collaborating to provide a pathway to provide a robust care package that can support and enable residents with uncomplicated diarrhoea and vomiting to remain in their usual place of residence.

The CCG obtained further healthcare associated infection assurance on its commissioned services via:

- Antimicrobial formulary adherence is reported through provider quality assurance/contract board meetings.
- attendance at North Yorkshire Antimicrobial Subgroup meeting;
- the monitoring and audit of primary care compliance with antimicrobial prescribing and formulary adherence via the CCG's lead for medicine management;
- review of provider's annual healthcare associated infections reduction plan and infection control strategies;
- the CCG undertook provider visits as required;
- proactive work with care homes and primary care on strategies to reduce incidents of norovirus.

1.7.4 Influenza

Influenza has been intermittently present in community and secondary care settings throughout the winter in 2016-17. Collaboration between the CCG and its local authority partners promoted the need for vaccination and this was supported by a robust communication strategy. Data collection on the numbers of patients immunised remains unreliable as not all practices made records of their vaccination rates.

1.7.5 Serious Incidents and Never Events

The CCG is committed to provide the best possible service to its patients, service users, staff and other stakeholders. It recognises that on occasions, serious incidents or near misses will occur and that these require a robust, unbiased and systematic review to identify any causes or contributing factors. The promotion of patient safety by proactively reducing the risk of error and learning from patient safety incidents is a key priority for the CCG.

Throughout 2016-17 the CCG worked closely with its providers to reduce patient harm. Strategic action plans to reduce falls and pressure ulcers were shared with the CCG by York Teaching Hospital NHS Foundation Trust to demonstrate its progress and examples of the improvements it had made.

The CCG attended falls and pressure ulcer panels where Serious Incidents were robustly reviewed. A continued area for improvement remained to ensure the CCG's commissioned services were compliant with Duty of Candour particularly around providing evidence of written apologies to patients and their families and, where appropriate, the involvement of them in incident investigations. It was apparent from a recently shared internal audit report that York Teaching Hospital NHS Foundation Trust was aware of issues and had plans in place to provide increased training and awareness raising. This will remain a key focus in 2017-18.

Tees, Esk and Wear Valleys NHS Foundation Trust invited the CCG to contribute to their Serious Incident panel where cases are robustly discussed by a multidisciplinary team to reduce the risk of recurrence and to comply with Duty of Candour. The actions are either incorporated into an action plan if they are agreed to be root causes or contributory findings or disseminated to all staff via a lessons learnt if they are incidental findings.

The CCG has a responsibility to report and investigate incidents that occur within its own organisation. It also needs to ensure the Governing Body is aware of Serious Incidents that occur and action plans are monitored by the Quality and Patient Experience Team. The CCG had no serious incidents in 2016-17.

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers should be implemented by all healthcare providers. There have been three Never Events in 2016-17 each relating to wrong site surgery performed by York Teaching Hospital NHS Foundation Trust.

1.7.6 Maternity Services

York Teaching Hospital NHS Foundation Trust's maternity services continue to benchmark favourably with regional data.

1.7.6.1 Smoking status at time of delivery

An improved position continued throughout 2016-17 with overall less women smoking at time of delivery than in Q2, but slightly more than Q1 with an increase in the total numbers of women smoking.

1.7.6.2 Better births - National Maternity Review

York Teaching Hospital NHS Foundation Trust developed an action plan to outline the priorities and actions in the implementation of recommendations from the National Maternity Review. Many positive actions occurred whilst awaiting more detailed national guidance. Quarterly meetings continued to be held between commissioners and providers to the action plan.

Work to progress local maternity systems through the Humber, Coast and Vale Sustainability and Transformation Plan work progressed well in 2016-17 and will continue throughout 2017-18.

1.7.6.3 Maternity Services Liaison Committee

Significant progress was made in 2016-17 against the Maternity Services Liaison Committee's key priorities of home birth, reduction of still birth, breast feeding and perinatal mental health along. The CCG's Head of Engagement is supporting the committee with its plans to engage service users. An annual plan with related actions was devised and an annual report against actions and achievements will be produced at the end of Q4 2018.

1.7.7 Patient experience

The CCG is committed to working in partnership with patients, the public and other key stakeholders for the improvement of health and patient experience across the local community. This includes providing all stakeholders with the opportunity to seek advice, raise concerns or make a complaint, about any commissioned services, or policies and procedures the CCG has developed and implemented.

Patient experience data was collated from our commissioned providers and this gave the CCG important insights that supported its quality and assurance processes in its work to providing stakeholders with the opportunities to have their say.

We also used information from other sources to provide additional patient experience examples for example via Healthwatch, Patient Opinion, and NHS Choices. This feedback ensured that patient experience was heard, that lessons were learned and that the information was used to influence commissioning decisions that promoted the delivery of high quality services.

Some examples of how patient experience and feedback has been utilised in commissioning decisions:

1.7.7.1 Community equipment and wheelchair services

Concerns had been raised, substantiated by those received via the CCG, about delays in providing equipment to wheelchair users. The four North Yorkshire CCGs who commission the wheelchair service worked very closely with the previous service provider to address these. A new provider took over the service on 1 December 2016.

The CCG worked closely with Healthwatch teams in York and North Yorkshire to encourage the involvement of people using community equipment and wheelchair services.

1.7.7.2 Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder Service

The CCG received numerous complaints and concerns from patients who had been diagnosed in adulthood with ADHD and ASD and needed a medication review and / or on-going support. Whilst the commissioned pathway was clear for people with these conditions this valuable feedback highlighted a gap in service provision. In response, the CCG reviewed its commissioned services provided by Tees, Esk and Wear Valleys NHS Foundation Trust. This resulted in discussions with the provider to undertake medication reviews under a set of criteria agreed under a contract variation.

Additionally, mental health expertise has supported the Independent Funding Review Panel so that cases are reviewed in a way that has mitigated delays for service users.

1.7.8 Safeguarding Adults and Children

NHS Vale of York CCGs is statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and vulnerable adults. The CCG has appropriate systems in place for discharging its responsibilities in respect of safeguarding which are included below:

- A programme of staff training in recognising and reporting safeguarding issues is in place with refreshed and approved policies for the CCG and for Primary Care colleagues in year.
- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements with bi–monthly safeguarding reports as part of those arrangements.
- Appropriate arrangements are in place to co-operate with local authorities and other partner agencies in the operation of Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs), membership on both Boards by the Executive Director of Quality and Nursing and Designated Professionals for Safeguarding.

- Has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood.
- The CCG has a Named GP for safeguarding children and adults and, as part of collaborative arrangements with the 3 remaining North Yorkshire CCGs, has secured the expertise of a Nurse Consultant for Primary Care (safeguarding adults and children).
- Expertise in safeguarding adults and a lead for the Mental Capacity Act and Prevent, supported by the relevant policies and training shared across North Yorkshire CCGs with a Deputy Role within the CCG.
- Through contractual arrangements the CCG ensures that it commissions safe services and continues to be an active partner working with agencies to keep adults and children safe from abuse, neglect and harm.

In 2016-17 NHS England undertook a Safeguarding Assurance Audit. The final report identified the CCG has robust arrangements in place, with only three areas of non/partial compliance. An action plan to address the outstanding areas was agreed by the CCG's Executive Director of Quality and Nursing. Progress against the plan was monitored via the Quality and Patient Experience Committee.

In December 2016 the CCG received notification of a City of York Council's Children Looked After and Safeguarding Review by the Care Quality Commission. A further review was undertaken across North Yorkshire in February 2017. The final reports are expected in early Spring 2017. Verbal feedback from the Lead Inspectors acknowledged that the CCG is aware of the areas of strength, as well as the areas of challenge. Once in receipt of the final reports the Safeguarding Team's Designated Nurses will co-ordinate the development of an action plan.

The outcome of the City of York Council Ofsted inspection of services for children in need of help and protection, children looked after and care leavers in November 2016 rated the Local Safeguarding Children Board as Outstanding, only one or two in England to receive this judgement.

The CCG completed the Section 11 Audit for North Yorkshire and City of York Local Safeguarding Children's Boards and attended the Section 11 challenge event in March 2017.

1.7.9 Quality in Primary Care

The CCG had full delegated responsibility for primary care commissioning in 2016-17 and as such has worked in partnership with primary care colleagues on the development of assurance processes for the quality and safety of services. This work will be further progressed in the forthcoming year. The Care Quality Commission has rated all GP practices in the Vale of York as 'good'.

1.8 Sustainability Report

1.8.1 Commissioning for Sustainable Development

Sustainability can be defined as meeting the needs of today without compromising the needs of tomorrow.

Commissioning for Sustainable Development is the process that commissioners follow to improve the sustainability of an organisation and the way it provides services. It is also a process used to develop how the organisation interacts with the community. Commissioning for Sustainable Development is about striking the right balance between the three key areas of financial, social and environmental sustainability when making commissioning decisions.

The CCG is committed to shaping and commissioning services that:

- meet the health needs of the local community;
- provide value for money;
- are environmentally sound.

To support these ambitions, the CCG has developed and implemented a Sustainability Development Management Plan. This is published on the CCG's website at http://www.valeofyorkccg.nhs.uk/about-us/delivering-sustainability/.

1.8.2 Travel

Throughout 2016-17 the CCG actively encouraged the use of remote communication to replace face to face meetings. It provided access to a range of remote working and teleconferencing facilities. The CCG supported opportunities for telephone, web and videoconferencing to reduce the need for travel. The CCG's office based has very good public transport links and cycle facilities and the promotion of initiatives to reduce car usage were also implemented.

In the 2016-17staff travel survey, 76% of staff travelled via public transport, on foot or cycle to work.

1.8.3 Sustainability in the clinical environment

The CCG introduced a major marketing campaign in September 2016 to raise awareness and call on the public to help reduce waste prescription medicines. The campaign 'Our NHS – let's take care of it' and 'It's in your hands' asked patients to review their medication with their GP and to stop prescriptions for items that are not needed. In addition, the campaign drew attention to the

prescribing of common items such as paracetamol which can be obtained without recourse to a GP.

The CCG used lean methodology to improve results in reducing waste in clinical setting and co-ordinated improvement work with its providers.

1.8.4 Adaptation to climate change

The CCG worked with its partners to put in place resilience and emergency planning measures. These were regularly updated and checked. The city of York is situated on a floodplain and the area has made headlines for flooding.

One aspect of climate change is the potential for a shift to wetter weather, and flood planning at a city-wide level is increasingly important.

1.8.5 Sustainable Workforce

The CCG promoted good physical and mental health to its own employees. To uphold staff supported in the workplace, the CCG also provided development opportunities to all staff.

1.9 Equalities

1.9.1 Tackling health Inequalities

Health inequalities are the differences in the health of different parts of the population. For example, people in more deprived areas have a shorter life expectancy than those who live in less deprived areas. Unhealthy behaviours such as smoking, physical inactivity, poor diet, alcohol and stress increase the risk of long-term illness and poor health. Inequalities also exist between groups according to other factors, such as gender, ethnic background, certain sorts of disability and sexual orientation.

Tackling health inequalities is a long-term process, but with the strength of partnership working, joint plans can be created to promote self-care and prevention work that will help people improve their health and wellbeing.

That is why, in addition to offering tailored and individual support services, the CCG has worked with its Health and Wellbeing Board partners in the City of York, North Yorkshire and the East Riding of Yorkshire to create an environment that made healthier choices easier. The CCG took a holistic approach to reducing health inequalities by:

- considering the impact on health inequalities in every decision and policy delivered;
- allocating resources based on most need;
- integrated working to meet the needs of individuals and communities with poorer health outcomes;
- working with individuals and communities to develop community based solutions to improve the health and wellbeing of the population.

As a member of three Health and Wellbeing Boards, the CCG used the joint strategic needs assessments (JSNAs) to help identify the health and wellbeing needs of the local population and to inform the development of services to reduce health inequalities.

There is a dedicated website for York's JSNA to help to make sure the information in the JSNA is more widely accessible. To view the website go to www.healthyork.org.

North Yorkshire County Council published a Vale of York summary as part of the Joint Strategic Needs Assessment Annual Update in 2016. This is available at www.datanorthyorkshire.org/JSNA/articles/north-yorkshire-jsna-annual-update-2016-ccgs/

The East Riding of Yorkshire Joint Strategic Needs Assessment focused on improving the mental and emotional health of children and young people,

supporting independent living for older people, reducing health inequalities. More details are available at http://dataobs.eastriding.gov.uk/jsna/jsnahome

1.9.2 Health inequality in the Vale of York

People in the Vale of York have good health overall, with life expectancy at birth which is above the national average. However there are a number of health inequalities and areas where the Vale of York is doing less well than the national or regional average.

Fig 6: Vale of York health indicators

1.9.3 Equality and Diversity

The CCG is committed to reducing health inequalities and it advocated equality and diversity as an integral part of its work throughout 2016-17.

Further information on the CCG's approach to equality and diversity and the legal requirement can be found in the Equality, Diversity and Human Rights Strategy and Implementation Plan 2013-17 which is available on the CCG's website at www.valeofyorkccg.nhs.uk/about-us/equality-and-diversity/.

To reduce inequalities and health inequity, the plan supports the CCG's commitment to give everyone in the community the opportunity to be heard and give their opinions about local healthcare services.

In May 2016 the CCG's Governing Body took part in training to further develop their understanding of their roles and responsibilities in this area.

As part of its commitment to reducing health inequalities the CCG used Equality Impact Analysis to measure the impact of its decisions and how these affect the local population, particularly protected groups. This helped to identify any action needed to reduce or remove negative impact. As part of this process the CCG considered and analysed a range of information and data including engagement activities and this informed its decision making both as a commissioner and as an employer. This included the review of new mental health hospital provision for Vale of York, which included extensive engagement activity.

To further support the comprehensive use of Equality Impact Analysis in 2017-18, the CCG will be delivering updated training for staff that will focus on the links between engagement, equality and health inequalities and the use of Equality Impact Analysis.

Policies and Equality Impact Analysis information are available on the CCG's website at www.valeofyorkccg.nhs.uk/publications/policies/.

1.9.4 Our commitment to patients and carers

The CCG is committed to making sure that equality and diversity is a priority when it plans and commissions local healthcare. The CCG worked closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs. The CCG used the national Equality Delivery System 2 (EDS2), designed to support the commissioning role and providers of services to deliver better outcomes for the local population and provide working environments for staff that are

personal, fair and diverse. More information is available at www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf.

In February 2016, the CCG engaged with fellow CCGs in North Yorkshire and its providers to review and agree the following EDS2 shared priorities:

1.9.4.1 Directory of Services – to provide better information on how to access services.

1.9.4.2 Information sharing – to generate and share information and knowledge across a wider area. Provider and local CCGs agreed to work together and share information to provide a better understanding of the needs of our communities across acute and mental health and learning disability services.

1.9.4.3 Develop options for improved representation – to gather the experiences of local people, to share the purpose of EDS2 and develop ways to help people to be more widely involved. It was identified that CCGs will attend and / or receive minutes from various stakeholder meetings that take place across the areas the organisations serve. It was also agreed to work collaboratively, share and action feedback as appropriate. CCG's committed to raise awareness of the EDS2 process at relevant meetings.

1.9.4.4 Communication about the EDS2 process - addressed in line with action 3. In January 2017 the CCG published its Public Sector Equality Duty Report that highlighted inequalities experienced by protected groups and described its work to implement equality objectives and meet its obligations. The report is available on the CCG's website at www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/5-january-2017/item-11-annex-a-psed-report-2016-17.pdf.

1.9.5 Commitment to our staff

To ensure staff did not experience discrimination, harassment and victimisation the CCG had in place policies to support staff. Policy topics included flexible working, bullying and harassment, the employment of disabled people, home working and retirement. The CCG's policies are available on the website at www.valeofyorkccg.nhs.uk/publications/policies/.

The implementation of these policies, along with occupational health support, ensured the continuation of employment and provision of appropriate training. They ensured access for employees, including disabled staff members, to training, career development and promotion opportunities.

Equality Impact Assessments were completed for all policies, where relevant. To remove the barriers experienced by disabled people, the CCG recognised the need to make reasonable adjustments on an individual staff basis and it involved occupational health services as appropriate. In December 2016 the CCG signed up to the Disability Confident Employer scheme.

The CCG welcomed the national focus on the NHS Workforce Race Equality Standard and the progress that its local NHS providers had made to improve workforce race equality. Further information on the standard can be found at www.england.nhs.uk/about/gov/equality-hub/equality-standard/.

There was a small number of staff in the CCG in 2016-17 and the risk of breaching confidentiality was therefore minimal meaning that the CCG was not required to publish statistical data for the Workforce Race Equality Standard. However, the CCG collected and analysed this data to inform the ongoing development of its action plans. In addition, any issues identified were taken to the CCG's Staff Engagement Group.

In 2017-18 the CCG will be preparing for mandatory Workforce Disability Equality Standard work. Information about this is available at www.england.nhs.uk/about/gov/equality-hub/wdes/

1.9.6 Monitoring NHS Provider Organisations:

As a commissioner of health care, the CCG had a duty to ensure that all of its local healthcare service providers met their statutory public sector equality duties under the Equality Act 2010. As well as regular monitoring of performance, patient experience and service access the CCG worked with providers to consider their progress on their equality objectives, EDS2, the Workforce Race Equality Standard and the implementation of the Accessible Information Standard, which became law in July 2016.

Each provider organisation was subject to the specific duties and published its own data. As commissioners of primary care the CCG also worked with its practices to ensure they met their equality duties. This work with providers was seen as crucial in supporting the CCG as party of a whole system approach to address health inequalities.

1.9.7 Conclusion

The CCG continued to make progress against its own equalities goals, and adapted to the latest developments in equalities and diversity legislation and practice. The work at a whole-system level across the STP footprint has begun to shape the work to tackle health inequalities at scale. Within the Vale of York area, the CCG worked with partners to reduce the effects of inequality at a local level.

1.10 Health prevention activities

A number of areas of work were established to focus on the reduction of key causes of ill-health and to assist individuals in making healthy lifestyle choices. These activities are listed below.

1.10.1 Health coaching

The CCG was the first in the country to trial the Health Navigator project, a telephone based care coaching service that is widely used in Sweden and Denmark. In partnership with Health Navigator and York Teaching Hospital NHS Foundation Trust, the CCG delivered an effective preventative strategy that simultaneously provided better care for patients and reduced stress on A&E departments.

A dedicated care coach supported patients with consistent, planned telephone contact. Phone calls focused on strengthening a patients' ability to self-manage and navigate the healthcare system and helped them to better understand their chronic conditions and better manage their care.

1.10.2 Alcohol

The tender and procurement of a new Alcohol and Illicit Drugs Service took place in 2016-17. The provider will be announced in 2017-18. The specification concentrated on the joint, ongoing work about alcohol and illicit drugs with the CCG's partners and the need to provide a robust abstinence based treatment for service users.

The Clinical Steering Group continued to meet with all local partners and work has focused on managing service users within the community, where possible. It is anticipated that to ensure more integrated care, a reduction in pressure from frequent users coupled with preventative work is required, to better manage people before they need specialist services.

1.10.3 Surgical outcomes optimisation

The CCG introduced new criteria to ask patients with a BMI of 30 or above to lose weight before elective surgery. It also introduced criteria to request smoker status patients to quit smoking for at least two months before any elective surgery.

Eating healthily, taking exercise and stopping smoking has real difference to health optimisation outcomes and the result of surgery. A variety of support services to signpost patients to were provided.

1.11 Contribution to Health and Wellbeing Strategies

1.11.1 Health and Wellbeing Boards

The CCG sat on three Health and Wellbeing Boards.

- The York Health and Wellbeing Board - established as a statutory committee of City of York Council
- The North Yorkshire Health and Wellbeing Board - a statutory committee of North Yorkshire County Council
- The East Riding of Yorkshire Health and Wellbeing Board - a statutory committee of East Riding of Yorkshire Council.

The CCG supported the Joint Strategic Needs Assessments using a range of information and local and national statistics to identify the health and wellbeing needs of its communities and highlight the health inequalities that could lead to some people dying prematurely.

The findings from the respective Joint Strategic Needs Assessments were used in the development of three Health and Wellbeing Board Strategies and a brief summary of the priorities is provided in the table below.

York Health and Wellbeing Board	East Riding of Yorkshire Health and Wellbeing Board	North Yorkshire Health and Wellbeing Board
Joint Health and wellbeing Strategy Making York a great place for older people to live. Reducing health inequalities. Improving mental health and intervening early. Enabling all children and young people to have the best start in life. Creating a financially sustainable system. Plus cross-cutting themes including safeguarding, joint	East Riding residents achieve healthy, independent ageing. Health and wellbeing inequalities in the East Riding are reduced. Children and young people enjoy good health and wellbeing. Life Course approach to priorities: Stage 1 – Start Well. Stage 2 – Develop Well. Stage3 – Live and Work Well.	**Start Well** Children and young people, including CAMHS services. **Live Well** Fewer hospital admissions and lower premature death rates from heart disease, stroke and cancer, with the biggest improvements in the most deprived areas of the county. **Age Well** More health and social care staff working together across local GP surgeries and primary health care centres to support older people in

working, carers, housing, data.	Stage 4 – Aging Well and End of Life.	the local community. **Dying Well** A greater range of support options for people in their last years of life. **Connected Communities** A stronger link between work programmes across health and social care that make it clearer for people to see how things are connected. Also more support for military families, more dementia-friendly communities.
Council Plan – health related priorities Every child has the opportunity to get the best possible start in life. Residents are encouraged and supported to live healthily. Residents controlling their own care, and enjoying integrated care from the council and NHS. Vulnerable people are safe and feel safe.	**East Riding Council Plan / Community Plan** Children and young people are happy, healthy, confident, safe and reach their full potential**.** Older people enjoy a healthy independent lifestyle. Communities are healthy, thriving, prosperous and safe. Regeneration transforms deprived areas and reduces health and other inequalities. We value and care for the diverse character of the area.	**Council Plan – health related priorities** Joining up health and social care. Improving care for people with dementia. Public Health (including alcohol and substance abuse) to develop Distinctive Public Health programme.

Table 13: Health and Wellbeing Boards' priorities

The CCG consulted regularly on a formal and informal basis with the local Health and Wellbeing Boards. In preparation for the submission of plans for 2017-18 the CCG gave partners early sight of the proposals and priorities. Listed below are some examples of the progress made to date.

- The CCG worked closely with Tees, Esk and Wear Valleys NHS Foundation Trust on the development of collaborative commissioning for Tier 3 and Tier 4 Child and Adolescent Mental Health Services plans. Tees, Esk and Wear Valleys NHS Foundation Trust subsequently became part of the pilot for Tier 4 services.

- The CCG worked with public health teams to prepare for the commissioning of specialist obesity services.

- In line with Better Care Fund plans, work took place with local authority partners to integrate community based health and care services to reduce avoidable admissions and delayed transfers of care. This included promoting wellness, independence and self-care, providing access to community based long term condition support and complex case management.

- The re-procurement of community equipment and wheelchairs.

Tackling health inequalities was an area of concern for all health and wellbeing boards in 2016-17. Due to the current economic climate, local authorities were required to make savings from the public health budget. This led to a re-examination of services provided by the CCG's local authority partners. The CCG will continue to work with local authority partners throughout 2017-18 to understand the longer term impact.

Concerns had been raised that children's and young people's emotional and mental health services in the city of York were fragmented. The York Health and Wellbeing Board worked with the CCG to develop a set of recommendations that supported a revision to the delivery of these services.

1.11.2 Scrutiny committees (Adult Social Care, Public Health and Health)

There are three committees that review and scrutinise the performance of health, adult social care and public health service. To provide assurance that the CCG meets its duties to consult as outlined in the NHS Act (2006), the CCG continued to keep committees informed of key decisions and plans throughout 2016-17.

Signature of Accountable Officer

Phil Mettam
Accountable Officer
NHS Vale of York CCG

Dated: 25 May 2017

Section 2
Accountability

2.1 Members' Report

For the Director's Report please see section 1.2.

2.1.1 The CCG's membership

The CCG represents 26 practices in the Vale of York area. Its membership is known as the CCG's Council of Representatives. Its members are listed in the table below.

Practice	Website
Beech Tree Surgery	www.beechtreesurgery.co.uk
Dalton Terrace Surgery	www.daltonterracesurgery.nhs.uk
East Parade Surgery	www.eastparademedical.co.uk
Elvington Medical Practice	www.elvingtonmedicalpractice.co.uk
Escrick Surgery	www.escricksurgeryyork.co.uk
Front Street Surgery	www.frontstreetsurgery.nhs.uk
Haxby Group Practice	www.haxbygroup.co.uk/york/
Helmsley Surgery	www.helmsleymedicalcentre.co.uk
Jorvik Gillygate Practice	www.jorvikmedicalpractice.co.uk
Kirkbymoorside Surgery	www.thekirkbymoorsidesurgery.co.uk
Millfield Surgery	www.millfieldsurgery.co.uk
MyHealth	www.myhealthgroup.co.uk
Old School Medical Practice	www.oldschoolmedical.gpsurgery.net
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	www.stillingtonsurgery.co.uk
Tadcaster Medical Centre	www.tadcastermedicalcentre.co.uk
Terrington Surgery	www.terringtonsurgery.nhs.uk
Tollerton Surgery	www.tollertonsurgery.co.uk
Unity Health	www.unityhealth.info
York Medical Group	www.yorkmedicalgroup.nhs.uk

Table 14: The CCG's membership

2.1.2 Council of Representatives meeting attendances in 2016-17

	2016								2017		
Practice	**21 April**	**19 May**	**23 June**	**21 July**	**22 Sept**	**20 Oct**	**17 Nov**	**15 Dec**	**19 Jan**	**16 Feb**	**16 Mar**
Beech Grove Medical Practice	Y(f)	Y(f)	A	A	A	Merged with Front Street Surgery from 1 October 2016					
Beech Tree Surgery	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(f)	PM (m)	Y(m)	Y(m)	Y(m)	Y(m)
Clifton Medical Practice	Y(f)	A	Y(f)	Merged with York Medical Group 1 July 2016							
Dalton Terrace Surgery	PM (m)	PM (m)	PM (m)	Y(m)	PM (m)	Y(m)	A	PM (m)	Y(m)	Y(m)	A
East Parade Medical Practice	A	A	N	N	N	N	A	N	A	A	A
Elvington Medical Practice	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Escrick Surgery	Y(f)	Y(f)	PM (f)	Y(f)	Y(f)	Y(f)	PM (f)	Y(f)	Y(f)	Y(f)	Y(f)
Front Street Surgery	A	Y(m)	Y(m)	Y(m)	A	Y(m)	A	Y(m)	A	Y(m)	Y(m)
Haxby Group Practice	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	PM (m)	Y(m)
Helmsley and Terrington Surgeries	Y(m)	A	Y(m)	N	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m) + PM(m)
Jorvik Gillygate Practice	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	A	Y(m) + PM(f)	PM(f)
Kirkbymoorside Surgery	N	Y(m)	A	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	A	A
Millfield Surgery	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(m)	Y(f)	Y(f)
MyHealth	Y(m) +PM (f)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	N	N	Y(m)
Old School Medical Practice	Y(m)	N	Y(m)	Y(m)	Y(m)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)
Petergate Surgery	Y(f)	A	Y(f)	Merged with York Medical Group 1 July 2016							
Pickering Medical Practice	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Pocklington Group Practice	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Posterngate Surgery	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Priory Medical Group	Y(f) +PM (m)	Y(f)	Y(f) +PM (m)	Y(f) +PM (m)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)
Scott Road Medical Centre	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)
Sherburn Practice	Y(m)	Y(f)	Y(f)	Y(m)	Y(m)	Y(m)	Y(m) + PM(f)	Y(m)	Y(m)	Y(m)	Y(m)
South Milford Surgery	A	PM (f)	PM (f)	A	A	N	N	N	PM(f)	PM(f)	A
Stillington Surgery	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Tadcaster Medical Centre	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(f)	Y(m)	Y(m)	Y(m)	Y(m)
Tollerton Surgery	Y(f)	Y(f)	Y(f)	A	A	Y(f)	N	Y(f)	A	Y(f)	A
Unity Health	Y(f) + PM(f)	PM(f)	PM(f)	PM(f)	PM(f)	A	Y(m)	Y(m) + PM(f)	Y(m)	Y(m) + PM(f)	Y(m)
York Medical Group	Y(f) + Y(m)	Y(f)	Y(f) + PM (m)	Y(f)	Y(f)	Y(f)	Y(f) + Y(m)	Y(f)	Y(f)	Y(f)	Y(f)
Dr Stuart Calder, Training Programme Director – Deputy Chair	A	Y	A	Y	A	Y	Y	Y	Y	Y	Y

Table 15: Council of Representatives meeting attendances in 2016-17

Key to table contents

m = male
f = female
Y = Attended
A = Apologies
N = Neither attended nor sent apologies
PM = Practice Manager represented practice / attended with member

2.1.3 Composition of the Governing Body

The work of the CCG is led by the Governing Body, and the members of the Governing Body throughout 2016-17 were as follows:

Governing Body members

Keith Ramsay

Governing Body Lay Chair

Keith is the Governing Body Lay Member and Chair of the Primary Care Commissioning Committee. Keith has held a range of senior roles and the success of several organisations is attributable to his expertise where he set the strategic direction for health, welfare and community projects and the performance management of billions of pounds of public funding.

Phil Mettam

Accountable Officer

From 3 October 2016

Phil joined the team in October 2016 following his role as Chief Officer at Bassetlaw CCG, an organisation rated as “Outstanding” by NHS England. Phil has held senior roles across Primary Care Trusts (PCT) in Nottingham and at Trent Strategic Health Authority. He has also held a number of leadership roles across the Yorkshire and Humber region including Deputy Chief Executive at Bassetlaw PCT and a senior role in industry with British Coal. Phil is a chartered secretary by profession.

Helen Hirst

Interim Accountable Officer

. 25 April 2016 to 2 October 2016

Helen was Interim Accountable Officer of the CCG. Helen is also Accountable Officer of Bradford City and Bradford Districts CCGs. Prior to this she was programme director for primary care with the Department of Health/NHS Commissioning Board Authority.

Previously, Helen also worked in a part-time capacity for NHS England as director of CCG development. From 2006 to 2010 Helen was Deputy Chief Executive and Director of Primary Care at NHS Bradford and Airedale and has worked in the NHS in Bradford since 1992.

Dr Mark Hayes

Chief Clinical Officer

To 31 January 2017

Dr Hayes was the Chief Clinical Officer of the CCG since its launch in April 2013. Under his leadership the CCG achieved national recognition for the integration of health and social care services.

Dr Andrew Phillips

Joint Medical Director

Andrew qualified as a GP following a career in the Royal Navy. Since his appointment to the Governing Body in 2011 he has continued his passion for service transformation. Andrew combines his role as a GP with his responsibilities as Clinical Lead for Unplanned Care and an active membership of the Yorkshire and Humber Clinical Senate with his priorities to promote compassionate care in future service redesign whilst he supports primary care functions throughout innovations in healthcare.

Rachel Potts

Executive Director of Planning and Governance

Rachel has over 30 years' experience of working in the NHS and has held senior management posts across a wide range of NHS commissioner and provider organisations. Her roles have covered areas such as strategic planning, contracting, performance, governance and assurance. She had a lead role in the establishment of the CCG and has led work in system redesign and working across health and social care. Rachel has a Master's degree in health and social care.

Tracey Preece

Chief Finance Officer

Tracey joined the CCG as Chief Finance Officer in November 2013. She has almost 18 years of NHS finance experience after graduating from the NHS Financial Management Training Scheme in 2002 and has held a number of senior finance positions across Yorkshire and the North East. Tracey is a graduate of York University and an Associate Member of the Chartered Institute of Management Accountants.

Michelle Carrington

Executive Director of Quality and Nursing

Michelle is a registered nurse with over 26 years of experience, mainly in acute care. She has held a number of senior roles including Practice Development and Service Improvement, Assistant Chief Nurse and Head of Patient Safety at York Trust. Michelle joined the CCG in September 2014.

Dr Tim Maycock

Clinical Director

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 the CCG on the East Yorkshire Health and Wellbeing Board and acting as clinical lead for the Primary Care Programme.

Dr Shaun O'Connell

Joint Medical Director

Shaun is the GP Lead for Prescribing and Planned Care. He has been a GP trainer, GP appraiser and was a member of the Council of the Royal College of General Practitioners for eight years and of the Local Medical Committee for many years. He has experience from working as a GP partner, a salaried GP and GP locum and continues to practise as a salaried GP at South Milford Surgery.

Dr Louise Barker

Clinical Director

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 teaching medical students at Hull York Medical School.

Dr Emma Broughton

Clinical Director

Emma graduated in 1999 from Edinburgh Medical School. She trained as a specialist in obstetrics and gynaecology in both Edinburgh and Yorkshire prior to moving into General Practice in 2011. Emma is a partner at Priory Medical Group, in addition works at Lifeline, as a GP Specialist in Substance Misuse. Emma also continues to practice minor surgery and offer women's health services in the community.

David Booker

Lay Member

David trained as a social worker and worked in a number of roles in local government and third sector organisations. His latest role was as UK Director for Volunteering at Barnardo's. In his role as Lay Member of the CCG's Governing Body and Chair of the Quality and Finance Committee, David helps to ensure the CCG is efficient and responsive and listens to the views of local stakeholders.

Dr Paula Evans

Chair of CCG Council of Representatives

Paula started her NHS career in 1989 after graduating from the University of Nottingham. After working in paediatrics and undertaking GP training in London's East End, she moved in 1997 to take up a partnership in what is now York Medical Group practice. She also maintained an interest in haematology by working as a clinical assistant at York Hospital, until becoming a GP trainer in 2002. Her medical education portfolio includes HYMS and Foundation Year supervision.

Dr Arasu Kuppuswamy

Secondary Care Doctor Member

Dr Kuppuswamy works as a Consultant Psychiatrist. He has Clinical Lead responsibilities for his trust that have included both the Acute and Community Pathways. He is keen on providing person centred quality care. He is keen on not only providing quality services for the patients under his care but also for the local population. This has encouraged him to involve himself in Transformation projects for the Trust. He is now keen to apply his knowledge and enthusiasm at a CCG level.

Sheenagh Powell

Lay member and Chair of Audit Committee

Sheenagh has many years' experience of working in the NHS including roles as a board member, Finance Director and Chief Executive. Sheenagh's career crosses NHS organisations including Primary Care Trusts, an NHS Foundation Trust and NHS England. She has two grown up children and being semi-retired enjoys her life in Blubberhouses, near Harrogate.

Elaine Wyllie

Strategic Programme Consultant

1 January 2017 – 5 April 2017

Elaine brings a wealth of knowledge based on over 30 years' experience working in roles across the NHS and local authorities. As well as operating at a senior level in commissioner, provider and assurance roles, Elaine is well used to working with partners to develop services across health and social care and has been involved in national redesign work on healthcare procurement services. Her experience is underpinned by a Masters in Business Administration.

Jim Hayburn

Strategic Programme Consultant

31 October 2016 to 31 March 2017

Jim brings considerable NHS experience to the CCG. He has worked in NHS Trusts, CCG's and within NHS England managing a wide portfolio of programmes.

Members in attendance

Dr John Lethem

Local Medical Committee Liaison Officer

John has been a local GP since 1989. He was a founder board member of York Health (Practice Based Commissioning) Group and was Chairman from 2007 to 2010. He has been a member of the LMC for 15 years.

Dr Stuart Calder

Vice Chair of the Council of Representatives

From 21 April 2016

Stuart Calder has been a Programme Director for the York GP Training Scheme since 1997, working as a GP trainer prior to that. He enjoyed 36 years as a GP in York, before ceasing clinical practice in 2013 to focus on GP education and training. He also pursues a keen interest in Medical Ethics as a lecturer for the Yorkshire and Humber School of Primary Care. He has been a GP appraiser since 2003.

Sharon Stoltz

Director of Public Health, CYC

Sharon is the Director of Public Health for the City of York. She is an experienced public health professional having worked across the NHS and in local authorities. Before working in York Sharon was the Director of Public Health at Barnsley Metropolitan Borough Council and Head of Commissioning at Bassetlaw Primary Care Trust. Sharon is a qualified nurse, midwife and health visitor and has joint registration with the UK Public Health Register and Nursing and Midwifery Council.

Louise Johnston

Practice Manager representative

To 15 December 2016

Louise is Managing Partner at Unity Health in York. She is an experienced and innovative leader who has previously worked in the education sector. Louise was voted into her CCG Governing Body role by GP Practice Managers in the Vale of York, acting as their representative and giving them a voice. Her role is to engage with Practice Managers and support their professional development whilst increasing recognition of the importance of the Practice Manager role.

Siân Balsom,

Lay Member Healthwatch York

To 19 January 2017

Siân is the Director of Healthwatch York. She is a law graduate and after leaving university she held management, business support and marketing roles in retail and manufacturing organisations. After a period in the private sector, Siân moved into various roles in the third sector working at Coalfields Regeneration Trust, the Big Lottery Fund. Middlesbrough Voluntary Development Agency and York CVS (Centre for Voluntary Service). Siân is a Trustee of Scarborough and Ryedale Carers Resource and is Chair of the Trustee Board.

2.1.4 Governing Body members' declarations of interest

The table below provides the Governing Body members' declarations of interest. These are also published on the CCGs website at www.valeofyorkccg.nhs.uk/about-us/our-registers-of-interest/.

Name	Interest declared	Date completed / last reviewed
Keith Ramsay **Governing Body Chair**	Director of Thackary Medical Museum (Self) since 2013 Director of Association of Business Executives (ABE UK LTD) (Self) since 2014 Director of Jigsaw Consultancy Ltd (Self & Spouse) since 2008 Director of In Communities Commercial (Self) since 2013	11 January 2017
Dr Louise Barker **Clinical Director**	GP partner of Haxby Group, which has pharmacies and are a limited company, Haxby is a part of Nimbus federation that is looking to develop or be part of an accountable care system (Self) Since October 2016. Spouse is a psychiatrist working for TEWV the CCGs mental health provider (Spouse) In addition works with LK Aesthetics a small non-cosmetic facial aesthetic treatment not seeking business with the CCG (Self) since April 2014.	19 January 2017
David Booker **Lay Member, Chair of Finance and Performance Committee**	Trustee of Nidderdale Plus, Company director of Nidderdale Ltd, Pateley Bridge, Local voluntary community organisation. (Self) since 12/2016	17 January 2017

Name	Interest declared	Date completed / last reviewed
Dr Emma Broughton **Clinical Director**	GP Partner at Priory Medical Group, a member of the Nimbus alliance of practices, additional responsibilities within member practices including acting Safeguarding lead at Heworth Green Surgery. Priory Medical Group are part of the regional research network since (Self) since 01.02.11. Additional work with Yorkshire Skin Clinic undertaking one surgery per month (Self) since 01.02.11.	11 April 2016
Dr Stuart Calder **Council of Representatives Member**	Director of York Medical Society since 2015.	17 May 2017
Michelle Carrington **Executive Director of Quality and Nursing**	No Interests to declare	11 January 2017
Dr Paula Evans **Council of Representatives Member**	Profit sharing GP Partner of York Medical Group, which participates in research through NIHR, including commercial studies. York Medical Group is also a part of the City and Vale Alliance (CAVA) of practices (Self) Director and shareholder of Acomb Medical Ltd pharmacy (self) Acomb Medical Limited is part of the CAVA federation of GP practices Previously inspector for CQC (self) 2014-2016 Spouse employed by Capita at FERA. (Spouse) Bank out of hours GP, hourly rate, up to 30 hours per annum. (Self) since 2012 YHHEE GP training seven days per annum (Self) since 2003.	11 January 2017

Name	Interest declared	Date completed / last reviewed
Dr Mark Hayes **Chief Clinical Officer (to 21 July2016)**	No Interests to declare	23 March 2016
Helen Hirst **Interim Accountable Officer**	Director of Bradford & Airedale Lift Co (Self) Chief Accountable Officer with Bradford City CCG and Bradford Districts CCG (Self) since 01.04.13	4 May 2016
Dr Arasu Kuppuswamy **Secondary Care Doctor Member**	Developing module on schizophrenia sponsored by a pharmaceutical company. Chair of meeting sponsored by a pharmaceutical company.	6 April 2017
Dr Tim Maycock **Clinical Director**	Director of Beckside Developments. Partner at Pocklington Group Practice (Pecuniary)	10 January 2017
Phil Mettam **Accountable Officer**	Substantive employee of NHS Bassetlaw CCG.	18 May 2017
Dr Shaun O'Connell **Joint Medical Director**	Employee of South Milford Surgery with interest in South Milford Pharmacy. Working one day per week as clinical GP surgeries, home visits and associated admin (Self) Spouse is an employee of YTHFT (Spouse) Holds shares in GlaxoSmithKline (Self)	10 January 2017
Dr Andrew Phillips **Joint Medical Director**	Employed with Yorkshire Doctors Urgent Care (YDUC) Out of Hours service in contract with SRCCG, Lead clinician for YDUC Out of Hours Contract for the CCG. (Self) 12 hours per week. Private Medical contractor to Helmsley Medical Practice (self) from 01/08/16. Director of Focus Medical Ltd through which I provide locum GP services on an ad hoc basis.	10 January 2017

Name	Interest declared	Date completed / last reviewed
Rachel Potts **Executive Director of Planning and Governance**	No Interests to declare	18 May 2017
Sheenagh Powell **Lay Member and Chair of Audit Committee**	Independent member of Harrogate and Rural District CCG Audit Committee (Self) since 11.2014.	28 January 2017
Tracey Preece **Chief Finance Officer**	Spouse senior manager with Ernst & Young LLP since June 2014. (Spouse)	11 January 2017
Sian Balsom **Director, Healthwatch York**	Director of Healthwatch York (Self) since 02.03.13. Chair of Scarborough and Ryedale carers resource (Self) since 13.01.2010. Shareholder Golden Ball Co-Operative Public House (Self and Spouse) since October 2013	13 January 2017
Jim Hayburn **Interim Executive Director of System Resources and Performance**	Director of own consultancy company, JHL Associates	19 May 2017
Louise Johnston **Practice Manager Representative**	Managing partner at Unity Health, Director of Unity Health Trading Limited, Director of Nimbuscare Limited, Shareholder of Unity Health Trading Limited, Shareholder of Nimbuscare Limited. Practice manager representative Governing Body (non-voting member), Partner at Unity Health, Member of group of practices in receipt of cluster funding from the research network. Involved in establishing the Vale of York Clinical Network which is possibly seeking to enter into contracts with the CCG. Self	18 March 2016

Name	Interest declared	Date completed / last reviewed
Dr John Lethem **Local Medical Committee Liaison Officer, Selby and York**	GP Principal Partner of Unity Health York, a member of the NIMBUS alliance. Spouse Peggy Lethem is a pharmaceutical Sales representative working for Zambon ProPharma. Local Medical Committee Officer (Medico-Political) Practice has received susbsidised trial of WebGP online GP consultation facility	18 May 2017
Sharon Stoltz **Director of Public Health, City of York Council**	No interests to declare.	18 May 2017
Elaine Wyllie **Strategic Programme Consultant**	Company Director at Wybeck Associates Limited	20 April 2017

Table 16: Governing Body members' declarations of interest

2.1.5 Personal data-related incidents

The CCG has not reported any serious incidents to the Information Commissioners Office in 2016-17.

2.1.6 Statement of disclosure to auditors

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

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

2.1.7 Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. The CCG does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

2.2 Statement of Accounting Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of the CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for the points below.

- The propriety and regularity of the public finances for which the Accountable Officer is answerable.

- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).

- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

- The relevant responsibilities of accounting officers under Managing Public Money.

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

- Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year 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 Group Accounting Manual 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements.

- 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 under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter, except in relation to the following:

- The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2016-17 expenditure performance is £23.759m over the income received. It has therefore breached its duty under the NHS Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, which sets statutory duties for CCGs to ensure that their capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (the Revenue Resource Limit and Capital resource Limit). A formal notification of this position was made in March 2017 by the Clinical Commissioning Group's external auditors, Mazars LLP, to the NHS Commissioning Board (NHS England) and also the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014.

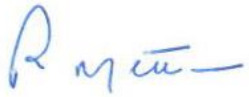
I also confirm that:

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

any relevant audit information and to establish that the CCG's auditors are aware of that information;

- the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signature of Accountable Officer



Phil Mettam
Accountable Officer
NHS Vale of York CCG

Dated: 25 May 2017

2.3 Annual Governance Statement

2.3.1 Introduction and context

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

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

With effect from 1 September 2016 the CCG was subject to directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. Details of the Legal Directions are available at www.england.nhs.uk/commissioning/ccg-assess/directions/

2.3.2 The main provisions of the Legal Directions

The main provisions of the Legal Directions referred to above are:

"(4) The Board directs that:

(a) Vale of York CCG shall within four (4) weeks of the date of these Directions produce a revised Improvement Plan that sets out how it shall ensure that the capacity, capability and governance of the CCG is made fit for purpose including agreeing with the Board how it will strengthen its financial leadership.

(b) The content of the Vale of York CCG Improvement Plan shall meet any requirements as set out by the Board and shall provide for the implementation of the recommendations of the Capability and Capacity Review date 28 January 2016.

(c) Vale of York CCG shall promptly implement the Improvement Plan in accordance with the Board's instructions.

(d) The Board may direct Vale of York CCG in any other matters relating to the Improvement Plan and any variation to it.

(5) The Board further directs that:-

(a) Vale of York CCG shall as part of the revised Improvement Plan include a Financial Recovery Plan that:

(i) sets out how Vale of York CCG shall ensure that in the financial year 2016/17 it achieves an in-year deficit of no more than £7m and how it will operate within its annual budget for the financial year 2017/18 and thereafter;

(ii) confirms that all facts, figures and projections within the Financial Recovery plan have been subjected to independent scrutiny by an organisation approved by the Board;

(iii) provides a complete analysis of the causes of the current underlying financial position;

(iv) includes a clear demonstration of clear links to internal budgets, reporting, activity plans, cash plans and contracting;

(v) includes a clear risk assessment of the Financial Recovery Plan; and

(vi) includes any other requirements stipulated by the Board.

(b) The Financial Recovery Plan, shall be subject to the Board's approval.

(c) Vale of York CCG shall implement the Financial Recovery Plan.

(d) Vale of York CCG will co-operate with the Board including but not limited to the prompt provision of information requested by the Board and making senior officers available to meet with the Board and to discuss the Financial Recovery Plan, the implementation and the progress of the same.

(e) It may direct Vale of York CCG in any other matters relating to the Financial Recovery Plan.

2.3.2.1 Executive Team and Senior Appointments

(6) The Board directs that:

(a) Vale of York CCG shall nominate an Interim Accountable Officer to the Board.

(b) The Board will determine the process to be followed to make such nomination.

(c) Vale of York CCG will look to nominate an Interim Accountable Officer for a term of no less than 12 months from the date of the departure of the current interim Accountable Officer.

(d) The nomination of the Interim Accountable Officer will be subject to prior approval by the Board.

(e) Vale of York CCG will co-operate with the Board regarding the appointment of the Interim Accountable Officer, including but not limited to the prompt provision of information, documents and records

requested by the Board and making senior officers available to meet with the Board.

(7) The Board further directs that:

(a) Vale of York CCG will notify the Board of the need to make any appointments to its Executive Team or its next tier of management.

(b) Where it considers it necessary to do so, the Board will determine the process to be followed by Vale of York CCG in making appointments as referred to in paragraph 7(a).

(c) The appointment of any person to a position referred to in paragraph 7(a) and the terms of such appointment will be subject to prior approval by the Board.

(d) Vale of York CCG will co-operate with the Board regarding the appointment of any person in accordance with this paragraph 7, including but not limited to the prompt provision of information, documents and records requested by the Board and making senior officers available to meet with the Board."

In response to these directions, the CCG developed an Improvement Plan, and it continues to work closely with NHS England to deliver against the agreed actions.

2.3.3 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

2.4 Governance arrangements and effectiveness

2.4.1 The Clinical Commissioning Group Governance Framework

The Governing Body works to the CCG Constitution to discharge its functions and apply the principles of good governance. The Constitution sets out the roles and responsibilities between the Governing Body and Council of Representatives (the membership body of the CCG).

2.4.2 The CCG's Constitution

The 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 was revised in October 2015, to take account of changes to Committees, the Scheme of Delegation in light of delegated commissioning responsibilities and to provide additional detail on the roles and responsibilities of each Governing Body Member.

The Constitution covers:

- the CCG's 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 CCG as an 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 was implemented throughout 2016-17.

Following the legal directions, a number of changes have been made to the organisation's governance arrangements and committee structures, as

discussed below, and the Constitution is currently in the process of revision to reflect the changes agreed at recent meetings of the Governing Body and Council of Representatives.

The CCG's Constitution is available on its website at: www.valeofyorkccg.nhs.uk/data/uploads/about-us/governance/voyccg-constitution-version-4-final-october-15.pdf

2.4.3 Governing body and committee structure

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

Following the receipt of its Capability and Capacity Review report from PricewaterhouseCoopers in January 2016, the CCG made an initial series of changes in early 2016. During the summer of 2016 the CCG held a workshop with Governing Body to discuss outstanding concerns. An interim Accountable Officer was appointed in May 2016 during the period of transition to new structures.

In September 2016 the CCG became the subject of legal directions from NHS England. See section 2.3.2 for more details.

In October 2016 a new Accountable Officer was appointed, and a further review of structures was undertaken. Governance actions were set out in the draft Improvement Plan. As a result, the Council of Representatives agreed at their December meeting that the following committees would support the Governing Body:

- Audit Committee
- Executive Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Quality and Patient Experience Committee
- Remuneration Committee
- Clinical Executive Committee

The Council of Representatives also:

- agreed the Terms of Reference for the Primary Care Commissioning Committee and the Clinical Executive;

- delegated approval of the Terms of Reference to the relevant Committee and ratification by the Governing Body;

- noted the feedback from members and agreed the composition of the Governing Body.

Throughout September 2016 to March 2017 the organisation has seen a level of change and restructuring to meet the CCG's current responsibilities. Terms of Reference for each committee were reviewed and then approved by the Governing Body, as appropriate.

2.4.4 CCG's committee structure

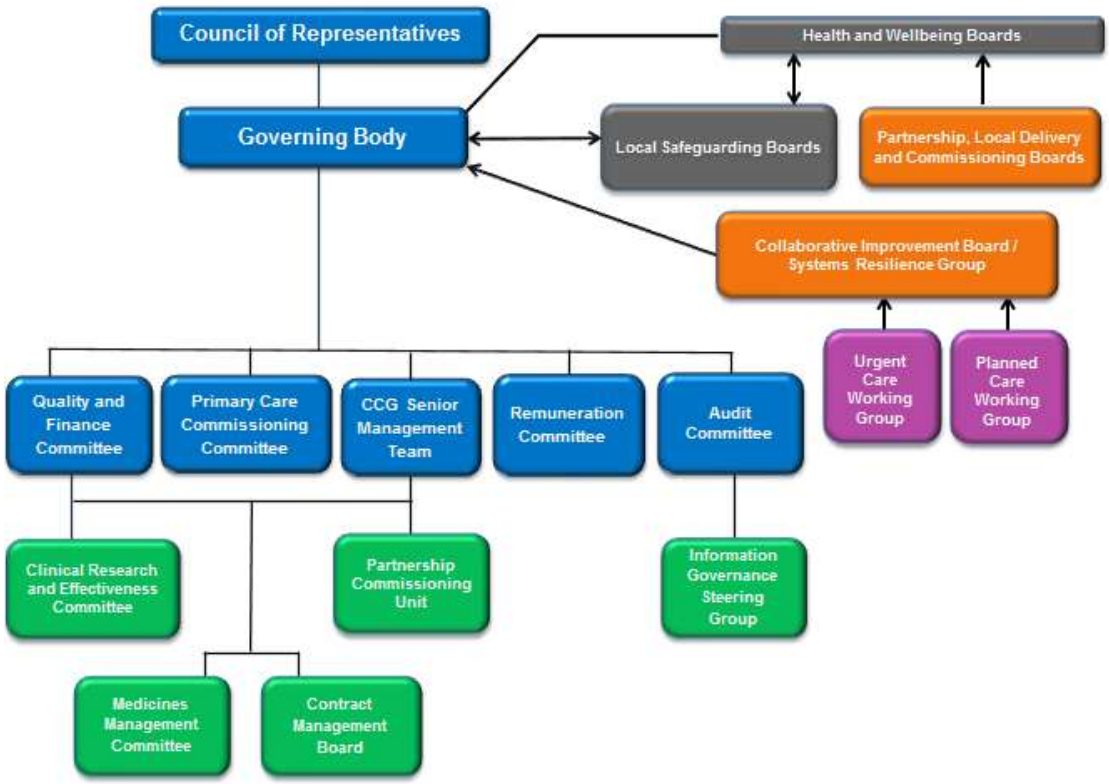


Fig 7 - The CCG's committee structure at 1 April 2016

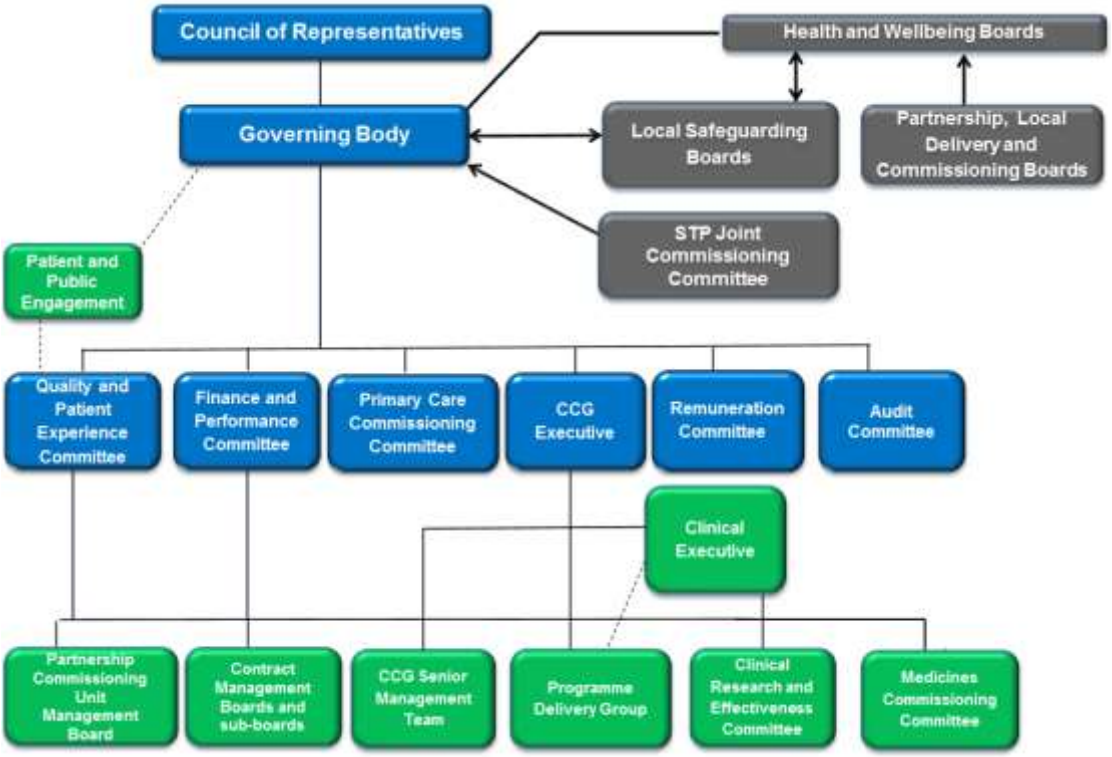


Fig 8 - The CCG's committee structure at 31 March 2017

2.4.5 Governing Body meetings

The Governing Body met eight times in public and was quorate on each occasion. There was an extraordinary meeting in October and six workshop sessions when discussion included Governing Body self-assessment, finance updates, equality and diversity, the development of an Accountable Care System, the revised governance structure and organisational development issues.

2.4.6 Governing Body meeting attendances

Governing Body member	Governing Body role	Attendance (public meetings)
Keith Ramsay	CCG Governing Body Chair	7/9
Dr Louise Barker	GP Member	5/9
David Booker	Lay Member and Chair of Finance and Performance Committee	8/9
Dr Emma Broughton	GP Member	7/9
Dr Stuart Calder from 21 April 2016	GP, Council of Representatives Member	4/8
Michelle Carrington	Executive Director of Quality and Nursing	9/9
Dr Paula Evans	GP, Council of Representatives Member	8/9
Dr Mark Hayes to 21 July 2016	Chief Clinical Officer	0/2
Helen Hirst from 25 April to 2 October 2016	Interim Accountable Officer	2/2
Dr Arasu Kuppuswamy	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust - Secondary Care Doctor Member	9/9
Dr Tim Maycock	GP Member	9/9
Phil Mettam from 3 October 2016	Accountable Officer	5/6
Dr Shaun O'Connell	GP Member and Joint Medical Director	6/9
Dr Andrew Phillips	GP Member and Joint Medical Director	7/9
Rachel Potts	Executive Director of Planning and Governance	9/9
Sheenagh Powell	Lay Member and Audit Committee Chair	8/9
Tracey Preece	Chief Finance Officer	7/9
Attendees – Non voting		
Siân Balsom to 19 January 2017	Director, Healthwatch York	6/7
Jim Hayburn from 31 October 2016	Interim Executive Director of System Resources and Performance	4/5
Louise Johnston to 15 December 2016	Practice Manager Representative	2/5
Dr John Lethem	Local Medical Committee Liaison Officer, Selby and York	8/9
Sharon Stoltz	Director of Public Health, City of York Council	4/9
Elaine Wyllie from 1 January 2017	Strategic Programme Consultant	3/3

Table 17: Governing Body meeting attendances

2.4.7 CCG committees, their role and highlights

The table below details 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.

Committee	Role and performance highlights
Audit Committee	Chaired by the Lay Member with the lead role in governance and conflict of interest, the Audit Committee provides the Governing Body with independent assurance on systems and processes through challenge and scrutiny of internal audit, external audit and other bodies. It has 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, financial reporting, and Auditor Panel function. The Committee met eight times in 2016/17, two occasions of which were as the Auditor Panel, and was quorate on each occasion. There is a schedule of preceding private meetings of members with internal and/or external audit. **Members** Sheenagh Powell (Committee Chair), Lay Member with the lead role in governance David Booker, Lay Member and Chair of Finance and Performance Committee Dr Arasu Kuppuswamy, Secondary Care Clinician **Performance and highlights** Review of Terms of Reference and work plan Establishment of Auditor Panel Regular updates on Detailed Financial Policies and Procedures, Scheme of Delegation and progress against Financial Recovery Plan Review of draft Annual Report and Annual Accounts Receiving regular assurance from internal and external audit on reports issued to management Approving internal audit and external audit plans linked to the assurance framework Monitoring the implementation of audit recommendations Review of Assurance Framework and Risk Register processes Review of Information Governance Assurance Regular updates on Counter Fraud and Security

Committee	Role and performance highlights
	Review of Commissioning Support assurance Review of Partnership Commissioning Unit assurance, including attendance at two meetings by the Head of the Partnership Commissioning Unit Review of Primary Care Commissioning assurance Processes for review of Committee effectiveness, Internal Audit and Counter Fraud effectiveness, and External Audit effectiveness Development of a Quality Outcomes Framework
Remuneration Committee	Chaired by the CCG Governing Body Chair, the Remuneration Committee makes recommendations to the Governing Body on: terms and conditions of employment for employees of NHS Vale of York CCG including the use of Recruitment and Retention Premia, 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 policies and instructions relating to remuneration. The Committee convened seven times in 2016/17, twice via email and once via teleconference, and was quorate on each occasion. **Members** Keith Ramsay, CCG Governing Body Chair and Remuneration Committee Chair David Booker, Lay Member and Chair of Finance and Performance Committee Sheenagh Powell, Lay Member with the lead role in governance and Audit Committee Chair **Performance and highlights** Ratification of the appointment of Dr Arasu Kuppuswamy as Secondary Care Clinician on the Governing Body Arrangements for posts of Chair and Deputy Chair of the Council of Representatives Review of GP Governing Body members' remuneration Review of Senior Management Team remuneration Development of GP remuneration framework Appointment of Interim Accountable Officer Appointment of Accountable Officer

Committee	Role and performance highlights
	Establishment of new Executive Director and Medical Director posts Review of Practice staff remuneration Review of Committee Terms of Reference
Quality and Finance Committee	Chaired by a Lay Member of the Governing Body the Quality and Finance Committee met eight times and was quorate on each occasion. From November 2016 the quality and finance functions were split with establishment of the Finance and Performance Committee and the Quality and Patient Experience Committee. The overall objectives of the Quality and Finance Committee were to ensure that the CCG had strong contractual and quality performance, clinically appropriate and safe services, and to ensure that this was delivered within the financial plan. Where the Committee deemed necessary, matters of concern were escalated to the Governing Body. **Members** David Booker, Lay Member - Committee Chair Michael Ash-McMahon Deputy Chief Finance Officer Fiona Bell, Assistant Director of Transformation and Delivery Michelle Carrington, Executive Director of Quality and Nursing Dr Mark Hayes, Chief Clinical Officer to 21 July 2016 Helen Hirst, Interim Accountable Officer, from 25 April to 2 October 2016 Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member Dr Tim Maycock, Governing Body GP, Primary Care Lead Phil Mettam, Accountable Officer, from 3 October 2016 Dr Shaun O'Connell, GP Member and Joint Medical Director Dr Andrew Phillips, GP Member and Joint Medical Director Rachel Potts, Executive Director of Planning and Governance Tracey Preece, Chief Finance Officer Paul Howatson, Senior Innovation and Improvement

Committee	Role and performance highlights
	Manager, attended each meeting and a representative of NHS England Assurance and Delivery Team was invited. The CCG Governing Body Chair and Audit Committee Chair were invited to attend when procurement was an agenda item. **Performance and highlights** Monthly reports on the CCG's turnaround plan Monthly detailed consideration of the Quality and Performance Intelligence Report and Financial Performance Report Safeguarding report Monthly Corporate Risk Register update Partnership Commissioning Unit reports Procurement reports Prescribing Policies System Resilience schemes reports The last meeting of the Committee focused on a detailed review of performance of Quality, Improvement, Productivity and Performance schemes.
Finance and Performance Committee	Established in November 2016 and chaired by a Lay Member of the Governing Body the Finance and Performance Committee met five times and was quorate on each occasion. The paramount role of the Committee, which met five times and was quorate on each occasion, is to oversee the financial recovery of the CCG operating under legal Directions, which became effective from 1 September 2016, through scrutiny of all financial recovery plans on behalf of the Governing Body. Membership was confirmed at the February meeting and agreed in the context of the CCG being under legal Directions as: David Booker, Lay Member - Committee Chair Michael Ash-McMahon, Deputy Chief Finance Officer Fiona Bell, Assistant Director of Transformation and Delivery Michelle Carrington, Executive Director of Quality and Nursing Jim Hayburn, Interim Executive Director of System Resources and Performance

Committee	Role and performance highlights
	Phil Mettam, Accountable Officer Dr Shaun O'Connell, GP Member and Joint Medical Director Dr Andrew Phillips, GP Member and Joint Medical Director Rachel Potts, Executive Director of Planning and Governance Tracey Preece, Chief Finance Officer Elaine Wyllie, Strategic Programme Consultant Assistant Director of Delivery and Performance (to be appointed) **In attendance** (non-voting): Natalie Fletcher, Head of Finance Keith Ramsay, Lay Chair of the Governing Body Sheenagh Powell, Lay Chair of the Audit Committee Liza Smithson, Head of Contracting Jon Swift, Director of Finance, NHS England North (or deputy) **Performance and highlights** Establishment of Terms of Reference to support legal Directions Draft Medium Term Financial Strategy Draft Financial Plan 2017-18 Monthly Financial Performance Report, QIPP Dashboards, Performance Report and Contract Report Establishment of finance and performance year-end positions RightCare progress report
Quality and Patient Experience Committee	Established in December 2016 and chaired by the CCG Governing Body Chair, the Quality and Patient Experience Committee, which meets bi-monthly, met twice and was quorate on each occasion. There was also an additional single item meeting. The overall objective of the Committee is to ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement in line with the NHS Constitution (2011) underpinned by the CCG Quality Assurance Strategy. **Members** Keith Ramsay, CCG Governing Body and Committee Chair

Committee	Role and performance highlights
	Michelle Carrington, Executive Director of Quality and Nursing Jenny Carter, Assistant Director of Quality and Nursing Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member Dr Shaun O'Connell, GP Member and Joint Medical Director Dr Andrew Phillips, GP Member and Joint Medical Director Rachel Potts, Executive Director of Planning and Governance Elaine Wyllie, Strategic Programme Consultant Debbie Winder, Head of Quality Assurance and Maternity Interim Executive Director of Transformation and Delivery – to be appointed **In attendance** (non-voting): Karen Hedgley, Designated Nurse Safeguarding Children Victoria Hirst, Head of Engagement Christine Pearson, Designated Nurse Safeguarding Adults Victoria Pilkington, Director of the Partnership Commissioning Unit as required Gill Rogers, Patient Experience Officer Siân Balsom, Director of York Healthwatch (Local Healthwatch representative) Co-opted member of Scarborough Ryedale CCG as required **Performance and highlights** Establishment of Terms of Reference Quality and Patient Experience Report Safeguarding Adults and Children updates Update on development of a new City of York Healthy Child Service 0-19

Primary Care Commissioning Committee	Chaired by the CCG Governing Body Chair, the Primary Care Commissioning Committee met four times in public and was quorate on each occasion. **Members** (to December 2016) Keith Ramsay. CCG Governing Body and Committee Chair Michael Ash-McMahon, Deputy Chief Finance Officer Fiona Bell, Assistant Director of Transformation and Delivery Dr Louise Barker, Governing Body GP, Clinical Lead for Mental Health Dr Lorraine Boyd, GP, Council of Representatives Member Dr Emma Broughton, Governing Body GP, Lead for Women and Children and Joint Primary Care Lead Michelle Carrington, Executive Director of Quality and Nursing Dr Mark Hayes, Chief Clinical Officer to 21 July 2016 Helen Hirst, Interim Accountable Officer 25 April to 2 October 2016 Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member Dr Tim Maycock, Governing Body GP, Primary Care Lead Phil Mettam, Accountable Officer from 3 October 2016 Dr Shaun O'Connell, Governing Body GP member Dr Andrew Phillips, Governing Body GP member Constance Pillar, Assistant Head of Primary Care, NHS England – North (Yorkshire and Humber) Rachel Potts, Executive Director of Planning and Governance Tracey Preece, Chief Finance Officer **In attendance (non-voting)** Nigel Ayre, Healthwatch North Yorkshire representative Kathleen Briers, Healthwatch York representative Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York Shaun Macey, Senior Innovation and Improvement Manager Sharon Stoltz, Director of Public Health, City of York Council Following review at the December meeting of the Council

	of Representatives, membership of the Committee at its December meeting became: Keith Ramsay, CCG Governing Body and Committee Chair David Booker, Lay Member and Chair of Finance and Performance Committee Michelle Carrington, Executive Director of Quality and Nursing Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member Phil Mettam, Accountable Officer Helen Phillips, Primary Care Contracts Manager, NHS England – North (Yorkshire and the Humber) Tracey Preece, Chief Finance Officer Sheenagh Powell, Lay Member and Audit Committee Chair **In attendance** (non-voting) Dr Lorraine Boyd, GP, Council of Representatives Member Dr Andrew Phillips, Clinical Executive Chair Kathleen Briers, Healthwatch York representative Nigel Ayre, Healthwatch North Yorkshire representative Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York Shaun Macey, Senior Innovation and Improvement Manager Sharon Stoltz, Director of Public Health, City of York Council Membership of the Committee from the February meeting was: Keith Ramsay, CCG Governing Body and Committee Chair David Booker, Lay Member and Chair of Finance and Performance Committee Michelle Carrington, Executive Director of Quality and Nursing Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member

	Phil Mettam, Accountable Officer Helen Phillips, Primary Care Contracts Manager, NHS England – North (Yorkshire and the Humber) Tracey Preece, Chief Finance Officer Sheenagh Powell, Lay Member and Audit Committee Chair **In attendance** (non-voting): Dr Lorraine Boyd, GP, Council of Representatives Member Kathleen Briers, Healthwatch York representative Nigel Ayre, Healthwatch North Yorkshire representative Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York Shaun Macey, Head of Transformation and Delivery Dr Andrew Phillips, Joint Medical Director Sharon Stoltz, Director of Public Health, City of York Council **Performance and highlights** Prioritisation and progress of 2016-17 bids to the Estates and Technology Transformation Fund Development of a Primary Care Dashboard Review of Terms of Reference Development of Primary Care Commissioning Financial Report General Practice Forward View update Primary Care Update from NHS England North

Table 18 - CCG committees, their role and highlights

2.4.8 Remuneration Committee

Name	Role	Membership from	Attendance
Keith Ramsay	CCG Governing Body and Remuneration Committee Chair	April 2016	6/6
David Booker	Lay Member and Chair of Finance and Performance Committee	April 2016	4/6 *
Sheenagh Powell	Lay Member with a lead role in governance and Audit Committee Chair	April 2016	6/6

Table 19 - Remuneration Committee membership and attendances

One meeting was via teleconference and there were two 'virtual' meetings.

* Contributed by email exchange when unable to attend.

2.4.8.1 Non Remuneration Committee member attendances

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

Janet Thacker, Head of Human Resources and Learning and Developments for eMBED Health Consortium, attended three meetings and the teleconference in the capacity of external adviser.

Kerry Ryan, HR Business Partner for eMBED Health Consortium, attended one meeting in addition to Janet Thacker and Emma Collins (née Peasgood), in the capacity of external adviser.

Emma Collins, HR Business Partner for eMBED Health Consortium, attended four meetings, in addition to Janet Thacker on three occasions, in the capacity of external adviser; both were also on the teleconference.

Janet Thacker, Emma Collins and Kerry Ryan also provided a range of general HR advice to the CCG during 2016-17. They were employed by eMBED Health Consortium that were contracted to provide an 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 eMBED Health Consortium through the Service Level Agreement.

Helen Hirst attended two meetings and Phil Mettam attended the teleconference and one meeting.

2.4.9 Performance of the Governing Body, including their own assessment of their effectiveness.

The Governing Body undertook a review of its composition and supporting structures during 2016-17. The following actions were agreed with NHS England as part of the CCG's improvement work.

2.4.9.1 Actions to date

- Revised Terms of Reference for Primary Care Commissioning Committee.
- Instigated new templates for reporting.
- Governing Body self-evaluation and governance workshop to review decision-making structures.
- Commenced constitutional review and proposed structures.
- Additional capacity on internal control, full implementation of corporate assurance.

- System and review of risk management with supporting organisational training.
- Creation of an Executive Committee to manage the business decision-making on behalf of the Governing Body.
- Creation of the Clinical Executive to support clinical leadership, challenge and member engagement.
- Undertake a full constitutional review to refocus the organisation on system change delivery.
- Securing confidence and mandate from the Council of Representatives through early engagement and appropriate escalation of issues.
- Improving accountability for delivery and decision-making by reorganising teams to support the Executive Directors who will lead the delivery of agreed priorities.
- Improve personal accountability of all Governing Body members by introducing clear objectives linked to agreed priorities including QIPP delivery.

2.4.9.2 Planned action

- Improving responsiveness and ownership of CCG statutory duties and system risk by implementing organisational development plans.

2.4.10 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Corporate Governance Code.

2.4.11 Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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.

2.5 Risk management arrangements and effectiveness

2.5.1 The CCG's Risk Management Framework

The CCG's Risk Management Framework sets out the definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management.

The CCG recognises that that it is not possible to eliminate all risks. It believes that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources.

The CCG regularly evaluates risks, identifies the level of control required to effectively manage those risks and seeks to eliminate or reduce all identifiable risk to the lowest practicable level that has the potential:

- to harm its staff, patients, visitors and other stakeholders;
- to result in significant incidents;
- to result in loss of public confidence in the CCG and/or its partner agencies;
- for severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents.

In June 2016 the CCG's Risk Registers and the CCG Assurance Framework were aligned to the NHS England's revised CCG Improvement and Assessment Framework as outlined in the diagram below.

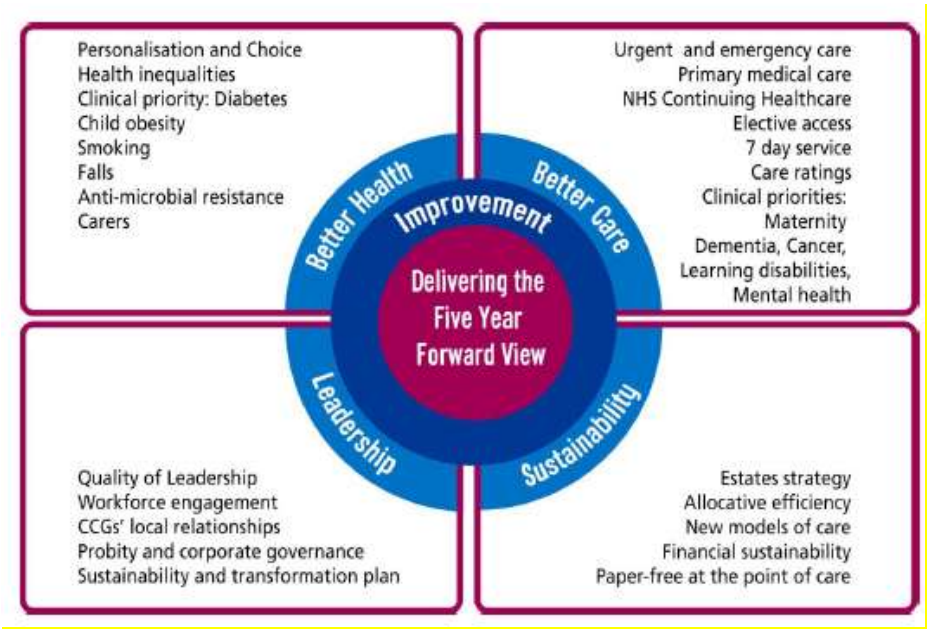


Fig 9 - NHS England's revised CCG Improvement and Assessment Framework

The revised framework was presented to the CCG's Audit Committee and Governing Body in July 2016 and regular updates against the framework are provided to both the Audit Committee and Governing Body.

Reports of all corporate significant risks were reported to each meeting of the Governing Body and risk portfolios were reported to committees at each session. A new addition to the 2016-17 CCG Improvement and Assurance Framework was the inclusion of performance against national assurance framework indicators. The Governing Body monitored management of significant risks and performance against national indicators throughout the year.

A copy of Risk Management Strategy is available on the CCG's website at www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/march-2017/cor03-risk-management-strategy-and-policy-3.0-dec-2015-formatted-01032017.pdf.

A review of the strategy is planned to take place in 2017.

2.5.2 Risk assessment

Risks that impact delivery of strategic objectives; compliance with the CCG licence; CCG statutory duties and the CCG's Operational Plan were classified as Corporate Risks. All corporate risks were assessed using a risk matrix methodology. The CCG adopted a risk assessment tool, based upon a 5 x 5 matrix. Risks were measured according to the following formula:

Probability (Likelihood) x Severity (Consequences) = Risk

All risks were rated on two scales, probability and severity, the highest probability being 5, and the highest Impact/Severity being 5. The assessment of risk to stakeholders and the organisation were made as follows:

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

Corporate risks were assigned a risk lead at a Director level and a risk owner to monitor risk levels and trends.

The CCG maintained project, programme and team risk registers. Programme Managers were responsible for engaging project stakeholders in the identification of project risks. These risks were managed and mitigated within teams; however, there was a defined escalation path for team risks. A team risk could be escalated to the Corporate Register if the impact of the risk had

potential to the impact delivery of strategic/corporate objectives and could not be managed within team.

Corporate risks that materialised were classified as events and reported to the CCG's management. Risk briefings were presented to senior managers and risk reports were presented monthly to the Quality and Finance Committee, bi-monthly to the Audit Committee, and on a quarterly basis to the Governing Body.

In addition to the on-going review of risks, the CCG implemented a horizon scanning process across to identify emerging risks and opportunities. This was reviewed fortnightly by senior managers and action was taken as appropriate.

The Accountable Officer report to the Governing Body provided a forum for future risks to be reported to the Governing Body.

2.5.3 Risk reduction

New policies, projects and service improvement work in 2016-17 included the completion of an Equalities Impact Assessment, a Sustainability Impact Assessment, a Privacy Impact Assessment and a Bribery Impact Assessment.

The processes were designed to reduce risks to service users, NHS finances and organisational reputation by ensuring the appropriate safeguards were considered at the beginning of all projects.

To encourage transparency and encourage reporting of incidents the CCG approved policies based on the theme of risk reduction including conflicts of interest and business standards and whistleblowing. The CCG worked with NHS Protect and Internal Audit services to reduce the risks of fraud.

The CCG had eight counter fraud days in its plan for 2016-17 that were allocated in accordance with NHS Protect standards for commissioners. Key pieces of work included:

- Strategic governance – to set out requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-crime measures were embedded at all levels across the organisation.

- Inform and involve – to set out the requirements to raise awareness of crime risks against the NHS, and working with NHS staff and the public to publicise the risks and effects of crime against the NHS.

- Prevent and deter – to set out requirements in relation to discouraging individuals who may be tempted to commit crime against the NHS and ensure that opportunities for crime to occur are minimised.

- Hold to account – to set out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes, and seeking redress.

The Local Counter Fraud Specialist provided updates to the Audit Committee on NHS counter fraud work, including on current and concluded fraud investigations and proactive counter fraud work undertaken by the NHS.

The Audit Committee approved the draft Counter Fraud Plan for 2017-18 which has been aligned to the Standards for Commissioners – fraud, bribery and corruption.

2.5.4 Stakeholder engagement

The CCG had a robust approach to public and stakeholder engagement in both strategic and operational planning, and this included engagement as a critical factor within the Assurance Framework. The CCG also used stakeholder engagement to identify emerging risks, for example issues identified through patient experience feedback or changes to partner organisations or finances.

The engagement and involvement of patients, partners and other stakeholders was intrinsic to the commissioning and procurement of services. This work was led Executive Director of Planning and Governance with the responsibility for engagement, and the Lay Chair, the Governing Body lead for this work. The CCG embedded a culture of stakeholder involvement and engagement in all roles, with every staff member being part of the process.

The CCG was transparent about the risks it faced and published these in the Governing Body meeting papers as part of the Finance and Performance Committee minutes.

2.5.5 Capacity to handle risk

The CCG's approach to risk management was outlined in its Constitution and documented in the CCG Risk Management Policy and Strategy. See section 2.5.1 for information about the strategy.

The CCG undertook a significant amount of work during the year to review and develop its risk management framework in line with the new CCG Improvement and Assessment Framework. A further review of risk reporting and escalation process will take place in 2017-18.

The CCG's Risk Management system was operated through the CCG's Integrated Governance System, Covalent. This provided the structure and mechanisms for capturing, managing and monitoring risks. Risks registers were recorded, reported and escalated from this system and structured as follows:

- Project / programme risks
- Team risks
- Corporate risks

The CCG implemented clear roles and responsibilities in relation to risk management as detailed in the CCG's Risk Management Policy and Strategy. Risks were escalated through this structure with red risks being escalated to the Governing Body via the Corporate Risk Register Report.

The CCG ensured a robust approach to reviewing and challenging project risk, including procurements. A member of the Executive Team was assigned as lead for each project or procurement. Risk logs were maintained and regularly reviewed by a senior programme lead. Significant risks were escalated to the Governing Body and were included in corporate risk registers, where appropriate.

Risk was a standing item on the Finance and Performance Committee agenda with a significant risk report being received at each meeting.

The CCG's auditors reviewed risk management arrangements as a part of an audit of Governance arrangements and provided a 'Significant Assurance' opinion.

The CCG implemented the Covalent system to support the consistent assessment, monitoring and management of risk. All teams had a designated Covalent risk lead.
Under the direction of the Executive Director for Planning and Governance, the CCG's Corporate Services and Assurance Manager provided a lead on the overall implementation and use of Covalent across the CCG. The format for presenting risk information was reviewed to provide clear and consistent risk reporting to committees and the Governing Body.

2.5.6 Risk assessment - current significant risks and mitigations

During 2016-17, a number of the identified financial risks materialised. This occurred because the financial position deteriorated and the CCG failed to deliver the planned deficit position. In addition, service improvement projects did not achieve the level of saving that was originally targeted.

Although the risks were clearly identified and recorded, it was clear that the approach to mitigating and managing these was not sufficiently robust.

For 2017-18, the CCG's Medium Term Financial Strategy articulates a new approach to system governance and risk sharing across the system. In particular, this includes contractual agreement with the CCG's main provider, York Teaching Hospital NHS Foundation Trust that commits both organisations to sharing the risk associated with the joint programme of work to deliver the required efficiencies on a scheme by scheme basis. This work will also help to ensure that collaborative remedial action is taken to ensure that the overall financial position is realised.

The risks of greatest financial significance reported to the March 2017 meeting of the Governing Body were:

- failure to achieve an assured position for the CCG's 2016-17 plan;
- Quality, Innovation, Productivity and Performance Plan failures to deliver anticipated savings;
- healthcare provider over-trades - acute, ambulance, mental health and continuing healthcare;
- delivery of plans in certain areas were affected by organisational change in the Partnership Commissioning Unit;
- the Better Care Fund – the impact of weaker delivery of schemes on the risk share set out in the Section 75 Agreement;
- the mobilisation of estates, workforce and technology - key enablers to facilitate service re-design and provision of supporting system business intelligence.

The CCG also had significant and realised risks in relation to performance against NHS Constitution targets. The CCG proactively managed these risks and comprehensive mitigating action plans were put in place. More information about these are available in the Performance Report.
The CCG's significant risks can be found in the Governing Body meeting papers that are published on the CCG's website at www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/.

2.5.7 Internal Control Framework

A system of internal control is the set of processes and procedures the CCG uses 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.

During 2016-17 the system of internal control allowed risk to be managed to a reasonable level rather than eliminating all risk. It provided a reasonable but not an absolute assurance of effectiveness. The system of internal control was based upon an 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;
- the impact should they be realised;
- manage them efficiently, effectively and economically.

The CCG used this system for internal control and arrangements for internal audit, external audit and counter fraud support. Underpinning the Prime Financial Policies, the CCG had detailed financial policies and a supporting Detailed Scheme of Delegation. This aligned to the CCG's financial systems to ensure the appropriate levels of approval.

The CCG implemented an annual review of the Prime Financial Policies and Detailed Scheme of Delegation. The financial system the CCG operated was kept up to date in line with these documents and was subject to internal audit for which, as part of its financial governance review, the CCG received a high level of assurance.

However, due to the failure to meet financial requirements, the risk and control mechanisms did not prevent the CCG being imposed with Legal Directions by NHS England. The CCG worked with NHS England to comply with the Legal Directions as follows:

- the CCG produced and implemented a revised Improvement Plan that set out how the CCG work will ensure that the capacity, capability and governance of the CCG is made fit for purpose, including how it will agree with NHS England as to how the CCG will strengthen its financial leadership;
- agreed a Financial Recovery Plan with NHS England that set out how the CCG will cap the financial deficit within the financial year 2016-17 and manage operating budgets for the financial year 2017-18 and thereafter;
- to undertake a risk assessment of the Financial Recovery Plan.

2.5.8 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out their annual internal audit of conflicts of interest and received an audit opinion that the arrangements offer significant assurance.

2.5.9 Data quality

The CCG received a business intelligence service the commissioning support team at eMBED Health Consortium. This team checked and validated data internally. The Governing Body and the CCG's committees were reviewed during 2016-17 and no concerns were raised regarding the quality of data supplied by eMBED Health Consortium. The format of reporting at the Finance and Performance Committee was altered to increase the amount of data presented to the committee to provide added detail of system pressures.

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

The CCG placed high importance on ensuring there wre robust information governance systems and processes in place to help protect patient and corporate information. 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 was supported by the CCG's Information Governance Toolkit and the annual submission process provided assurances to the CCG and other organisations that the CCG adequately discharged its duties.

The CCG's Information Governance Steering Group oversaw the compliance and delivery of the CCG's Information Governance Toolkit and it was accountable to the Audit Committee for discharging this duty. The Audit Committee was responsible for providing the Governing Body with assurance regarding Information Governance systems, including the management of information risk.

The CCG published a Privacy or Fair Processing Notice on its website - www.valeofyorkccg.nhs.uk/privacy. This provided information of the types of personal information the CCG held and processed; the legal basis for doing so and the purposes. This notice was reviewed in 2016-17 to ensure its accuracy.

All staff working for the CCG were required to undertake Information Governance training annually. Reminders and updates on information governance good practice and principles were also circulated throughout the year.

Risks to data security were managed by the CCG with advice, support and guidance from externally procured Information Governance and IT specialists provided by eMBED Health Consortium. Data maps documenting flows of personal data and security arrangements for information assets were formally reviewed in year. The risks were evaluated and where a need to mitigate and / or manage risk was identified, clear plans were included in Information Governance action plans.

The CCG achieved compliance at level 2 with the NHS Information Governance toolkit. This achievement was 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.

2.5.11 Business critical models

The CCG reviewed the MacPherson report on Government Analytical Models and concluded at the time that it did not create analytical models that sat with the criteria of the report.

The CCG received modelling advice and support from eMBED Health Consortium that included multi-disciplinary expertise for activity, business intelligence, workforce and service re-design services. The CCG used national modelling tools, including IHAM modelling, ONS information, national activity profiling and benchmarking, such as RightCare and Commissioning for Value information, and NHS England local benchmarking.

Quality assurance was delivered internally to the CCG through peer reviews and eMBED Health Consortium's internal audit programme.

The CCG gained 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.

2.5.12 Third party assurances

Assurances were received from the CCG's commissioning support provider eMBED Health Consortium in a letter format. The process for third party assurances will require further development in 2017-18.

2.5.13 Control issues

Significant control issues included the provisions of the legal directions, which were addressed via the Improvement Plan. The financial implications are discussed in the Review of Economy, Efficiency and Effectiveness of the Use of Resources in section 2.6.

2.6 The review of economy, efficiency and effectiveness of the use of resources

2.6.1 Financial performance in 2016-17

During 2016-17 the CCG's overall financial performance, including the key measures in the table below, was monitored and managed on a regular basis by the Quality and Finance Committee (now known as the Finance and Performance Committee). The Governing Body also received a finance report at each of its meetings. Monthly briefings and additional reports were provided to the NHS England regional team.

Duty	Duty Achieved?	Target	Actual
Expenditure not to exceed income (£'000s)	No	441,137	464,896
Revenue administration resource use does not exceed the amount specified in Directions (£'000s)	Yes	7,556	7,208
Revenue - 1% planned surplus is achieved	No	4,341	(23,759)
Cash - Must be less than maximum cash drawdown (£'000s)	Yes	468,990	467,523
Cash - 95% of NHS invoices by value are paid within 30 days	Yes	95.00%	99.89%
Cash - 95% of NHS invoices by number are paid within 30 days	Yes	95.00%	99.47%
Cash - 95% of Non NHS invoices by value are paid within 30 days	Yes	95.00%	99.67%
Cash - 95% of Non NHS invoices by number are paid within 30 days	Yes	95.00%	98.04%
Cash - period end cash balances are within 0.125% of drawdown	Yes	335	163

Table 20 - Financial performance and key measures in 2016-17

The CCG began the year planning for an in-year deficit of £7.1m and a cumulative deficit at the end of the year of £13.3m. However, the CCG, as with the NHS as a whole, experienced a range of financial and operational challenges. This impacted on the organisation's ability to deliver its financial position and in combination with growth in health services over and above that which was planned for and non-delivery of QIPP plans.

As a result of this deterioration throughout the year and as a result of its financial position, the CCG was formally placed under Legal Directions on 1 September 2016. It is likely, under Section 30 of the Local Audit and Accountability Act 2014, that the CCG's auditors, Mazars, will write a letter about the anticipated or actual breach of financial duties to the Secretary of State for Health. It is important to note this has not affected the CCG preparing the accounts on a Going Concern basis.

The CCG responded with the development of a Financial Recovery Plan, submitted to NHS England on 6 October 2016, and this included a plan to achieve an in-year deficit of no more than £7.1m (£13.3m cumulative). However, the pressures continued to grow and the Financial Recovery Plan

did not have the desired financial impact, although a number of the other areas of improvement it targeted have now been implemented.

The CCG is now reporting a cumulative deficit position of £23.8m after the release of the 1% risk reserve (£4.3m) at the end of 2016-17. This represents a significant deterioration of £10.4m from the planned deficit position.

The CCG recognised the need to undertake a different approach to its recovery and articulate a strategic plan to address the underlying causes of financial deficit and identify a path to sustainability. Following on from the initial capability and capacity review from December 2015 and its work supporting the Humber, Coast and Vale Sustainability and Transformation Plan, the CCG engaged PricewaterhouseCoopers to support the development of a Medium Term Financial Strategy and this informed the development of the 2017-19 financial plans.

As per the business rules, the CCG did not overspend its administrative costs (running costs). These were underspent by £348k against the administrative cost allocation.

2.6.2 Medium Term Financial Strategy

The current plan shows a cumulative deficit of £44.1m for 2017-18 and £53.9m for 2018-19. The scale of the financial recovery required is such that the CCG has therefore had to consider and plan for a much longer phased recovery and has developed a Medium Term Financial Strategy to articulate a plan which addresses the underlying causes of financial deficit and identifies a path to sustainability by 2020-21, whilst delivering the required business rules. The CCG has undertaken a fundamentally different approach to the development of its strategy based on a detailed understanding of its population needs which has allowed it to pinpoint a number of areas to focus on.

The Medium Term Financial Strategy was shared with CCG's Council of Representatives and NHS England prior to approval at Governing Body on the 2 March 2017.

The document is currently being shared with key stakeholders as part of a formal engagement plan. Early feedback is that there is strong support for the approach the CCG is taking and the principles being applied as the Medium Term Financial Strategy seeks to:

- outline a plan for how the CCG can reach a balanced and sustainable financial position;
- align with existing system plans, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan;

- meet key statutory financial targets and business rules;
- be consistent with the CCG's vision and support the delivery of the CCG objectives;
- recognise and meet the scale of the challenge in the Five Year Forward View;
- deliver operational and constitutional targets.

Moving forward, the CCG recognises it needs to play its part in redesigning and delivering a new health and social care system which is better able to care for patients, whilst also delivering financial sustainability. The MTFS for doing this is embedded in the work of the STP and includes a vision for new models of accountable care in the Vale of York, strategic commissioning across the system and new approaches to system governance and risk sharing.

Moving forward, the CCG recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals.

Development of the financial strategy will require close collaboration with providers and other STP partners, as well as a strong and realistic understanding of the capabilities required to deliver the new vision articulated.

2.6.3 Savings performance 2016-17

The Quality, Innovation, Productivity and Performance target in the 2016-17 Financial Plan was £12.2m, of which £4m was the value of the gap between contracted and financial plan values and £580k was unidentified at the start of the year. The CCG delivered £1.7m of QIPP savings against the identified plans of £7.6m.

Moving forward and as part of the Medium Term Financial Strategy the CCG identified six areas of financial opportunity to focus on: Elective Orthopaedics, Out of Hospital, Outpatients, Continuing Healthcare, Prescribing and High-cost Drugs. Combined, these six opportunities have the potential to release savings to the CCG in the order of £50m by 2020-21.

Following a Confirm and Challenge process led by NHS England the CCG identified specific interventions and schemes (including the six opportunity areas and others) with a total value of £47.7m. This would allow the CCG to reach in-year surplus by 2020-21 although a cumulative financial deficit of approximately £51m would still remain, or at best, £38m with further QIPP not yet identified.

2.6.4 Delegation of Functions

The CCG worked under shared arrangements with local CCGs on joint services including:

- Medicines Management
- Quality and clinical services
- Research
- Legal
- Specialist Commissioning Networks

The CCG procured the following services to support its commissioning from 1 April 2016:

- Procurement (non-Lead Provider Framework)
- Information Technology and Information Governance (eMBED Health Consortium)
- Business Intelligence (eMBED Health Consortium)
- HR and Workforce support (eMBED Health Consortium)
- Individual Funding Requests (North East Commissioning Support)

2.6.5 Partnership Commissioning Unit realignment

Phase 1 of the Partnership Commissioning Unit re-alignment has concluded, resulting in the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) of some staff to the four CCGs in North Yorkshire. For NHS Vale of York CCG the significant difference has been taking back in-house responsibility for mental health and learning disability commissioning, the management of these contracts and the clinical Continuing Healthcare Team. The CCG has become responsible for the commissioning of services for children and young people and maternity services in the City of York local authority area. It has also become responsible for hosting the Acquired Brain Injury Service on behalf of the other North Yorkshire CCGs. Services for Transforming Care, Personal Health Budgets, legal services and estates management are hosted by other CCGs.

Phase 2 of TUPE will include a consultation on the change of base for affected staff and the dividing of the finance and contracting teams.

The CCG will ensure that services are transferred safely and any gaps in services will be aligned to discussions regarding vacancies and affordability. To ensure continuity, recommendations from Internal Audit reports relating to the Partnership Commissioning Unit will be addressed within the CCG.

2.6.6 Better Care Fund

The Better Care Fund is a formal arrangement between health and social care partners. Plans have been established with the three local authorities that cross over the CCG boundaries as set out in the table below.

Health and Wellbeing Board	Host	Pooled budget £m	CCG contribution £m
City of York	NHS Vale of York CCG	12.2	11.2
North Yorkshire	North Yorkshire County Council	40.2	7.2
East Riding of Yorkshire	East Riding of Yorkshire County Council	22.5	1.3
Total		**74.9**	**19.7**

Table 21 – Better Care Fund contributions in 2016-17

These arrangements were formalised within Section 75 agreements between the relevant partners. The pooled budgets have been planned for again over the next two years, in line with the indicative growth figures provided by NHS England (1.79% in 2017-18 and 1.90% in 2018-19).

2.6.7 CCG assessment ratings

Further information on the CCG's performance assessment, including the Quality of Leadership indicator, can be seen at the MyNHS website: https://www.nhs.uk/service-search/Performance/Search . The rating is published annually and may not reflect recent changes.

2.7 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

FINAL 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 2017

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 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 Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit 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 Governance Statement.

The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer, 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 Governance Statement.

In response to the 'not assured' rating for CCG leadership in Spring 2016, an in-depth review of the governance arrangements commenced in the Summer under the direction of the Interim Accountable Officer. This included a review of all decision making meetings within the CCG. The review has been further developed in response to Legal Directions in September 2016, with a response included in the Improvement Plan submission in October 2016.

The Legal Directions focus on five key areas:

1. the production of a revised Improvement Plan;
2. the strengthening of the financial leadership of the CCG;
3. a financial recovery plan that ensures that the CCG achieves an in-year deficit of no greater than £7m in the financial year 2016/2017;
4. that NHS England will determine the process for making the new interim Accountable Officer appointment;
5. that NHS England will be involved in the process to make any new appointments to the Executive Team and the next tier of management.

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 weaknesses 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. During 2016/2017 the CCG has reviewed and updated its governance arrangements and its processes to manage and deliver the financial recovery plan, including the QIPP. As a result audit work around these areas was limited to the design of the arrangements. Audit of the operation of the arrangements has been included in the 2017/2018 plan.

The following table summarises the work completed to date in 2016/2017 in relation to each strategic objective.

Strategic Objective	**Audit**	**Overall Opinion**
Well led organisation with the skills and capacity to deliver statutory functions.	Conflicts of Interest	Significant
	Commissioning Support Contract Management	Limited
Effective clinical and quality assurance improving the quality and safety of commissioned services.	Prescribing and Medicines Management	Advisory review
Transforming local healthcare services	Primary Care Commissioning (Quality)	Limited
	Joint Commissioning	Significant
Financial sustainability supported by effective financial management.	QIPP	Significant
	Referral Management	Significant
	PCU QIPP	Limited
	Contract Management	Significant
	Budgetary Control and Reporting and Key Financial Controls	Significant
		Significant
	Financial Forecasting (PCU* Expenditure)	Significant
	Mental Health Act s117 Continuing Healthcare	Limited
Audit Areas Relating to Other Corporate Functions	Governance	Significant
	Information Governance Toolkit	Significant
	PCU* Information Governance Toolkit	Significant

* Note: The Partnership Commissioning Unit (PCU) 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 PCU in order to provide assurance to all four CCGS.

Unless explicitly detailed third party assurances have not been relied upon.

The Current Position

The Accountable Officer reported to the Governing Body at its meeting on 2 February 2017 that the CCG continues to work on implementing the Improvement Plan with regards to capability, capacity, financial leadership, governance, mobilising change and financial recovery.

An assurance review of the design of the revised governance arrangements has been completed, and provided Significant Assurance on the design of the arrangements.

The design and operation of the Assurance Framework and associated processes

During 2016/2017 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have focussed on the mandated areas of NHS England's Improvement and Assurance Framework. The Governing Body and the Audit Committee have reviewed the Improvement and Assurance Framework and associated risk registers for the mandated areas at each of their meetings:

- Better Health
- Better Care
- Sustainability
- Leadership

The Audit Committee in September 2016 discussed whether the Improvement and Assurance Framework fulfilled the function of providing assurance that key corporate and strategic risks were being managed and mitigated. A revised risk management framework based on the CCGs strategic priorities has been developed to provide assurance on management of risks to the priorities.

The consideration of risk is a standing agenda item on committee agendas with risk registers regularly being reviewed. The CCG continues to embed the Covalent system for recording and reporting of risk. An escalation process in Covalent has been agreed to escalate risk to the Corporate Risk Register. The Corporate Risk Register is reviewed by the Governing Body at each meeting. The Governing Body is well sighted on the risks facing the organisation, including the financial risks identified and which materialised during the year, through the Corporate Risk Register and via the Quality and Finance Committee.

Risk training sessions have been provided to the CCG to both raise awareness and improve identification and assessment of risk.

Internal Audit has undertaken two reviews of the CCGs governance arrangements during 2016/2017. The first is a review of Management of Conflicts of Interest and the second is a review of the revised governance arrangements in response to the legal directions. These reviews provided Significant Assurance.

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

The 2016/17 Internal Audit Operational Plan was initially approved by the Audit Committee on 3 March 2016. The audit plan was structured around the following key responsibilities of the CCG:

- Governance
- Quality and Safety
- Commissioning and Contract Management
- Stakeholder Engagement and Partnerships
- Financial Governance
- Information Governance.

The plan was aligned to the strategic objectives and risks of the CCG. The plan was further reviewed and reprioritised by the Audit Committee in the Autumn to ensure it met the CCG's revised needs. Specifically an audit of the revised governance arrangements was included in the plan to provide assurance about compliance with the legal directions.

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 it's 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.

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level during the development phase.

The outcome of the assurance audit reports from the 2016/2017 audit plan are summarised above.

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

- The outstanding risk issues flagged in the Head of Audit Opinion in 2015/2016 related to the arrangements in place for complying with the National Framework for Continuing Healthcare, arrangements for forecasting Continuing Health Care expenditure, and the commissioning of Section 117 aftercare agreements. These areas are managed on behalf of the CCG by the PCU. Further audits have been completed as part of the 2016/2017 audit plan to assess progress against the actions agreed following the previous audits. Significant progress has been made in respect of the arrangements for forecasting Continuing Health Care expenditure, and the commissioning of Section 117 aftercare agreements. There remains an outstanding risk in relation to compliance with the National Framework for Continuing Healthcare. In addition, the PCU is currently being disbanded and the

management arrangements for the PCU functions, including Continuing Health Care, will be realigned to the CCGs. The CCG faces a risk in relation to the transition of arrangements; this risk has been included on the CCG risk register.

- The CCG is operating under legal directions issued by the NHS Commissioning Board (NHS England) effective from 1 September 2016. The CCG has developed a Medium Term Financial Strategy which was approved by the Governing Body at its meeting in March and has been circulated widely to partners and stakeholders. It also underpins and informs the 2017-2019 Financial Plan. The CCG, alongside the NHS England Area Team, has undertaken a full review of the forecast financial position, including risks and mitigations. The CCG has delivered a £23.76m deficit (underlying £28.10m deficit) following confirmation of the national release of the 1% non-recurrent risk reserve.

The financial position has been impacted by increasing levels of demand in acute and ambulance services, and continuing health care. The financial position and the associated risks have been fully reported to the Governing Body during the year.

Helen Kemp Taylor
Managing Director and Head of Internal Audit
May 2017

2.8 Review of Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors 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 annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed, with improvements identified and being achieved.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, the Quality and Patient Experience Committee, and the Finance and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

2.9 Conclusion

During 2016-17 opinions of Limited Assurance were given in four areas (in respect of Primary Care Commissioning (Quality), Commissioning Support Contract Management, Continuing Healthcare and QIPP (Partnership Commissioning Schemes), and the CCG remains under Legal Directions.

However, significant assurance has been given that there is a generally sound system of internal control that is designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Signature of Accountable Officer

Phil Mettam
Accountable Officer
NHS Vale of York CCG

Dated: 25 May 2017

Section 3
Remuneration and staff

3.1 Remuneration Report

3.1.1 Remuneration Committee

The membership and work of the Remuneration Committee are covered in the Governance Statement on p77.

3.1.2 Policy on the remuneration of senior managers

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.

3.1.3 Remuneration of Very 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.

Independent HR advice is provided to the Remuneration Committee from an HR Director contracted from eMBED, the 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.

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 Committee will continue to receive regular performance objective reports on all of the CCG's senior team.

3.2 Senior manager remuneration (including salary and pension entitlements) 2016-17

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Keith Ramsay - Chair	15-20	0			0	15-20
Dr Mark Hayes - Chief Clinical Officer (to 31 January 2017)	60-65	0			0	60-65
Helen Hirst - Interim Accountable Officer (from 25 April 2016 to 2 October 2016)	25-30	0			10-12.5	35-40
Phil Mettam - Accountable Officer (from 3 October 2016)	75-80	0			22.5-25	100-105
Rachel Potts - Executive Director of Planning and Governance (Chief Operating Officer to 31 January 2017)	90-95	0			12.5-15	105-110
Tracey Preece - Chief Finance Officer	95-100	0			22.5-25	120-125
Michelle Carrington - Executive Director of Quality and Nursing (Chief Nurse to 31 January 2017)	75-80	200			42.5-45	120-125
Jim Hayburn - Interim Executive Director of System Resources (from 31 October 2016 to 31 March 2017) - see (a)	85-90	0			0	85-90
Elaine Wyllie - Strategic Programme Consultant (from 1 January 2017) - see (a)	35-40	0			0	35-40
Dr S O'Connell - Joint Medical Director (GP Governing Body Member to 31 January 2017)	130-135	0			32.5-35	165-170
Dr A Phillips - Joint Medical Director (GP Governing Body Member to 31 January 2017)	130-135	0			17.5-20	150-155
Dr T Maycock - Clinical Director (GP Governing Body Member to 31 January 2017)	65-70	0			17.5-20	85-90
Dr E Broughton - Clinical Director (GP Governing Body Member to 31 January 2017)	60-65	0			7.5-10	65-70
Dr L Barker - Clinical Director (GP Governing Body Member to 31 January 2017)	65-70	0			15-17.5	80-85
Sheenagh Powell - Lay Member and Audit Committee Chair	10-15	400			0	10-15
David Booker - Lay Member	10-15	100			0	10-15
Dr P Evans - Council of Representatives Member	10-15	0			2.5-5	15-20
Dr A Calder - Council of Representatives Member (from 21 April 2016)	10-15	0			0	10-15
Dr A Kuppuswamy - Secondary Care Doctor	5-10	0			2.5-5	10-15
Louise Johnston - Practice Manager Representative (to 15 December 2016)	5-10	0			0	5-10
Sian Balsom - Director, Healthwatch York (Co-opted) (to 19 January 2017) - see (b)	0	0			0	0
Dr J Lethem - Local Medical Committee Liaison Officer, Selby and York (Co-opted) - see (b)	0	0			0	0
Sharon Stoltz - Director of Public Health, City of York Council (Co-opted) - see (b)	0	0			0	0

NB all senior managers are continuing except where stated.

(a) Mr J Hayburn and Mrs E Wyllie were engaged through an off payroll arrangement with their remuneration paid through a contract with a corporate body. Remuneration shown above reflects the gross payments to that body and includes unrecoverable VAT.

(b) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.

(c) Dr M Hayes claimed pension benefits from 2015 and employment after this date was non pensionable. There are no pension figures to disclose for 2016-17.

Table 22 – Senior manager remuneration (including salary and pension entitlements 2016-17

3.3 Senior manager remuneration (including salary and pension entitlements) 2015-16

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Keith Ramsay - Chair	15-20				0	15-20
Rachel Potts – Chief Operating Officer	95-100				2.5-5	95-100
Dr M Hayes - Chief Clinical Officer	90-95				42.5-45	135-140
Tracey Preece - Chief Finance Officer - see (a)	95-100				17.5-20	115-120
Michael Ash-McMahon - Interim Chief Finance Officer - see (a)	5-10				0-2.5	5-10
Michelle Carrington – Chief Nurse	70-75				205-207.5	275-280
Dr S O'Connell - GP Governing Body Member	130-135				20-22.5	150-155
Dr T Maycock - GP Governing Body Member	65-70				12.5-15	80-85
Dr E Broughton - GP Governing Body Member	55-60				0	55-60
Dr A Phillips – GP Governing Body Member	130-135				15-17.5	150-155
Dr L Barker - GP Governing Body Member	65-70				10-12.5	75-80
Sheenagh Powell - Lay Member and Audit Committee Chair (from 1st June 2015) - see (b)	5-10				0	5-10
David Booker - Lay Member	10-15				0	10-15
Dr P Evans - Council of Representatives Member	5-10				5-7.5	15-20
Dr G Porter - Secondary Care Doctor (to 30th September 2015) - see (c)	5-10				0	5-10
Louise Johnston - Practice Manager Representative	5-10				0	5-10
Sian Balsom - Manager, Healthwatch York (Co-opted)	0				0	0
Dr J Lethem - Local Medical Committee Liaison Officer, Selby and York (Co-opted)	0				0	0
Kersten England - Chief Executive, City of York Council (Co-opted) (to 30th April)	0				0	0
Dr G van Dichele - Interim Director of Adult Services, City of York Council (Co-opted) (from 1st May to 6th August 2015)	0				0	0
Sharon Stoltz - Interim Director of Public Health, City of York Council (Co-opted) (from 1st September 2015)	0				0	0
Richard Webb - Corporate Director of Health and Adult Services, North Yorkshire County Council (Co-opted) (to 31st August 2015)	0				0	0

NB all senior managers are continuing except where stated.

(a) Mrs T Preece returned from maternity leave on 20th April, and the Chief Finance Officer role was covered by Mr M Ash-McMahon until this date.

(b) The post of Audit Committee Chair was vacant until S Powell was appointed with effect from 1st June 2014.

(c) The post of Secondary Care Doctor was vacant from 1st October 2015. Dr G Porter was employed by Airedale NHS Foundation Trust and the CCG was invoiced directly by them for his time.

(d) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.

Table 23 – Senior manager remuneration (including salary and pension entitlements 2015-16

3.4 Pension benefits as at 31 March 2017

Name and Title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employers contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Helen Hirst - Interim Accountable Officer (from 25 April 2016 to 2 October 2016)	0-2.5	0-2.5	50-55	145-150	867	29	932	0
Phil Mettam - Accountable Officer (from 3 October 2016)	0-2.5	2.5-5	30-35	100-105	601	37	676	0
Rachel Potts - Executive Director of Planning and Governance (Chief Operating Officer to 31 January 2017)	0-2.5	2.5-5	40-45	125-130	754	44	799	0
Tracey Preece - Chief Finance Officer	0-2.5	0	20-25	55-60	279	24	303	0
Michelle Carrington - Executive Director of Quality and Nursing (Chief Nurse to 31 January 2017)	0-2.5	5-7.5	25-30	80-85	406	50	456	0
Dr S O'Connell - Joint Medical Director (GP Governing Body Member to 31 January 2017)	2.5-5	0-2.5	15-20	40-45	259	50	309	0
Dr A Phillips - Joint Medical Director (GP Governing Body Member to 31 January 2017)	0-2.5	5-7.5	10-15	35-40	220	47	267	0
Dr T Maycock - Clinical Director (GP Governing Body Member to 31 January 2017)	0-2.5	0-2.5	10-15	25-30	156	16	172	0
Dr E Broughton - Clinical Director (GP Governing Body Member to 31 January 2017)	0-2.5	(2.5-0)	15-20	45-50	205	23	228	0
Dr L Barker - Clinical Director (GP Governing Body Member to 31 January 2017)	0-2.5	0-2.5	5-10	20-25	97	19	116	0
Dr P Evans - Council of Representatives Member	0-2.5	0-2.5	10-15	35-40	216	18	234	0
Dr A Kuppuswamy - Secondary Care Doctor	0-2.5	0-2.5	15-20	40-45	214	22	236	0

(a) Jim Hayburn and Elaine Wyllie were engaged through an off payroll arrangement and are not current members of the NHS Pension scheme.
(b) Dr M Hayes claimed pension benefits from 2015 and employment after this date was non pensionable. There are no pension figures to disclose for 2016-17.
(c) H Hirst and A Kuppuswarmy were employed by the CCG via secondment arrangements from other NHS organisations. These secondments were both on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer.

Table 24 – Pension benefits as at 31 March 2017

3.5 Pension benefits as at 31 March 2016

Name and Title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2016	Lump sum at pension age related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employers Contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
Keith Ramsay - Chair	0	0	0	0	0	0	0	0
Rachel Potts – Chief Operating Officer	0-2.5	0-2.5	40-45	120-125	724	21	754	0
Dr M Hayes - Chief Clinical Officer	0-2.5	5-7.5	20-25	65-70	324	-328	0	0
Tracey Preece - Chief Finance Officer	0-2.5	(2.5-0)	20-25	55-60	263	14	279	0
Michael Ash-McMahon - Interim Chief Finance Officer (to 20th April)	0-2.5	(2.5-0)	10-15	35-40	155	0	159	0
Michelle Carrington – Chief Nurse	7.5-10	27.5-30	25-30	75-80	249	154	406	0
Dr S O'Connell – GP Governing Body Member	0-2.5	(2.5-0)	15-20	40-45	233	23	259	0
Dr T Maycock – GP Governing Body Member	0-2.5	0-2.5	10-15	25-30	142	12	156	0
Dr E Broughton – GP Governing Body Member	0-2.5	(2.5-0)	15-20	45-50	202	1	205	0
Dr A Phillips – GP Governing Body Member	0-2.5	2.5-5	10-15	30-35	185	32	220	0
Dr L Barker – GP Governing Body Member	0-2.5	(2.5-0)	5-10	20-25	90	7	97	0

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Table 25 – Pension benefits as at 31 March 2016

3.6 Cash equivalent transfer values

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

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

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

3.6.1 Real increase in Cash equivalent transfer values

This reflects the increase in Cash equivalent transfer values (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 scheme or arrangement) and uses common market valuation factors for the start and end of the period.

3.6.2 Compensation on early retirement or for loss of office

There has been no compensation paid on early retirement or for loss of office.

3.6.3 Payments to past members

There have been no payments to past members in 2016-17.

3.6.4 Pay multiples

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

The banded full time equivalent remuneration of the highest paid member of the Governing Body of the Clinical Commissioning Group in the financial year 2016-17 was £175k - £180k (2015-16, £175k-£180k). This was 5.16 times (2015-16, 5.02) the median remuneration of the workforce, which was £34,393 (2015-16 £35,384).

The movement in median salary 2016-17 was due to further recruitment to the Referral Support Service administration team, following the transfer of the service from Yorkshire and

Humber Commissioning Support Unit to the Clinical Commissioning Group from 1st March 2016.

In 2016-17, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £5k - £10k to £130k - £135k (bands of £5,000). In 2015-16 remuneration ranged from £0k - £5k to £130k - £135k (bands of £5,000).

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

3.7 Staff Report

3.7.1 Number of senior managers

The total number of senior managers on the CCG payroll is 12. These are members of the CCG's Governing Body and the number includes Very Senior Manager (VSM) positions. This number does not include the seconded roles of the Accountable Officer and the Governing Body's Secondary Care Doctor Representative role nor does it include the off-payroll engagements of the Interim Executive Director of System Resources and Interim Executive Director of Joint Commissioning.

3.7.2 Staff numbers and costs

	Staff numbers	Staff costs £000
Permanently employed	107	5751
Other	4	340
Total	111	6091

Table 26 – Staff numbers and costs

3.7.3 Staff composition

Gender	Total (Female)	Total (Male)
Governing Body*	7	5
Band 8a	4	0
Band 8b	5	3
Band 8c	2	0
Band 8d	1	1
Band 9	0	0
VSM	0	0
Any other Spot Salary (e.g. GP Lead roles)	1	3
All other employees	40	15

*Includes VSM; does not include Accountable Officer or Secondary Care Doctor (secondments) or the Interim Executive Director of System Resources and Interim Executive Director of Joint Commissioning (off-payroll)

Table 27 – Staff composition

3.7.4 Sickness absence data

Absence	Total
Average sickness %	2.4%
Total number of full time equivalent days lost	471.7

Table 28 – Sickness absence data

3.7.5 Staff policies

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

Policies and processes in place to support this include:

- Managing Performance
- Disciplinary / Conduct
- Grievance
- Staff Induction
- Bullying and Harassment
- Flexible working
- Job descriptions (including statements regarding equality and diversity expectations)
- Annual appraisals with staff

Policies are available at: http://www.valeofyorkccg.nhs.uk/

We actively encourage people with disabilities to apply for positions in our organisation. We have a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job (formerly the 'two ticks' commitment, now part of the Disability Confident standard), as well as making reasonable adjustments to avoid any disabled employee being put at a disadvantage compared to non-disabled people in the workplace. Staff who have disabilities have the opportunity to discuss their development through our Personal Development and Review process. An equality impact analysis is undertaken on all newly proposed Human Resources policies to determine whether it has a disproportionate impact on people with a disability and, where identified, action is considered to mitigate this.

3.7.6 Expenditure on consultancy

The total spend on consultancy in 2016-17 is £384k as per Note 5 Operating Expenses in the accounts.

3.7.7 Off-payroll engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	2
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	22

Table 29 – Off-payroll engagements

Existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required as to taxation.

3.7.8 Exit packages, including special (non-contractual) payments

There has been one exit payment following an employment tribunal totalling £32k as per Note 4.4 Exit Packages Agreed in the Financial Year in the accounts.

3.7.9 Parliamentary Accountability and Audit Report

The CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements in Part 2 of this report. An audit certificate and report is also included in this Annual Report in Part 2 of this report.

Signature of Accountable Officer

Phil Mettam
Accountable Officer
NHS Vale of York CCG

Dated: 25 May 2017

3.8 Independent Auditor's Report to the Governing Body of NHS Vale of York CCG

INDEPENDENT AUDITOR'S REPORT TO THE GOVERNING BODY OF NHS VALE OF YORK CCG

We have audited the financial statements of NHS Vale of York CCG for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. 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 International Financial Reporting Standards as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual as contained in the Department of Health Group Accounting Manual 2016-17 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England ("the Accounts Direction").

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

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the exit packages narrative note;
- the analysis of staff numbers and related narrative notes; and
- the pay multiples narrative note.

This report is made solely to the members of the Governing Body of NHS Vale of York CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and is also responsible for ensuring the regularity of expenditure and income. 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 require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014.

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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 assessing:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. 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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on the 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 2017 and of its net expenditure and income for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Opinion on regularity

As disclosed in note 19 of its financial statements, the CCG failed to meet its statutory duties under:

- section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2016/17; and
- section 223I(3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in the Direction.

Except for the incurrence of expenditure in excess of the specified targets, in our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied

to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Annual Report Directions made under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS England; or
- we issue a report in the public interest under section 24, schedule 7 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24, schedule 7 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Exception reports

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

Auditor's responsibilities

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 15 March 2017, we issued a report to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014, for the breach of financial duties under:

- section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2015/16; and
- section 223I(3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in the Direction.

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

We report to you if we are not satisfied that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

The CCG reported a deficit of £23.759 million in its financial statements for the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting further cumulative deficits of £44.1 million for 2017-18 and £53.9 million for 2018-19.

The CCG has not succeeded in agreeing a plan that addresses the brought forward deficit in its budget and has been entered, by NHS England, in to the special measures regime.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable financial and performance information (including, where relevant, information from regulatory/monitoring bodies) to support informed decision making and performance management, managing risks effectively and maintaining a sound system of internal control, planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions and working with third parties effectively to deliver strategic priorities.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the C&AG in November 2016, we are not satisfied that, in all significant respects, NHS Vale of York put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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 Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Kirkham
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

25 May 2017

Part 2

Annual Accounts and Financial Statements

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(1,137)	(2,919)
Other operating income	2	(498)	(272)
Total operating income		**(1,635)**	**(3,191)**
Staff costs	4	6,109	4,821
Purchase of goods and services	5	459,120	441,360
Depreciation and impairment charges	5	75	76
Provision expense	5	73	(410)
Other operating expenditure	5	1,154	1,785
Total operating expenditure		**466,531**	**447,632**
Net operating expenditure		**464,896**	**444,441**
Total net expenditure for the year ended 31 March 2017		**464,896**	**444,441**
Of which:			
Administration income and expenditure			
Employee benefits	4.1.1	4,823	3,747
Operating expenses	5	2,587	3,355
Other operating revenue	2	(204)	(347)
Net administration expenditure before interest		**7,206**	**6,755**
Programme income and expenditure			
Employee benefits	4.1.1	1,286	1,074
Operating expenses	5	457,835	439,456
Other operating revenue	2	(1,431)	(2,844)
Net programme expenditure before interest		**457,690**	**437,686**
Comprehensive expenditure for the year ended 31 March 2017		**464,896**	**444,441**

The notes on pages 5 to 35 form part of this statement.

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets			
Property, plant and equipment	8	454	529
Total non-current assets		**454**	**529**
Current assets			
Trade and other receivables	9	2,918	3,431
Cash and cash equivalents	10	163	48
Total current assets		**3,081**	**3,479**
Total assets		**3,535**	**4,008**
Current liabilities			
Trade and other payables	11	(18,429)	(21,485)
Provisions	12	(73)	(117)
Total current liabilities		**(18,502)**	**(21,602)**
Assets less liabilities		**(14,967)**	**(17,594)**
Financed by taxpayers' equity			
General fund		(14,967)	(17,594)
Total taxpayers' equity		**(14,967)**	**(17,594)**

The notes on pages 5 to 35 form part of this statement.

The financial statements on pages 1 to 35 were approved by the Audit Committee on behalf of the Governing Body on 24 May 2017 and signed on its behalf by:

Philip Mettam
Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2017

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17		
Balance at 1 April 2016	**(17,594)**	**(17,594)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17		
Net operating expenditure for the financial year	(464,896)	(464,896)
Net funding	467,523	467,523
Balance at 31 March 2017	**(14,967)**	**(14,967)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16		
Balance at 1 April 2015	**(15,246)**	**(15,246)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16		
Net operating expenditure for the financial year	(444,441)	(444,441)
Net funding	442,093	442,093
Balance at 31 March 2016	**(17,594)**	**(17,594)**

The notes on pages 5 to 35 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(464,896)	(444,441)
Depreciation and amortisation	5	75	76
(Increase)/decrease in trade and other receivables	9	513	(1,094)
Increase/(decrease) in trade and other payables	11	(3,056)	4,087
Provisions utilised	12	(117)	(408)
Increase/(decrease) in provisions	12	73	(410)
Net cash outflow from operating activities		**(467,408)**	**(442,190)**
Net cash outflow before financing		**(467,408)**	**(442,190)**
Cash flows from financing activities			
Grant in aid funding received		467,523	442,093
Net cash inflow from financing activities		**467,523**	**442,093**
Net increase/(decrease) in cash and cash equivalents	10	**115**	**(97)**
Cash and cash equivalents at the beginning of the financial year		**48**	**145**
Cash and cash equivalents (including bank overdrafts) at the end of the financial year		**163**	**48**

The notes on pages 5 to 35 form part of this statement.

Notes to the financial statements

1. Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group (CCG) 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. The legacy provision from North Yorkshire and York Primary Care Trust relating to retrospective Continuing Healthcare claims is the responsibility of NHS England and is reported within their accounts. The Clinical Commissioning Group undertakes the administration of these claims on behalf of NHS England.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014 for the anticipated or actual breach of financial duties.

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 the 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 a going concern basis.

Although Note 19 shows that in 2016/17 the CCG breached its financial duty to break even under Section 30 of the Local Audit and Accountability Act 2014 the going concern status is not called into doubt because it has not been informed of an intention for dissolution without transfer of services to another body. Accordingly, whilst the financial performance and review of economy, efficiency and effectiveness of the use of resources sections of the annual report highlight significant risks to delivering the scale of savings required to break even in 2017/18 there is no material uncertainty regarding the CCG's continuing operational stability for the year ahead.

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 and certain financial assets and financial liabilities.

1.3 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the 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.

Notes to the financial statements

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.

Each year the Clinical Commissioning Group enters into pooled budgets with North Yorkshire County Council, City of York Council, East Riding of Yorkshire Council and the following Clinical Commissioning Groups for the Better Care Fund (note 16):
NHS Airedale, Wharfedale and Craven CCG
NHS East Riding of Yorkshire CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
Consideration has been given as to whether 'IFRS 10 - Consolidated Financial Statements' applies to this pooled budget arrangement, but has been deemed irrelevant as no individual organisation has sole control over the fund.
Consideration has been given as to whether 'IFRS 11 - Joint Arrangements' applies to this pooled budget arrangement, and as a consequence it has been deemed a 'jointly controlled operation'. These accounts have therefore been produced in accordance with this as set out above. This is a change from the Clinical Commissioning Group's accounting policy in 2015-16 where the Better Care Fund was not deemed to be a pooled budget, however this does not change the disclosure requirements.

Consideration has been given as to whether 'IFRS 12 - Disclosure of Involvement with Other Entities' applies to this pooled budget arrangement. The majority of this standard is deemed irrelevant on the basis that no individual organisation has sole control over the fund, and no individual organisation has full or joint control over another entity, or significant influence over another entity. However, as IFRS 11 applies, we have considered disclosure requirements for joint arrangements and these have been met through this policy note and note 16 of the accounts.

1.4 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

1.4.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see 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 Clinical Commissioning Group 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 the following organisations where there is no year-end agreement in place: York Teaching Hospital NHS Foundation Trust, Leeds Teaching Hospital NHS Trust, North Lincolnshire and Goole Hospitals NHS Foundation Trust, Ramsay Health Care UK and Nuffield Health.

Notes to the financial statements

· Gross/Net Accounting Arrangements for Hosted Services

Throughout 2016-17, NHS Scarborough and Ryedale Clinical Commissioning Group has hosted the Partnership Commissioning Unit for the provision of Continuing Healthcare services and the commissioning of Mental Health, Adult Safeguarding and Childrens services, on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG. All payments relating to these services have been transacted through the NHS Scarborough and Ryedale CCG ledger.

With effect from 1 April 2017 the Partnership Commissioning Unit will cease to exist and the Mental Health and Childrens' commissioning functions have transferred to other Clinical Commissioning Groups. The new host organisation will be responsible for the recharge arrangements for these services. NHS Scarborough and Ryedale CCG will continue to host:

- Childrens and Adult Safeguarding on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG.
- Legal Services on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Vale of York CCG and NHS East Riding of Yorkshire CCG.
- Continuing Healthcare on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG and NHS Hambleton, Richmondshire and Whitby CCG.

Financial arrangements pertaining to all former Partnership Commissioning Unit services for all Clinical Commissioning Groups remain unchanged for the foreseeable future.

The costs of Partnership Commissioning Unit hosted services between the Clinical Commissioning Groups are as follows:

Continuing Healthcare/Funded Nursing Care*

NHS Hambleton, Richmondshire and Whitby CCG actual basis 19.48% £14,173,431 (2015-16 actual basis 19.20% £11,538,616)

NHS Harrogate and Rural District CCG actual basis 20.97% £15,256,986 (2015-16 actual basis 19.40% £11,656,160)

NHS Vale of York CCG actual basis 40.21% £29,254,842 (2015-16 actual basis 40.66% £24,430,543)

NHS Scarborough and Ryedale CCG actual basis 19.34% £14,073,874 (2015-16 actual basis 20.74% £12,458,754)

Other Mental Health** (previously referred to as Mental Health Out of Contract Placements)*

NHS Hambleton, Richmondshire and Whitby CCG actual basis 26.61% £3,022,354 (2015-16 actual basis 21.10% £2,379,198)

NHS Harrogate and Rural District CCG actual basis 23.38% £2,655,602 (2015-16 actual basis 16.49% £1,859,429)

NHS Vale of York CCG actual basis 35.48% £4,029,380 (2015-16 actual basis 44.20% £4,983,732)

NHS Scarborough and Ryedale CCG actual basis 14.53% £1,650,409 (2015-16 actual basis 18.21% £2,053,213)

Notes to the financial statements

Specialist Neurological Rehab*
In 2016-17 the Clinical Commissioning Groups have an arrangement to charge NHS Hambleton, Richmondshire and Whitby CCG their actual costs incurred whilst all remaining costs are risk shared between NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, and NHS Vale of York CCG based on the following apportionment:

NHS Hambleton, Richmondshire and Whitby CCG actual basis £268,695 (2015-16 actual basis £157,202)
NHS Harrogate and Rural District CCG risk share 25.60% £567,399 (2015-16 risk share 25.60% £456,670)
NHS Vale of York CCG risk share 53.50% £1,185,775 (2015-16 risk share 53.50% £954,369)
NHS Scarborough and Ryedale CCG risk share 20.90% £463,228 (2015-16 risk share 20.90% £372,828)

The Partnership Commissioning Unit staff are employed by NHS Scarborough and Ryedale CCG. The costs of these staff are apportioned between the Clinical Commissioning Groups on a weighted capitation basis, as follows:

NHS Hambleton, Richmondshire and Whitby CCG 19.32% £763,050 (2015-16 19.03% £664,476)
NHS Harrogate and Rural District CCG 19.73% £779,171(2015-16 19.87% £693,842)
NHS Vale of York CCG 46.26% £1,827,022 (2015-16 46.30% £1,617,152)
NHS Scarborough and Ryedale CCG 14.70% £580,561 (2015-16 14.80% £516,983

NHS Scarborough and Ryedale CCG also hosts the following:

i) Childrens Safeguarding services on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG
ii) Primary Care Safeguarding services on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG (from 1 April 2016)
iii) Strategic Clinical Networks on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Vale of York CCG, NHS East Riding of Yorkshire CCG and NHS North Lincolnshire CCG (which transferred from the Yorkshire and Humber Commissioning Support Unit from 1 April 2016)

The cost of these hosted services are apportioned as follows:

i) Children's Safeguarding
NHS Hambleton, Richmondshire and Whitby CCG 20.10% £63,693 (2015-16 19.57% £61,644)
NHS Harrogate and Rural District CCG 23.93% £75,810 (2015-16 23.30% £73,395)
NHS Vale of York CCG 37.38% £118,454 (2015-16 38.15% £120,188)
NHS Scarborough and Ryedale CCG 18.59% £58,901 (2015-16 18.98% £59,787)

ii) Primary Care Safeguarding
NHS Hambleton, Richmondshire and Whitby CCG 18.97% £14,029
NHS Harrogate and Rural District CCG 20.39% £15,079
NHS Vale of York CCG 45.45% £33,613
NHS Scarborough and Ryedale CCG 15.19% £11,234

iii) Strategic Clinical Networks
NHS Hambleton, Richmondshire and Whitby CCG 11.46% £23,459
NHS Harrogate and Rural District CCG 12.94% £26,493
NHS Vale of York CCG 28.24% £57,844
NHS Scarborough and Ryedale CCG 9.49% £19,430
NHS East Riding of Yorkshire CCG 24.13% £49,417
NHS North Lincolnshire CCG 13.74% £28,142

Notes to the financial statements

Medicines Management
NHS Vale of York CCG also receives recharges for Medicines Management which is hosted by NHS Harrogate and Rural District CCG. This arrangement commenced from the 1 April 2016 when services transferred from the Yorkshire and Humber Commissioning Support Unit.
The costs of these hosted services are apportioned between the Clinical Commissioning Groups as follows:

NHS Hambleton, Richmondshire and Whitby CCG 14.48% £123,752
NHS Harrogate and Rural District CCG 18.23% £155,797
NHS Vale of York CCG 21.09% £180,144
NHS Scarborough and Ryedale CCG 17.97% £153,560
NHS Airedale, Wharfedale and Craven CCG 28.23% £241,194

Referral Support Service
In 2016-17 the Referral Support Service was taken in-house by the NHS Vale of York CCG who provide the service on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and District CCG and NHS Scarborough and Ryedale CCG. Prior to this the Referral Support Service was provided via an SLA with the Commissioning Support Unit. The cost of this service is apportioned between the Clinical Commissioning Groups as follows:

NHS Hambleton, Richmondshire and Whitby CCG actual basis 6.94% £38,563
NHS Harrogate and Rural District CCG actual basis 28.01% £155,680
NHS Vale of York CCG actual basis 37.00% £205,673
NHS Scarborough and Ryedale CCG actual basis 28.05% £155,913

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

* 2016-17 costs relate to 2016-17 expenditure only and exclude costs relating to prior years. Where prior year costs have been incurred in 2016-17 these have been recharged on the risk share basis.
** This budget now includes expenditure for several small value contracts.

1.4.2 **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:

· 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 based upon historic prescribing patterns.
- Purchase of Healthcare - the full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner, based on Clinical Commissioning Group predicted forecast outturns.
- General Medical Services (GMS) and Personal Medical Services (PMS) - the full year figure for the Quality and Outcomes Framework (QOF) is estimated based on GP practice achievement in 2015-16. Payment for 2016-17 will be reconciled and paid to GP practices in June 2017.

The Clinical Commissioning Group has achieved the following level of accuracy in estimation during 2016-17:
Prescribing > 95%
Purchase of Healthcare >98% (based on our main provider)

Notes to the financial statements

· Provisions

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

- Continuing Healthcare Provision - the Clinical Commissioning Group has reflected the Partnership Commissioning Unit's estimation of the Continuing Healthcare provision wholly. The Clinical Commissioning Group has made a provision for the backlog of cases that has arisen during the financial year in respect of Continuing Healthcare. Data is available regarding the number of patients currently awaiting a full Continuing Healthcare assessment. Assumptions around the number of patients ultimately requiring a package and the anticipated price of such packages are derived from current information in the patient database, or from information provided by the clinical team where data is not available. Significant progress has been made and it is expected that the backlog will be cleared within the next financial year.

1.5 **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.

1.6 **Employee Benefits**

1.6.1 **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 has been calculated and deemed immaterial and has therefore not been recognised in the financial statements.

1.6.2 **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.

1.7 **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.

1.8 **Property, Plant and Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,

Notes to the financial statements

- 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.

1.8.2 **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.

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

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.

1.8.3 **Subsequent Expenditure**

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

1.9 **Depreciation and Impairments**

Depreciation is charged to write off the costs or valuation of property, plant and equipment, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible 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.

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

1.10 **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.

1.10.1 **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 or 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.

1.11 **Cash and 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.

1.12 **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 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.00%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

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.

Notes to the financial statements

1.13 **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.

1.14 **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.

1.15 **Continuing Healthcare Risk Pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for Continuing Healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims. 2016-17 is the final year of the risk pool scheme.

1.16 **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.

1.17 **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.

1.17.1 **Loans and 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.

Notes to the financial statements

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.

1.18 **Financial Liabilities**

Financial liabilities are recognised on the Statement of Financial Position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 **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.

1.19 **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.

1.20 **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 or deficit in the period in which they arise.

1.21 **Losses and 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.

Notes to the financial statements

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).

1.22 **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 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2. Other Operating Revenue

	2016-17 Total	2016-17 Admin	2016-17 Programme	2015-16 Total
	£'000	**£'000**	**£'000**	£'000
Recoveries in respect of employee benefits	18	18	0	44
Prescription fees and charges	14	0	14	228
Education, training and research	1	1	0	0
Charitable and other contributions to revenue expenditure: non-NHS	15	15	0	0
Non-patient care services to other bodies	1,137	162	975	2,919
Other revenue	450	8	442	0
Total other operating revenue	**1,635**	**204**	**1,431**	**3,191**

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

3. Revenue

Revenue is from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee Benefits and Staff Numbers

4.1.1 Employee Benefits	2016-17	Total	
	Total £'000	**Permanent employees £'000**	**Other £'000**
Salaries and wages	5,146	4,814	332
Social security costs	434	430	4
Employer contributions to NHS Pension scheme	529	525	4
Gross employee benefits expenditure	**6,109**	**5,769**	**340**
Less recoveries in respect of employee benefits (note 4.1.2)	(18)	(18)	0
Total - net admin employee benefits including capitalised costs	**6,091**	**5,751**	**340**
Less employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,091**	**5,751**	**340**

Full details of Governing Body members' remuneration is incuded in the Clinical Commissioning Group's Annual Report.

	2015-16	Total	
	Total £'000	Permanent employees £'000	Other £'000
Salaries and wages	4,061	3,889	172
Social security costs	303	303	0
Employer contributions to NHS Pension scheme	457	457	0
Gross employee benefits expenditure	**4,821**	**4,649**	**172**
Less recoveries in respect of employee benefits (note 4.1.2)	(44)	(44)	0
Total - net admin employee benefits including capitalised costs	**4,777**	**4,605**	**172**
Less employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,777**	**4,605**	**172**

4.1.2 Recoveries in respect of Employee Benefits

	2016-17			2015-16
	Total £'000	**Permanent Employees £'000**	**Other £'000**	Total £'000
Employee benefits - revenue				
Salaries and wages	(14)	(14)	0	(36)
Social security costs	(2)	(2)	0	(4)
Employer contributions to the NHS Pension Scheme	(2)	(2)	0	(4)
Total recoveries in respect of employee benefits	**(18)**	**(18)**	**0**	**(44)**

4.2 Average Number of People Employed

	2016-17			2015-16
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Total	**111**	**107**	**4**	**86**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Staff Sickness Absence and Ill Health Retirements

	2016-17 Number	2015-16 Number
Total days lost	1,393	895
Total staff years	111	86
Average working days lost	**13**	**10**

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0

	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme.

4.4 Exit Packages Agreed in the Financial Year

	2016-17 Compulsory redundancies		**2016-17 Other agreed departures**		**2016-17 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	32,379	1	32,379
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**1**	**32,379**	**1**	**32,379**

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2016-17 Departures where special payments have been made		2015-16 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of other agreed departures

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually Agreed Resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	1	32,379	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**1**	**32,379**	**0**	**0**

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.

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 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers' contributions of £374,011 were payable to the NHS Pensions Scheme (2015-16: £319,151) at the rate of 14.3% of pensionable pay. In 2016-17, a further £137,771 employers contributions were payable to the NHS Pensions Scheme by the PCU on behalf of NHS Vale of York CCG (2015-16: £137,768). The Scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012.

5. Operating Expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,706	3,420	1,286	3,665
Executive governing body members	1,403	1,403	0	1,156
Total gross employee benefits	**6,109**	**4,823**	**1,286**	**4,821**
Other costs				
Services from other Clinical Commissioning Groups and NHS England	517	271	246	3,622
Services from foundation trusts	265,600	15	265,585	251,823
Services from other NHS trusts	32,213	0	32,213	29,938
Purchase of healthcare from non-NHS bodies	47,594	0	47,594	46,596
*Chair and Non-Executive Members	44	44	0	42
Supplies and services – clinical	381	0	381	676
Supplies and services – general	19,577	839	18,738	14,247
Consultancy services	384	381	3	185
Establishment	520	267	253	375
Transport	12	10	2	23
Premises	1,439	398	1,041	510
Depreciation	75	75	0	76
Audit fees	72	72	0	72
Other non-statutory audit expenditure				
· Internal audit services	37	37	0	37
Prescribing costs	49,055	0	49,055	50,849
General ophthalmic services	122	0	122	132
GMS, PMS and APMS	41,139	0	41,139	41,509
Other professional fees excluding audit	145	105	40	54
Grants to other bodies	1,068	0	1,068	1,740
Education and training	59	57	2	77
Provisions	73	0	73	(410)
CHC risk pool contributions	254	0	254	635
Other expenditure	42	16	26	3
Total other costs	**460,422**	**2,587**	**457,835**	**442,811**
Total operating expenses	**466,531**	**7,410**	**459,121**	**447,632**

*Chair and Non Executive Members costs were included in Employee benefits excluding governing body members in 2015-16. The 2015-16 comparatives have been adjusted to reflect the separation of these costs in the 2016-17 accounts.

6. Better Payment Practice Code

6.1 Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	4,536	85,188	4,050	41,375
Total non-NHS trade invoices paid within target	4,447	84,909	3,922	41,080
Percentage of non-NHS trade invoices paid within target	**98.04%**	**99.67%**	**96.84%**	**99.29%**
NHS payables				
Total NHS trade invoices paid in the year	3,553	336,726	3,273	318,523
Total NHS trade invoices paid within target	3,534	336,368	3,200	317,594
Percentage of NHS trade invoices paid within target	**99.47%**	**99.89%**	**97.77%**	**99.71%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2016-17 £'000	2015-16 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Operating Leases

In 2016-17, the Clinical Commissioning Group leased its corporate offices (West Offices) initially from NHS Property Services and more recently directly from the City of York Council.

Until 31 October 16, the Clinical Commissioning Group was recharged for space within West Offices by NHS Property Services. From 1 November 16, the Clinical Commissioning Group leased the space in West Offices directly from the City of York Council. The tenancy agreement for this space is being finalised.

For 2016-17, NHS Property Services costs have been calculated and invoiced to the Clinical Commissioning Group based upon the market rent cost of the building. Prior to this, amounts due to NHS Property Services were based upon cost recovery.

NHS Property Services charges the Clinical Commissioning Group subsidy and void charges for properties or areas within properties previously occupied by providers from whom the Clinical Commissioning Group commissions healthcare services.

In 2016-17, the Clinical Commissioning Group paid £1,181,428 (2015-16: £357,969) for rent and subsidy and void costs. In addition £137,503 was charged to the Clinical Commissioning Group from the Partnership Commissioning Unit for hosted services (2015-16: £141,585). The subsidy and void charges will continue in 2017-18 subject to the new NHS Property Service Vacant Space Policy and will be subject to a six or twelve month transition arrangement after which NHS Property Services will be liable for the cost of these buildings.

7.1 As Lessee

7.1.1 Payments Recognised as an Expense

	2016-17				2015-16			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	1,318	(1)	**1,317**	0	500	2	502
Total	**0**	**1,318**	**(1)**	**1,317**	**0**	**500**	**2**	**502**

7.1.2 Future Minimum Lease Payments

	2016-17				2015-16			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable								
No later than one year	0	0	0	**0**	0	276	0	276
Between one and five years	0	0	0	**0**	0	551	0	551
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**827**	**0**	**827**

8. Property, Plant and Equipment

	2016-17			2015-16		
	Plant and machinery £'000	**Information technology £'000**	**Total £'000**	Plant and machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 1 April	**756**	**5**	**761**	**756**	**5**	**761**
Additions purchased	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0
Cost or valuation at 31 March	**756**	**5**	**761**	**756**	**5**	**761**
Depreciation 1 April	**227**	**5**	**232**	**151**	**5**	**156**
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	75	0	75	76	0	76
Transfer (to)/from other public sector body	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0
Depreciation at 31 March	**302**	**5**	**307**	**227**	**5**	**232**
Net book value at 31 March	**454**	**0**	**454**	**529**	**0**	**529**
Purchased	454	0	454	529	0	529
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March	**454**	**0**	**454**	**529**	**0**	**529**
Asset financing:						
Owned	454	0	454	529	0	529
Total at 31 March	**454**	**0**	**454**	**529**	**0**	**529**

8.1 Economic lives

Plant and machinery has an economic life of 10 years. IT equipment has been fully depreciated.

9. Trade and Other Receivables

	Current 2016-17 £'000	Current 2015-16 £'000
NHS receivables: revenue	1,353	142
NHS prepayments	866	863
NHS accrued income	128	48
Non-NHS and other WGA* receivables: revenue	72	825
Non-NHS and other WGA prepayments	152	84
Non-NHS and other WGA accrued income	261	1,462
VAT	85	0
Other receivables and accruals	1	7
Total trade and other receivables	**2,918**	**3,431**
Included above:		
Prepaid pensions contributions	0	0

The Clinical Commissioning Group has no non-current trade and other receivables.

The vast 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.

*Whole of Government Accounts

9.1 Receivables Past their Due Date but Not Impaired	2016-17 £'000	2015-16 £'000
By up to three months	4	545
By three to six months	0	39
By more than six months	8	17
Total	**12**	**601**

£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 2017 (31 March 2016: nil).

9.2 Provision for Impairment of Receivables	2016-17 £'000	2015-16 £'000
Balance at 1 April 2016	**0**	**(15)**
Amounts recovered during the year	0	15
Balance at 31 March 2017	**0**	**0**

10. Cash and Cash Equivalents

	2016-17 £'000	2015-16 £'000
Balance at 1 April 2016	**48**	**145**
Net change in year	115	(97)
Balance at 31 March 2017	**163**	**48**
Made up of:		
Cash with the Government Banking Service	163	48
Cash and cash equivalents in statement of financial position	**163**	**48**
Balance at 31 March 2017	**163**	**48**

11. Trade and Other Payables

	Current 2016-17 £'000	Current 2015-16 £'000
NHS payables: revenue	3,269	7,205
NHS accruals	2,406	1,927
Non-NHS and other WGA payables: revenue	1,318	2,655
Non-NHS and other WGA accruals	10,721	9,374
Social security costs	43	35
VAT	0	1
Tax	40	41
Other payables and accruals	632	247
Total trade and other payables	**18,429**	**21,485**

The Clinical Commissioning Group has no non-current trade and other payables.

Other payables include £57,080 outstanding pension contributions at 31 March 2017 (31 March 2016: £51,964).

12. Provisions

	Current 2016-17 £'000	Current 2015-16 £'000
Continuing Healthcare	73	117
Total	**73**	**117**

The Clinical Commissioning Group has no non-current provisions.

	Continuing Healthcare £'000	Total £'000
Balance at 1 April 2016	**117**	**117**
Arising during the year	73	73
Utilised during the year	(117)	(117)
Reversed unused	0	0
Unwinding of discount	0	0
Change in discount rate	0	0
Transfer (to)/from other public sector body	0	0
Transfer (to)/from other public sector body under absorption	0	0
Balance at 31 March 2017	**73**	**73**
Expected timing of cash flows:		
Within one year	73	73
Between one and five years	0	0
After five years	0	0
Balance at 31 March 2017	**73**	**73**

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 Clinical Commissioning Group.

13. Contingencies

13.1 Contingent Liabilities	**2016-17 £'000**	2015-16 £'000
NHS Litigation Authority Legal Claims	271	332
Net value of contingent liabilities	**271**	**332**

There is a requirement for the Clinical Commissioning Group to note the value of provision carried in the books of the NHS Litigation Authority in regard to Existing Liabilities Scheme and Clinical Negligence Scheme for Trusts claims.

The Clinical Commissioning Group has identified a contingent liability relating to current continuing healthcare assessment requests for historical claims for the period 1 April 2004 to 31 March 2012. Any eligible case costs relating to the period up to 2012-13 would be covered by the NHS England provision but the outcome of current assessments is unknown. We are therefore unable to reasonably assess the value of these assessments due to a number of uncertainties.

13.2 Contingent Assets

The Clinical Commissioning Group had no contingent assets as at 31 March 2017 (31 March 2016: nil).

14. Financial Instruments

14.1 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.

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 Detailed Financial Policies and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

14.1.1 Currency Risk

The Clinical Commissioning Group is principally a domestic organisation with the vast majority of transactions, assets and liabilities being in the UK and sterling based. The Clinical Commissioning Group has no overseas operations and therefore has low exposure to currency rate fluctuations.

14.1.2 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.

14.1.3 Credit Risk

The majority of the Clinical Commissioning Group revenue comes from parliamentary funding and 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.

14.1.4 Liquidity Risk

The Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

14.2 Financial Assets

	Loans and receivables 2016-17 £'000	Total 2016-17 £'000
Receivables:		
· NHS	1,481	1,481
· Non-NHS	333	333
Cash at bank and in hand	163	163
Other financial assets	1	1
Total at 31 March 2017	**1,978**	**1,978**

	Loans and receivables 2015-16 £'000	Total 2015-16 £'000
Receivables:		
· NHS	190	190
· Non-NHS	2,287	2,287
Cash at bank and in hand	48	48
Other financial assets	7	7
Total at 31 March 2016	**2,532**	**2,532**

14.3 Financial Liabilities

	Other 2016-17 £'000	Total 2016-17 £'000
Payables:		
· NHS	5,675	5,675
· Non-NHS	12,671	12,671
Total at 31 March 2017	**18,346**	**18,346**

	Other 2015-16 £'000	Total 2015-16 £'000
Payables:		
· NHS	9,133	9,133
· Non-NHS	12,276	12,276
Total at 31 March 2016	**21,409**	**21,409**

15. Operating Segments

The Clinical Commissioning Group has only one segment: commissioning of healthcare services.

16. Pooled Budgets

The Clinical Commissioning Group has entered into three pooled budget arrangements with partner organisations, under section 75 of the Health Care Act 2006 for the management of commissioning resources related to the Better Care Fund (BCF). All parties to these agreements contribute to a pooled commissioning budget which is overseen by the relevant Health and Wellbeing Board (HWB).

The three pooled arrangements relate to City of York, North Yorkshire and East Riding of Yorkshire Health and Wellbeing Board boundaries.

For the City of York HWB, the Clinical Commissioning Group hosts the pooled budget. For the North Yorkshire and East Riding of Yorkshire HWBs, the hosts are North Yorkshire County Council and East Riding of Yorkshire Council respectively.

The Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2016-17 £'000	2015-16 £'000
Income	0	0
Expenditure	19,618	19,366

Details of the total pooled commissioning budgets for 2016-17 are set out below:

	Health and Wellbeing Board 2016-17				
	City of York £'000	**North Yorkshire £'000**	**East Riding of Yorkshire £'000**	**Total BCF pooled budgets £'000**	2015-16 Total BCF pooled budgets £'000
Contributing organisation					
NHS Vale of York CCG	11,200	7,175	1,243	**19,618**	19,366
NHS Airedale, Wharfedale and Craven CCG	0	3,079	0	**3,079**	2,914
NHS Scarborough and Ryedale CCG	0	7,468	0	**7,468**	7,538
NHS Hambleton, Richmondshire and Whitby CCG	0	9,121	0	**9,121**	9,152
NHS Harrogate and Rural District CCG	0	9,415	0	**9,415**	9,557
NHS Cumbria CCG	0	408	0	**408**	319
NHS East Riding of Yorkshire CCG	0	0	19,112	**19,112**	19,212
City of York Council	1,003	0	0	**1,003**	951
North Yorkshire County Council	0	3,538	0	**3,538**	10,315
East Riding of Yorkshire County Council	0	0	2,127	**2,127**	2,008
Total Better Care Fund (pooled budget)	**12,203**	**40,204**	**22,482**	**74,889**	**81,332**

Details of the utilisation of NHS Vale of York CCG contributions in 2016-17 are set out below:

	Health and Wellbeing Board 2016-17				2015-16
	City of York £'000	**North Yorkshire £'000**	**East Riding of Yorkshire £'000**	**Total NHS Vale of York CCG contributions £'000**	Total NHS Vale of York CCG contributions £'000
Supporting Social Care commissioned schemes	5,043	2,731	428	**8,202**	9,778
Supporting Health commissioned schemes	6,157	4,444	504	**11,105**	7,639
Total utilisation against BCF - identified schemes	**11,200**	**7,175**	**932**	**19,307**	**17417**
Withheld Performance Fund	**0**	**0**	**0**	**0**	1,949
Total utilisation of NHS Vale of York CCG contributions	**11,200**	**7,175**	**932**	**19,307**	**19,366**

Both the City of York and North Yorkshire BCFs were fully utilised in year whilst the East Riding of Yorkshire BCF was under spent. The CCG met its requirement to create the East Riding of Yorkshire pooled budget and the minimum spend on social care was utilised by the local authority, but the expenditure on Health commissioned schemes was lower than the fund value due to an underspend on one of the schemes and because there is currently jointly agreed uncommitted resource.

17. Related Party Transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Louise Barker - Clinical Director - Partner works as Consultant Psychiatrist in Tees, Esk and Wear Valleys NHS Foundation Trust	38,565	(1)	54	0
Dr Louise Barker - Clinical Director - Salaried GP at Haxby Group Practice	4,133	(1)	10	0
Dr Emma Broughton - Clinical Director - Partner at Priory Medical Group	6,543	(3)	237	(2)
Dr Emma Broughton - Clinical Director - Partner at Priory Medical Group which is a member of the Nimbuscare Ltd Alliance of GP Practices	377	(61)	11	0
Dr Tim Maycock - Clinical Director - Partner at Pocklington Group Practice	203	(1)	61	0
Dr Shaun O'Connell - Joint Medical Director - Salaried GP at South Milford Surgery	1,779	0	0	0
Dr Shaun O'Connell - Joint Medical Director - Spouse an anaesthetist at York Teaching Hospital NHS Foundation Trust	214,054	0	1,577	0
Dr Andrew Phillips - Joint Medical Director - Private Medical Director to Helmsley Medical Practice	479	0	0	0
Dr Andrew Phillips - Joint Medical Director - Provides Out of Hours sessions for Northern Doctors Urgent Care	4,084	0	0	0
Sian Balsom - Co-opted Member of Governing Body (to 19 January 17) - Manager at Healthwatch York - employed by York CVS	49	0	0	0
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group	3,908	(6)	2	0
Dr Paula Evans - Council of Representatives Chair - Provides GP training at Yorkshire and Humber Health Education England	0	(1)	0	0
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group which is part of City and Vale Alliance	21	0	5	0
Dr John Lethem - Local Medical Committee Liason Officer, Selby and York (co-opted) - Partner and GP Principal for Unity Health	1,446	0	0	0
Dr John Lethem - Local Medical Committee Liason Officer, Selby and York (co-opted) - Partner and GP Principal for Unity Health which is a member of the Nimbuscare Ltd Alliance of GP Practices	377	(61)	11	0
Dr John Lethem - Local Medical Committee (LMC) Liason Officer, Selby and York (co-opted) - LMC	298	0	0	0
Louise Johnston - Practice Manager Representative (to 15 December 16) - Managing Partner at Unity Health	1,446	0	0	0
Louise Johnston - Practice Manager Representative (to 15 December 16) - Managing Partner at Unity Health which is a member of the Nimbuscare Ltd Alliance of GP Practices	377	(61)	11	0
Sheenagh Powell - Lay Member and Audit Committee Chair - Paid member of NHS Harrogate and Rural District CCG Audit Committee	136	(181)	43	0

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Sheenagh Powell - Lay Member and Audit Committee Chair - Financial Consultant at NHS Barnsley CCG to 31 May 2016	43	0	0	0
Sharon Stoltz - Director of Public Health, City of York Council (co-opted)	4,687	(63)	243	(63)
Dr Arasu Kuppuswamy - Secondary Care Doctor - Consultant at South West Yorkshire Partnership NHS Foundation Trust	29	0	0	0
Jim Hayburn (from 31 October 16) - Interim Executive Director of System Resources - Director JHL Associates Ltd	88	0	9	0
Elaine Wyllie (from 1 January 17) - Interim Executive Director of Joint Commissioning - Director Wybeck Associates Limited	131	0	12	0
Helen Hirst (from 25 April 16 to 2 October 16) - Interim Accountable Officer - seconded from NHS Bradford Districts CCG	18	0	1	0
Helen Hirst (from 25 April 16 to 2 October 16) - Interim Accountable Officer - seconded from NHS Bradford City CCG	18	0	0	0
Phil Mettam (from 3 October 16) - Accountable Officer - seconded from NHS Bassetlaw CCG	79	0	0	0

The roles detailed in the table above are those held as at 31 March 2017.

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
- York Teaching Hospital NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospital NHS Trust
- South Tees Hospitals NHS Foundation Trust
- Northern 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 transactions with other government departments and other central and local government bodies. Other material transactions have been with City of York Council and North Yorkshire County Council.

18. 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.

19. Financial Performance Targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target £'000	**2016-17 Performance £'000**	2015-16 Target £'000	2015-16 Performance £'000
Expenditure not to exceed income	442,772	466,531	438,146	444,441
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	441,137	464,896	438,146	444,441
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	7,556	7,208	7,602	6,754

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2016-17 expenditure performance is £23.759m over the income received. It has therefore breached its duty under the NHS Act 2006,as amended by paragraph 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012,which sets statutory duties for CCG's to ensure that the capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (the Revenue Resource Limit and Capital Resource Limit). A formal notification of this position was made in March 2017 by the Clinical Commissioning Group's external auditors, Mazars LLP, to the NHS Commissioning Board (NHS England) and also the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Vale of York CCG has released its 1% reserve to the bottom line, resulting in an improvement to the in-year financial position of £4.34m. This improvement has been offset against other cost pressures from the current financial year and used to improve the CCG's in-year deficit.

20 Losses and Special Payments

20.1 Losses

The total number of Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2016-17 Number	**Total Value of Cases 2016-17 £**	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	0	0
Store losses	1	432	0	0
Book keeping losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**1**	**432**	**0**	**0**

20.2 Special Payments

	Total Number of Cases 2016-17 Number	**Total Value of Cases 2016-17 £**	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £
*Compensation payments	1	32,379	0	0
Extra contractual payments	0	0	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**1**	**32,379**	**0**	**0**

*An employee of Scarborough and Ryedale CCG employed within the Partnership Commissioning Unit was dismissed for gross misconduct.The employee took the case to an Employment Tribunal which found in the employee's favour.Compensation of £72,254 was awarded to the employee (NHS proportion £32,379).