NHS
Vale of York
Clinical Commissioning Group

Annual Report
2018-19

Annual Report and Accounts 2018-19

Issue date	24 May 2019
Document number	ARA 2018-19
Prepared by	NHS Vale of York Clinical Commissioning Group's Governing Body

Annual Report and Accounts 2018-19

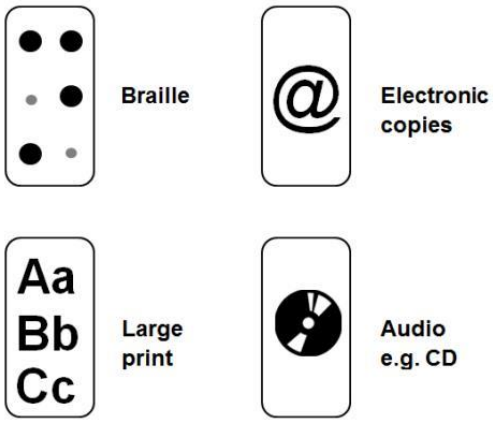
NHS organisations are required to publish an annual report and financial accounts at the end of each financial year. This report provides an overview of the CCG's work between 1 April 2018 and 31 March 2019.

The report is made up of three parts. The first section contains details of the organisation's performance for 2018-19, with the second section covering details of governance and risk. The third is the financial accounts for the year 2018-19. An electronic copy of this document is available on the CCG's website.

As a publicly accountable body, the CCG is committed to being open and transparent with its stakeholders. In 2018-19 the Governing Body met seven times and the CCG hosted a number of engagement events to involve local patients and stakeholders. Details of these meetings and events are published on the CCG's website at www.valeofyorkccg.nhs.uk.

Alternative formats of documents and information

Information contained in this report can also be requested in other languages. If you need this or if you would like additional copies of this report, please contact the CCG.



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Section one

Performance Report

Phil Mettam
Accountable Officer

24 May 2019

Foreword

By the Clinical Chair of the Governing Body and Chair of Council of Representatives

This is my first report or reflection in role as Clinical Chair of the CCG. There are many positives to report including continued financial stabilisation and the start on the journey to primary care networks.

My biggest relief is that the clinical workforce is starting to come together in various fora to meet, share learning and start to build and rebuild relationships. The NHS system for too long has created gaps across commissioned systems and it is time that these gaps are narrowed and filled so we can continue to truly develop what matters most, improved population health and a reduction in health inequalities across our city and across the vale.

This year we have introduced Protected Learning Time for all primary care clinicians in the CCG, we have refocussed our governing body meetings to secure clinical discussions and we have engaged our secondary care colleagues to see how we can improve pathways to help patients that need care in and out of hospital.

Our biggest challenge is keeping the money worries away from these sensible and vital initiatives so that we can truly transform our systems, protect and nurture York Teaching Hospital NHS Foundation Trust and attract clinicians to come and work in a motivated and dynamic healthcare system.

Dr Nigel Wells
Clinical Chair of the Governing Body and Chair of the Council of Representatives

1. Introduction and overview

This section provides an overview of the context in which the CCG operates, with a summary of significant developments during 2018-19. This is followed by a more detailed analysis of both financial and operational performance.

Figure 1 - Vale of York Area

1.1 CCG footprint

The CCG serves towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of over 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 2018-19, the CCG had 26 member GP practices in its operating area and an in-year commissioning budget of £461.7m. 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.

The CCG's footprint (the area for which it commissions services) 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 (covering Selby and parts of Hambleton and Ryedale districts) and a part of the East Riding of Yorkshire Council area (Pocklington).

The CCG has established localities within its boundaries which represent groupings of populations and associated primary care providers with whom the CCG can work with to develop commissioning plans, service transformation and quality improvements to address the specific needs of those sub-CCG population cohorts. These localities include:

- City of York / Central locality (co-terminous with the city and including the flow of patients referred from Pocklington)
- North locality (including the towns of Easingwold and Kirkbymoorside; interfacing with Ryedale and neighbouring Scarborough)
- South locality (including the towns of Selby and Tadcaster / Sherburn)

1.2 The year in review - a note from the Accountable Officer

This year was another period of financial stabilisation for the organisation, and a further improvement on the previous year. It required a sustained effort to commission services that offered greater value and efficiency. I would like to thank, and pay tribute to the CCG staff for their continued hard work in helping us to deliver this position.

It was also a year when the new Governing Body created an environment that encouraged more clinical debates linked to the statutory duties of the organisation. Once again the CCG delivered against many constitutional standards however, the Governing Body remained concerned about many of the standards relating to mental health services. On the limited number of occasions that non-recurrent financial support became available I was pleased to support the Governing Body in their decision to prioritise mental health services for children and primary care. This is aligned with feedback from the public who have previously and currently expressed their view that these areas are their priority too.

The Governing Body's engagement with member practices has grown and strengthened, and this has led to more discussion about services and the specific needs of patients within each of our three localities. The development of Protected Learning Time for clinicians and professionals in general practice is a really important step forward in creating a structured environment for shared learning which will lead to improved care for patients. It will also create an environment which supports the retention of local clinicians and offers a basis for future recruitment.

Our partnerships with local authorities have further strengthened and I would like to thank colleagues for their ongoing support and positive feedback via the national survey of CCGs. Our stakeholder survey results have again improved and we will continue to be led by our values and actively seek opportunities for collaborating to improve outcomes and value.

I would like to thank the Governing Body for their support in helping us to deliver the achievements for patients set out in the main body of the report.

2019-20 could be another difficult year due to the local financial environment; it will be important that our Governing Body continue to act on behalf of our local population.

Phil Mettam
Accountable Officer

1.3 Performance overview: 2018-19 financial performance

The CCG has continued to stabilise its financial position in 2018-19, and for the first time since it was established in 2013-14 has improved the in-year financial performance when compared to the previous financial year. The 2018-19 in-year financial position is a deficit of £18.6m, an improved position on the 2017-18 deficit of £20.1m.

The CCG's financial position was in line with plan at quarter 1 and therefore the CCG received £1.4m of non-recurrent Commissioner Sustainability Funding (CSF) in 2018-19 which contributed to this improved performance. Without receipt of CSF, the CCG's in-year deficit would be £20.0m, which still represents a marginal improvement over 2017-18.

The CCG's plan for the financial year was a deficit of £14.0m. The deterioration to a pre-CSF deficit of £20.0m was in part due to non-elective activity at the local acute hospital being above the level anticipated and expected cost reductions at the hospital proving difficult to secure. In addition, an unplanned increase in Continuing Health Care charging identified by NHS Scarborough and Ryedale CCG as part of the winding up of the historic Partnership Commissioning Unit (a shared service for certain elements of commissioning covering the North Yorkshire and York area and managed by NHS Scarborough and Ryedale CCG) had a negative in-year impact on plan. These issues were identified, quantified and reported in a timely way through the CCG's Committee structure and Governing Body and a financial recovery plan was put in place to ensure that the deterioration was minimised and secured the year on year improvement in the CCG's financial position.

In delivering the year-end position above, the CCG has achieved £7.8m of in-year Quality, Innovation, Productivity and Prevention programme savings which is consistent with the level of delivery demonstrated in 2017-18. In addition to this, the schemes delivered in 2018-19 will have a full year impact in 2019-20 of £4.0m. Therefore, the recurrent value of Quality, Innovation, Productivity and Prevention programme savings delivered in 2018-19 totals £11.8m. As in previous years, the 2018-19 delivery has been underpinned with robust performance measurement and monitoring of delivery using a combination of finance and business intelligence metrics, bespoke for each Quality, Innovation, Productivity and Prevention programme project. Additionally, the CCG delivered £5.2m of further savings as a result of the in-year financial recovery actions which is the most significant financial improvement plan the CCG has delivered to date.

The CCG's opening underlying recurrent position for 2018-19 was a deficit of £21.7m. The exit underlying position for 2018-19 is a deficit of £24.5m, which takes into account a non-recurrent reduction on the CCG's main acute contract with York Teaching Hospital NHS Foundation Trust, following agreement of an Aligned Incentive Contract in 2018-19. However, taking into account the full year effect of Quality, Innovation, Productivity and Prevention programme schemes reduces this underlying deficit to £20.5m, which is included within the financial plan for 2019-20, and represents an improvement on opening underlying position. This is the second year of improvement in the underlying position which demonstrates the impact of stabilising the CCG's financial position.

In 2018-19 the CCG has operated under an Aligned Incentive Contract with York Teaching Hospital NHS Foundation Trust for the first time. The Aligned Incentive Contract covers all

three of the Trust's main commissioners and has provided commissioners and the provider reduced variability to in-year charging, whilst allowing increased focus on clinical development rather than contractual discussions. The Aligned Incentive Contract has moved the focus of contractual discussions to the cost of delivering healthcare, rather than national tariff values.

The CCG's internal audit function has carried out annual audits covering contract management, budgetary control and reporting and key financial controls. At the time of writing the audit outcomes are to be finalised. The CCG received 'significant assurance' in all of these areas in 2017-18 and anticipates the same level of assurance in 2018-19.

On prescribing, the Vale of York area remains the lowest in Yorkshire and Humber on weighted per capita prescribing costs and has continued the Prescribing Indicative Budgets scheme implemented in 2017-18 which incentivises practices to better manage the prescribing budget and has delivered significant in-year savings of £1.4m. Together with York Teaching Hospital NHS Foundation Trust the CCG has supported uptake of biosimilar drugs. In 2018-19 a programme was undertaken to switch patients to a biosimilar version of Adalimumab where clinically appropriate, resulting in in-year savings of £0.9m across both organisations, with an estimated full year recurrent saving of £3.1m.

The CCG has made significant progress with the financial reporting and control relating to Continuing Health Care in 2018-19. Following disestablishment of the North Yorkshire CCG's Partnership Commissioning Unit, the CCG regained all commissioning functions relating to Continuing Health Care. A new IT system has been implemented and a detailed data cleanse process undertaken in conjunction with the other North Yorkshire CCGs. The CCG has delivered a significant in-year Quality, Innovation, Productivity and Prevention programme saving of £2.1m on Continuing Health Care, with an estimated full year recurrent saving of £3.5m, by undertaking a systematic clinical review of packages to ensure patients are receiving up to date and appropriate care packages.

1.4. Performance analysis

Overall accountability for the delivery of NHS Constitution performance targets sits with the CCG Accountable Officer, supported by the Assistant Director for Performance and Delivery who provides assurance to the Governing Body through the Finance and Performance Committee which meets monthly.

Responsibility for delivery of each performance target is held with each Executive Director and their team, with the action and recovery plans which drive performance delivery and improvement being incorporated into their programmes of work. These performance action plans ensure:

1. There is continued and sustainable delivery of performance where these are already delivering at target
2. Identification of the trajectory for return to performance target where this is not currently being delivered
3. Development and delivery of agreed actions with partners which support this return to target, including any escalation or proposals for investment in equipment, productivity improvements to optimise capacity or interventions which address specific pressures on services and are underpinning suboptimal performance (e.g. diagnostic equipment for

sleep services; additional funding from the Humber, Coast and Vale Health and Care Partnership Cancer Alliance to increase diagnostic capacity for cancer patients).

The Integrated Performance Report presented monthly to Finance and Performance Committee is structured around the provision of evidence to support assurance around delivery as outlined above.

Finance and Performance Committee reports directly to Governing Body and its role is to ensure that services which the CCG commissions meet all NHS Constitutional targets and support local people in being able to access the services they need in a timely manner, avoiding any negative impact on the patient experience while they wait. In this way the Finance and Performance Committee works alongside the Quality and Patient Experience Committee to triangulate performance and quality assurance and improvement.

Any escalations or requests for approval to support recovery plans are taken to Governing Body monthly if required.

Contractually this is formally monitored with providers through formal contract management boards and subgroups (Tees, Esk and Wear Valleys NHS Foundation Trust), Nuffield Health York Hospital and Ramsay Healthcare UK) and during 2018-19 with York Teaching Hospital NHS Foundation Trust through the Aligned Incentive Contract governance framework which incorporates working groups around performance, quality and safety, management and operational improvement e.g. Planned Care Steering Group and the Health and Care Resilience Board (formerly the A&E Delivery Board) and its associated sub-groups (Emergency and Urgent Care and Complex Discharge Group).

1.4.1 Performance summary 2018-19

The CCG continued to discharge its duties providing quarterly assurance checkpoints with NHS England, supported by comprehensive performance reporting to Finance and Performance Committee.

Internal audit of performance assurance in January 2018 reported ‘significant assurance’ around the governance of performance assurance in the CCG.

1.4.1.2 A summary of the CCG performance in 2018-19 across key NHS Constitution targets

		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E	% of attendances where patient was discharged, admitted or transferred within 4 hours of arrival	≥95%	85.1%	90.1%	90.0%	88.0%	92.5%	90.3%	90.9%	89.6%	87.6%	81.5%	81.5%	81.5%
Diagnostic	% of patients waiting over 6 weeks for a Diagnostic test	≤1%	4.4%	4.8%	3.1%	4.1%	6.3%	4.5%	4.4%	7.3%	11.0%	11.1%	8.6%	8.2%
RTT	% of patients on incomplete pathways waiting no more than 18 weeks from referral	≥92%	85.0%	85.3%	85.1%	86.0%	85.4%	85.4%	85.4%	84.4%	84.1%	84.0%	84.3%	83.3%
Cancer	% seen within 14 days of urgent referral - all cancer types	≥93%	95.9%	95.8%	94.9%	86.6%	89.6%	84.3%	91.4%	91.2%	95.9%	86.5%	96.1%	90.7%
	% seen within 14 days of urgent referral - breast symptoms	≥93%	96.9%	92.0%	93.3%	94.0%	97.3%	100.0%	100.0%	92.2%	88.6%	91.1%	93.1%	82.0%
	% of patients receiving first definitive treatment within 31 days of diagnosis	≥96%	98.45%	99.05%	99.06%	97.42%	96.77%	96.30%	94.40%	97.35%	94.64%	94.86%	97.27%	95.41%
	% of patients receiving second or subsequent treatment within 31 days - Surgery	≥94%	95.00%	93.94%	100.00%	95.60%	94.74%	90.00%	92.11%	96.36%	85.19%	88.64%	100.00%	90.24%
	% of patients receiving second or subsequent treatment within 31 days - Drug	≥98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	% of patients receiving second or subsequent treatment within 31 days - Radiotherapy	≥94%	98.11%	100.00%	100.00%	98.60%	100.00%	98.00%	100.00%	100.00%	97.44%	97.96%	98.04%	96.72%
	% of patients receiving first definitive treatment within 62 days of urgent GP referral	≥85%	78.70%	78.23%	83.19%	74.75%	76.14%	71.30%	78.02%	76.60%	78.02%	83.17%	77.78%	82.83%
	% of patients receiving first definitive treatment within 62 days of referral from an NHS cancer screening service	≥90%	92.86%	83.33%	95.00%	81.25%	90.00%	92.31%	100.00%	75.00%	80.00%	100.00%	76.92%	80.00%
IAPT	Improving Access to Psychological Therapies - Access Rate (3 month rolling basis)	4.75% per quarter	3.71%	3.46%	3.39%	3.42%	3.74%	3.63%	3.69%	2.52%	2.79%	2.83%	-	-
	Improving Access to Psychological Therapies - Recovery Rate (3 month rolling basis)	50%	44.3%	48.8%	50.4%	48.9%	46.9%	46.7%	47.5%	46.25%	41.89%	39.06%	-	-
EIP	Early Intervention in Psychosis - % seen within 2 weeks (3 month rolling basis)	53%	22.2%	18.5%	31.0%	29.6%	38.9%	46.7%	66.7%	71.4%	65.2%	52.4%	54.2%	-

Please note - TEWV has reported a Data Quality error in November 2018 - a large amount of data was not submitted by provider so as figures are based on a rolling 3 months this will affect nationally published Access and Recovery rates for November, December and January. Due to the way the data is processed by NHS Digital, the CCG is unable to calculate exactly what performance would have been had the TEWV data been submitted, but it is estimated that Access would have been approximately 3.8% in November and 4.1% in December, and Recovery approximately 46.2% in November and 43.2% in December.

.Table 1 - Local performance position for key NHS Constitution indicators

1.4.2 NHS Constitution performance headlines

The CCG met the **Cancer** two week wait (fast track referrals) performance target in five of the twelve months of 2018-19 despite significant increases in fast track referrals, which made up 85% of all GP referral growth. National screening programmes and publicity around certain cancers have also increased demand for fast track referrals.

The CCG failed to meet the 62 Day Cancer target from GP referral to first treatment in 2018-19 but there has been improvement towards year end despite significant diagnostics pressures affecting some of the cancer pathways, including urology. There have also been workforce capacity issues affecting dermatology and oncology services across York and Scarborough.

The CCG failed to meet the Diagnostic target of 99% throughout 2018-19 and the deterioration in performance has been driven by pressures from increases in referrals, including fast track referrals and capacity constraints in workforce, estate and equipment.

A&E performance at York Teaching Hospital NHS Foundation Trust consistently sat at around 90% throughout the first three quarters of 2018-19, however has declined to 81.5% across quarter 4. The local system partners have confirmed a more resilient winter delivery in 2018-19 with increased activity being managed.

Referral to Treatment (RTT) performance has consistently been around 85% throughout 2018-19 but with some specialties having workforce shortages affecting their performance (e.g. maxillo-facial surgery, dermatology, ENT and urology), and above planned bed closures due to infection control during December to February having a knock-on impact on the elective capacity available to deliver the waiting list. During 2018-19 the CCG and acute providers were asked to maintain the total waiting list at March 2018 levels and have worked to jointly monitor this waiting list alongside referral rates.

Local performance on **Delayed Transfers of Care** remains among the worst nationally. Reporting is focused on the local authority and Health and Wellbeing Board footprint, meaning that a single picture for the CCG is not readily available. However, City of York Council makes up the larger part of the CCG population, and here the results for 2018-19 show that over the 12 month period up to the end of January 2019, on average each day 29 hospital beds were occupied by York-resident patients that were subject to Delayed Transfers of Care. This is the 13th highest rate in England (of the 151 upper tier local authority areas). The NHS were wholly responsible for 16 of these beds being occupied (the 22nd highest rate amongst NHS providers), and CYC were wholly responsible for 12 of these beds being occupied (the 11th highest rate of local authorities).

The guidance on reporting was refreshed in 2018-19 to improve consistency across the country. The changes to recording as a result may see York's performance deteriorate further, although this will not reflect a change in circumstance for individual patients.

The Complex Discharge Steering Group oversees the wide ranging work to improve whole system flow and reductions in length of stay, for example by implementing the High Impact Changes and the SAFER bundle. Performance is reported quarterly to the York Health and Wellbeing Board as part of the Better Care Fund update.

While all partners have continued to work together through the Complex Discharge Group to deliver programmes of work which support patients being cared for in the right place, there is an urgent need to work differently in 2019 onwards to address the key factors causing patients to be waiting in acute hospital beds when they should be at home or in a more appropriate care setting.

Mental health performance indicators have proved challenging to deliver in 2018-19. The IAPT service has benefitted from two Intensive Support Team visits but has failed to deliver the required contract position. As with many IAPT services, recruitment of suitable qualified staff has proved a challenge but there has been increased efficiency through the use of group therapy. In addition toward the end of the year there has been the implementation of on-line referrals in order to target access rates. The CCG is planning to invest further in the service in the coming year to ensure improvements in access occur without a corresponding reduction in recovery rates.

Early Intervention Psychosis referrals are high in the local area. The service was anticipated to improve access to first appointment rates in line with investment this year; however, workforce recruitment has proved a challenge. Caseloads remain above that expected and there is no capacity in the service to expand to include individuals who are deemed to have an 'at risk mental state.' Analyses into the service and pressures have facilitated a joint provider and commissioner understanding of the pressures and the investment required beyond the Five Year Forward View (5YFV) timetable.

Dementia coding and identification on GP registers remains a real focus for improvement. The CCG has found improvement challenging within an environment of dementia care home closures, out of area placements and an inability to reconcile Tees, Esk and Wear Valleys NHS Foundation Trust data and primary care registers. Slight improvements in year have slipped and this correlates with numbers of deaths and moves out of area. We are jointly focussing on what the services could deliver to ensure all those with dementia are properly captured on a primary care register and are supported appropriately.

Following investment in **Children and Young People's Mental Health** (CYPMH) services this year, there are signs that the long waiting lists are beginning to reduce and whilst still too long this is in the context of increasing growth. Further investment will be required.

1.4.3 Improvement and Assessment Framework

All CCGs are assessed annually by NHS England against the Improvement and Assessment Framework (IAF). There are 4 possible achievement ratings to be gained – Inadequate, Requires Improvement, Good or Outstanding.

The CCG Improvement and Assessment Framework comprises indicators selected by NHS England to track and assess variation across performance, delivery, outcomes, finance and leadership.

The CCG also monitors and delivers improvement plans which support the achievement of NHS England Improvement and Assessment Framework indicators and reviews these quarterly with NHS England.

The full 2018-19 year-end assessment for the CCG will be available from July 2019 at https://www.nhs.uk/service-search/performance/search. The table below summarises the most recent full year assessment available for the CCG which covers 2017-18, and a comparison to the previous year's assessment.

Headline IAF ratings	2017-18	2016-17	DOT	Comments
Overall CCG assessment	Requires Improvement	Inadequate	↑	The CCG's overall rating improved from Inadequate in 2016-17 to Requires Improvement in 2017-18. The driving force behind this uplift was the improvement of the Quality of CCG leadership indicator from Red to Amber.
In-year financial performance	Red	Red	–	The CCG's rating against the finance domain remained static year on year at Red.
Quality of CCG leadership	Amber	Red	↑	The improvement from the red rating against the leadership domain in 2016-17 to amber in 2017-18 allowed the CCG to uplift overall rating from Inadequate to Requires Improvement.

Table 2 - Improvement and Assessment Framework ratings

The 2017-18 Improvement and Assessment Framework assessment for the CCG improved to 'Requires Improvement' compared to 'Inadequate' in 2016-17 and the CCG was removed from Special Measures due to the improvements and stabilisation in performance, finance and leadership.

The most recently published Improvement and Assessment Framework dashboard from Q3 2018-19 was released on 25 April 2019. The 2018-19 framework contains 58 indicators, including seven additional measures not previously contained in the Improvement and Assessment Framework. In addition to the new indicators a number of existing measures were amended or definitions updated. Of the total 58 indicators contained in the 2018-19 framework, three were not available for publication in the Q3 dashboard.

At the point of the Q3 publication, of the 55 available indicators the CCG had eight indicators falling within the highest quartile nationally, with an additional three not nationally ranked but achieving maximum value (e.g. green / fully compliant). The table below highlights these areas of high performance for the Vale of York area.

Indicator	Period assessed	CCG value	England value	National ranking
% 10-11 year olds classified overweight / obese	2014-15 to 2016-17	29.1%	33.9%	22/195
AMR: Appropriate prescribing	2018 12	0.980	0.977	47/195
AMR: Broad spectrum prescribing	2018 12	4.3%	8.7%	2/195
Cancer patient experience	2017	8.9	-	28/195
% of deaths with 3+ emergency admissions in last 3 months of life	2017	4.43%	5.40%	38/194
Patient experience of GP services	2018	87.3%	83.8%	35/195
Primary care access	2019 02	100%	-	1/191
Primary care workforce	2018 09	1.24	1.05	21/195
Delivery of the MHIS	2018-19 Q3	Compliant	-	-
Probity and Corporate Governance	2018-19 Q3	Compliant	-	-
CCG compliance with standards of public and patient participation	2017	Green	-	-

Table 3 - High performing Improvement and Assessment Framework indicators

1.4.4 Clinical priority assessments

As part of the Improvement and Assessment Framework the CCG receive supplementary assessments specifically regarding six Clinical Priority Areas. In August 2018 the CCG received its 2017-18 assessments for the areas of Cancer and Maternity, with the remaining four assessments for Mental Health, Dementia, Learning Disabilities and Dementia received in January 2019. While there had been performance improvements in a number of areas during 2017-18 there remains an on-going requirement for further performance improvement against all Clinical Priority Areas which were all rated as ‘Requiring Improvement’ or ‘Inadequate’.

Clinical priority assessments	2017-18
Cancer	Requires Improvement
Maternity	Requires Improvement
Mental Health	Requires Improvement
Dementia	Requires Improvement
Learning Disabilities	Requires Improvement
Diabetes	Inadequate

Table 4 - Clinical Priority Assessment Ratings

A summary of the indicators included in each Clinical Priority Assessment along with progress in delivering performance improvement in 2018-19 where applicable is captured in the performance headlines in the tables on pages 19-26.

TABLE A 2017-18 Clinical Priority Assessment – Cancer Overall rating – Requires improvement				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
Cancers diagnosed at early stage	2016	53.4%	National trajectory 53.5%	2016 remains the latest published data. The CCG fell just 0.1% under national trajectory in this time period. There is a great deal of work currently underway in 2018-19 across the Cancer Alliance with the aim of improving early diagnosis.
62 day GP referral to treatment	2017-18	81.50 %	National standard 85%	CCG is below standard by 3.5%. The latest published quarterly performance is Q3 2018-19. Vale of York performance stood at 80.1% in Q1 deteriorating to 73.9% in Q2, but has improved to 77.5% in Q3. Despite performing under target the Vale of York remains the highest performing CCG in the Humber, Coast and Vale Health and Care Partnership area. Nationally this is a challenging indicator and national performance stands only slightly higher than the CCG at 79.5% in Q3. There are well developed Cancer Alliance and local plans to support early diagnosis and time to treatment with a focus on timed pathways in four key areas (lung, colorectal, breast and oesophageal cancers) and the diagnostics capacity plans continue to optimise current capacity and focus on extending capacity across the Humber, Coast and Vale Health and Care Partnership.

Indicator	Period assessed	CCG value	Benchmark	Comments
One year survival from all cancers	2015	71.6	National trajectory 72.4	CCG below trajectory by 0.8 2016 data has since been published and Vale of York performance remains static at 71.6 which is within the interquartile range nationally. Plans to improve early diagnosis and time to treatment (cancer two week and 62 day performance improvements) should ultimately affect one year survival.
Cancer patient experience	2016	8.9 out of 10	2015 National mean 8.74	CCG above national mean by 0.16 (better). Performance for 2017 has since been published and the CCG remains at 8.9 out of 10, maintaining high performance where others in the STP have deteriorated. NHS Vale of York CCG is now the highest performing CCG in the Humber, Coast and Vale Health and Care Partnership and remains in the highest quartile nationally.
TABLE B 2017-18 Clinical Priority Assessment – Maternity services Overall rating – Requires improvement				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
Stillbirth and Neonatal mortality rate	2016	4.4 per 1,000 births	2015 National mean 4.8 per 1,000 births	CCG below national mean by 0.4 (better). 2016 remains the latest published data with the CCG in the interquartile range nationally and performing better than national benchmark.
Women's experience of maternity services	2017	86.5 out of 100	2017 National mean 83.0 out of 100	CCG above national mean by 3.5 (better). 2018 data has since been published and performance has declined to 82.7, now equalling national performance.
Choices in maternity services	2017	63.6 out of 100	2017 National mean 60.8 out of 100	CCG above national mean by 2.8 (better). 2018 data has since been published and performance has declined to 53.6. National performance has also declined but not to the same extent so work will be undertaken to understand this deterioration in CCG performance.

Indicator	Period assessed	CCG value	Benchmark	Comments
Rate of maternal smoking at delivery	2017-18 Q1-Q3	9.9%	National trajectory 9.7%	CCG below trajectory by 0.2% (worse). This 0.2% equates to a reduction of just four women across the three quarters taken into account at assessment, so this target was very narrowly missed. Had the CCG met the national trajectory of 9.7% for this indicator, it is believed that the CCG would have achieved a Good rating for Maternity overall. The CCG saw a slight deterioration in the subsequent three quarters to Q2 2018-19 but has begun to see improvement in Q3. Work is underway with CYC who commission the smoking cessation services.

TABLE C 2017-18 Clinical Priority Assessment – Mental health Overall rating – Requires improvement				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
IAPT Recovery rate	Dec 17 – Feb 18	43%	National standard 50%	The most recent NHS Digital published data shows performance at 55.56% in Feb-19. This is the highest reported position across 18/19. Locally the position reported in Mar-19 is 48.1%. A business case has been received from Tees, Esk and Wear Valleys NHS Foundation Trust to review the size and scale of investment required to allow achievement of the IAPT related targets.
IAPT Access rate	Dec 17 – Feb 18	3.42%	National average 3.95%	The most recent NHS Digital published data shows performance at 3.84% across the period Dec18 to Feb-19. This is the highest reported position across the entirety of 18/19. Locally the position reported Jan-19 to Mar-19 is 3.53%.

Indicator	Period assessed	CCG value	Benchmark	Comments
EIP waiting times	Apr 17 – Mar 18	48%	National standard 50%	The performance of this measure continues to be volatile due to the low numbers involved. The most recent NHS Digital published data shows performance at 27.3% in Mar-19 although this has is not representative of the position annually which reports at 45.74%. An action plan has been developed to address the issue of performance in relation to this measure.
Inappropriate OOA placement bed days	2017-18 Q4	88.6 per 100k	Min - <10 Mid - 10-200 Max - >200	No inappropriate Out Of Area (OOA) placement bed days reported outside the CCG's commissioned Provider. However, OOA placement bed days within the CCG's current Provider in other areas remain on the agreed three year downward trajectory. Current position of 134 actual OOA as at January 2019, down from 258 the previous month.
Crisis resolution and home treatment services provision	2017-18 Q4	100%	Min - <40% Mid1 - 40-79% Mid2 - 80-99% Max – 100%	No data is published in the Improvement and Assessment Framework dashboard for this indicator but 100% of milestones have been achieved.

TABLE D 2017-18 Clinical Priority Assessment – Dementia Overall rating – Requires improvement				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
Dementia Diagnosis Rate	March 2018	60.5%	National standard 66.7%	The CCG's performance has remained relatively static since the point of assessment at March 2018, at highest up to 61.1% in August 2018. Performance has declined slightly over more recent months and as at February 2019 stood at 58.7%. The CCG have been working with primary care and the Dementia Service to ensure all diagnoses are accurately captured and reported. GP practices in the North locality have identified funding for a post to help improve referrals for Dementia. The CCG is also exploring possible service developments with Tees, Esk and Wear Valleys NHS Foundation Trust in 2019-20 to improve work with Care Homes to improve identification and diagnosis of Dementia. Mental Health services for older people have been identified as the next priority area for any additional funding in 2019-20.
Care Planning and post-diagnostic support	2017-18	78.6%	2014-15 quartiles Band 4 - <75.6% Band 3 - 75.6-77.6% Band 2 - 77.6-79.4% Band 1 - >79.4%	2017-18 performance stood at 78.6% which is the best annual performance for the CCG since 2014-15 and higher than national performance for the same period which stood at 77.5%. This remains the latest data published at this time.

TABLE E 2017-18 Clinical Priority Assessment – Learning disabilities Overall rating – Requires improvement				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
Reliance on specialist inpatient care for people with a learning disability and/or autism	2017-18 Q4	52 per million	2017-18 Q4 TCP plan trajectory	The CCG's performance against this indicator has deteriorated to 57 in the most recently published Improvement and Assessment Framework data covering Q3 2018-19. This performance places the CCG 103rd of 195 CCGs nationally.
Proportion of people with a learning on the GP register receiving an annual health check	2017-18	54.8%	2017-18 National mean 51.4%	The Vale of York performance in 2017-18 stands 3.4% above the national mean of 54.8% where previously it fell 7.8% below the 2016-17 mean of 48.8%. This is a significant achievement for the CCG.
Proportion of the population on a GP learning disability register	2017-18	0.31%	2017-18 National mean 0.49%	The CCG saw a very slight improvement in 2017-18 to 0.31% from 0.30% in 2016-17. This falls well below the national mean of 0.49% so despite a significant improvement in the rate of annual health checks there remains work to do to improve the proportion of the population on the learning disability register. The development of the Learning Disability Support Team hosted by Haxby Group Practice / Priory Medical Group should support this aim and help to provide better care coordination for all people with learning disabilities across the central locality practices.

TABLE F 2017-18 Clinical Priority Assessment – Diabetes Overall rating – Inadequate				
Indicator	**Period assessed**	**CCG value**	**Benchmark**	**Comments**
Achievement of NICE treatment targets	2017-18	35.3%	National median (40%) and 25th percentile (37.9%)	Performance has deteriorated slightly from 37.1% in 2016-17 to 35.3% in 2017-18. Transformation funding received in 2017-18 has been used to set up a Diabetes Specialist Outreach Team (DSOT) to provide patients who are disengaged from traditional methods of care with patient centred care support including psychological and support worker elements. It is anticipated that the full impact of this will not be seen until 2018-19 figures are released.
Structured education attendance	2016 cohort	4.2%	National average 7.3%	While this is an increase in performance for the CCG from 0.6% for the 2015 cohort to 4.2% for the 2016 cohort, this still falls well below national average. Though performance appears to be poor this is due to a coding issue rather than actual low attendance of Structured Education (SE). Each practice in the CCG has a different method for coding SE outcomes, none of which are in line with national coding guidance. This is a national issue which is reflected in the low national average. Actual Vale of York uptake based on data for 2017-18 supplied by the Community Diabetes Team (CDT) is believed to be 66% for Type 1 and 58% for Type 2. During 2018-19 there have been a number of education events hosted by the CCG and CDT, and the CCG's Diabetes Lead nurse has visited practices to understand issues and good practice. However these visits took place after the 2018 audit so it is unlikely that any improvement will be seen in the next published data.

				It is hoped that along with a revised LES to go out in April 2019-20 that performance figures will improve however process change for primary care will take time to embed so it is likely to be 2 years before improvement is reflected in the data.

Tables 5 A-F - Clinical priority assessment details

1.4.5 A&E 4 hour performance

Performance against the 4 hour A&E standard has improved during 2018-19: although the system still does not meet the 95% national standard, the first two quarters of the year met the local trajectories, with the third quarter just missing the local target of 90%. During the fourth, winter quarter there has been much more variability and some days of very disappointing performance. However, recovery has been rapid after these poor days and there has not been a sustained period of very high numbers of breaches.

The most significant issues during the winter of 2018-19 have been linked to an outbreak of norovirus, peaking in January and February 2019. The severity of the outbreak was initially under-estimated and internal and external escalation was slow. The CCG offered support and is attending the review meetings that are taking place to identify lessons learnt, and during the outbreak worked to ensure communications were well shared between partners.

Successful projects that were implemented this year to support urgent and unplanned care included:

- Continued promotion of respiratory rescue packs
- Alternative ‘time to think’ provision for those requiring self-funded care home beds
- The introduction of both a home IV service, reducing both bed stays and the visits to the Medical Elective Suite, alongside a pilot of community IV provision in GP surgeries.
- Planned ‘flipping’ of elective capacity for trauma and acute care over the winter
- Re-procurement of the Patient Transport Service (renamed Medical Non-Emergency Transport) to cover evenings, weekends and bank holidays
- Opening of the Children’s Assessment Unit into the evenings and weekends
- Provision of direct access for Elderly Medicine and General Practice clinicians to communicate and share information for clinical decision making
- Work alongside Social Care partners to offer and support weekend discharges via the York Integrated Care team
- Review of Continuing Health Care pathways to provide more rapid fast track discharge care for those at End of Life
- Continued provision of Psychiatric Liaison support in A&E for those requiring mental health rapid diagnosis and treatment

Attendances and admissions rose in 2018-19 in comparison with 2017-18 which full year analysis has shown to be a ‘low’ year; there was a particular peak in attendances during the first quarter of the year which was also seen nationally. This peak coincided with a number of

international sporting events and a sustained period of hot, sunny weather in the Spring / Summer of 2018. Attendances during the latter half of the year are where we would have expected based on forecasting.

Despite the challenges of higher attendances the performance against the comparative winter period in 2017-18 has increased by 4.5% this financial year, and the number of 12 hour breaches is down by 10 on the previous year – a significant improvement for patients waiting. A recent winter review included almost all system partners who input their lessons learnt into the group. The general oversight was that staff recognised that better plans were in place, we had ensured eventualities were prepared for in the vast majority of cases and although there had been difficult periods, again the communication between services had improved and patient pathways worked better. One partner reflected that 'we've even stopped talking about how well the communication works – because now it happens without us even thinking about it'.

The CCG has continued to support reducing the pressures on the local Emergency Department through the funding of Urgent Care Practitioners in local Care Homes and supporting inner-city GP home visits to avoid unnecessary Emergency Department attendances and admissions, the provision of additional staff in the Out of Hours team to work alongside staff in the Emergency Department and again reduce long waits where these are not required, supporting discharge projects with the Acute Trust and local council partners to ensure patients receive the support they need in their home to avoid being a repeat urgent admission, and the continued provision of information for healthcare professionals to support diagnosis and treatment for small children with urgent issues.

The role and impact of Urgent Care Practitioners has been reviewed and discussed by the Executive team at length, and new guidelines are currently being developed with Yorkshire Ambulance Service to really focus their interventions where they can have the greatest effect; in care homes and the community. Work supporting healthcare professionals to ensure they have up to date advice for diagnosis and treatment of young children continues well and the proportion of children with stays over a single day continues to fall.

The Urgent Treatment Centre based in York Emergency Department has been reviewed to understand that the patients it sees are appropriate. Take up of available appointments has improved since the NHS111 service has been able to book directly into slots after their triage process has completed. The NHS111 online app is continuing to be used, with additional promotion taking place around the key public holiday periods. The NHS app which will include this and a number of other key pieces of functionality such as direct booking into in-hours GPs will be released in 2019.

The Integrated Urgent Care programme has progressed during 2018-19 and a new specification for NHS111 services has been tendered and is currently in the mobilisation phase. Yorkshire Ambulance Service will continue to provide it and have been actively working towards some of the key targets during this financial year, which will put the area in a good position for 2019-20. As a CCG we are leading the region in having the high proportion of direct booking and clinical review of calls currently.

The CCG worked hard during 2018 to progress the availability of community and Primary Care services using the locality model. A number of new staff have been put in place during this period; including Care Coordination with a focus on frailty with support from Health Care Assistants across the North Locality, a new Mental Health support team in the Central Locality and there have been ongoing discussions around the transformation of the Minor Injury Unit into an Urgent Treatment Centre in Selby. This latter will be completed in 2019.

The Improving Access programme also commenced to provide additional evening, weekend and bank holiday appointments from the 1 October 2018 in all three localities. These are provided by Primary Care and have been strongly welcomed by patients who have previously found it difficult to make day time and in-week appointments. The provision of appointments through video consultation has also been explored in two of the localities which again has been welcomed by patients living in more rural areas. The additional capacity from GPs, Advanced Nurse Practitioners and other health professionals has been welcomed by partners in the urgent care system.

Priorities for 2019-20 to support Emergency Care include:

- Phase 2 of Emergency Department Front door model in Vale of York – optimisation of primary care streaming capacity to support minor illness and minor injury
- Community bed optimisation: Test of change with regards to new inclusion criteria and clinical models to support assessments of some Continuing Health Care patients within community beds with the aim to reduce number of patients needing to go out of area, and reduce length of stay for stranded and super stranded patients
- Bed capacity projects including ‘time to think’ beds for self-funders, use of complex discharge hubs, super-stranded patient focus
- Attendance management projects including respiratory diversionary pathways, frailty attack management, Urgent Treatment Centres
- Flow management projects including Children’s and Adolescents’ Mental Health crisis services, change in Continuing Health Care pathways
- Bed capacity projects including non-weight bearing patients, Discharge to Assess; particularly for patients who trigger for a Continuing Health Care assessment, overnight sitting support, community and home IV provision, social work weekend cover, mini-MADE provision(Multi-Agency Discharge Event), delivery of SAFER (patient flow process)
- Flow management projects including additional prescribing support for out of hours including repeat prescriptions and One Team reablement
- Attendance management projects including respiratory rescue packs, Health Navigator, Rapid Assessment and Treatment service, social prescribing, paediatric pathways.

1.4.6 Ambulance handovers

Ambulance handovers continue to be a challenging part of the Urgent Care System; not just in the CCG but regionally too. A significant piece of work was done around the ‘fit to sit’ ambition; to reduce the number of patients who are unnecessarily transported on a stretcher after having walked into an ambulance – this gives them the opportunity to access Urgent Treatment Centres as well as A&E and potentially have a quicker outcome. This took place in York

Teaching Hospital NHS Foundation Trust during November 2018. Subsequent to this, the issue was raised at a regional Urgent and Emergency Care Network event because a number of areas had similar problems in managing timely handovers and a group has been established. This work will continue into 2019-20.

1.4.7 Referral to Treatment 18 weeks (RTT)

	% of Incomplete Pathways within 18 Weeks (Target 92%)																		
	Cardiology	Cardiothoracic Surgery	Dermatology	Ear, Nose & Throat (ENT)	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	CCG Total
Apr-18	92.3%	66.7%	86.4%	85.0%	88.0%	99.0%	85.9%	95.0%	87.0%	92.8%	100.0%	76.7%	91.9%	73.3%	89.5%	71.0%	87.4%	80.9%	85.0%
May-18	90.7%	100.0%	90.5%	84.3%	88.5%	96.8%	85.0%	96.0%	90.1%	93.7%	94.1%	76.5%	92.0%	83.0%	91.3%	68.6%	88.5%	79.1%	85.3%
Jun-18	90.1%	100.0%	91.0%	83.1%	84.9%	95.7%	86.4%	94.0%	86.4%	91.0%	89.5%	75.8%	93.3%	83.7%	91.7%	69.1%	89.3%	81.2%	85.1%
Jul-18	92.0%	100.0%	90.7%	84.4%	88.0%	97.0%	86.5%	97.4%	88.5%	90.9%	100.0%	77.6%	93.3%	84.0%	91.3%	70.0%	90.3%	80.8%	86.0%
Aug-18	87.7%	50.0%	89.3%	83.5%	86.8%	95.7%	85.7%	96.8%	91.1%	92.3%	81.3%	77.2%	91.2%	85.8%	88.5%	71.6%	90.4%	79.6%	85.4%
Sep-18	88.3%	0.0%	88.5%	86.4%	85.7%	95.3%	84.8%	96.9%	93.7%	92.0%	90.5%	77.6%	89.7%	84.6%	86.8%	72.9%	90.3%	78.8%	85.4%
Oct-18	88.9%	0.0%	88.0%	86.7%	87.2%	95.3%	85.3%	98.7%	94.3%	91.8%	93.3%	76.9%	90.7%	86.2%	86.6%	73.7%	90.5%	76.5%	85.4%
Nov-18	89.0%	100.0%	83.9%	85.8%	87.1%	94.0%	84.0%	97.2%	93.6%	90.5%	94.7%	74.8%	91.0%	85.9%	85.3%	70.6%	90.3%	77.0%	84.4%
Dec-18	89.2%	100.0%	82.9%	83.2%	87.9%	93.2%	82.6%	100.0%	93.7%	90.7%	100.0%	75.1%	92.3%	82.1%	85.6%	68.5%	90.2%	77.5%	84.1%
Jan-19	89.8%	100.0%	83.0%	84.8%	85.0%	94.4%	81.0%	100.0%	94.2%	91.2%	100.0%	74.1%	92.7%	83.4%	86.5%	69.4%	89.4%	78.6%	84.0%
Feb-19	87.7%	100.0%	83.5%	86.5%	82.8%	92.9%	81.3%	98.9%	91.6%	91.1%	100.0%	76.3%	94.0%	81.3%	85.2%	69.9%	87.8%	80.8%	84.3%
Mar-19	88.0%	100.0%	84.9%	86.1%	79.9%	91.6%	80.3%	98.9%	89.3%	90.9%	85.7%	73.8%	94.0%	74.7%	86.4%	73.5%	84.6%	81.8%	83.3%

Table 6 - Referral to Treatment performance by treatment function

RTT: % Incomplete pathways within 18 weeks (Target ≥92%)					
NHS Vale of York CCG			York Trust		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
84.3%	83.3%	⇩	81.7%	80.8%	⇩

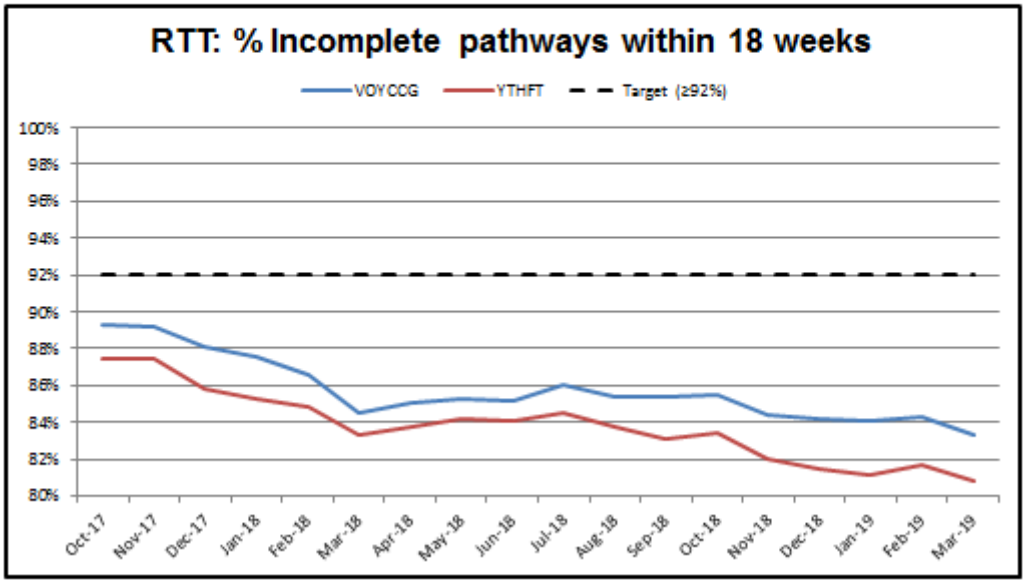


Table 7 - RTT Incomplete pathways within 18 weeks

Treatment Function	Total VOYCCG Incomplete Pathways	No. of 18 week breaches	% VOYCCG pathways within 18 weeks	52 week breaches
Cardiothoracic Surgery	5	-	100.0%	0
Geriatric Medicine	94	1	98.9%	0
Other	1,594	95	94.0%	0
General Medicine	214	18	91.6%	0
Neurology	519	47	90.9%	0
Gynaecology	957	102	89.3%	0
Cardiology	861	103	88.0%	0
Rheumatology	546	74	86.4%	0
Ear, Nose & Throat (ENT)	1,509	209	86.1%	0
Neurosurgery	21	3	85.7%	0
Dermatology	1,208	183	84.9%	0
Trauma & Orthopaedics	1,907	293	84.6%	7
Urology	1,068	194	81.8%	1
General Surgery	2,154	425	80.3%	1
Gastroenterology	1,070	215	79.9%	0
Plastic Surgery	154	39	74.7%	0
Ophthalmology	2,666	699	73.8%	0
Thoracic Medicine	596	158	73.5%	0
Grand Total	**17,143**	**2,858**	**83.3%**	**9**

Table 8 - RTT Incomplete Pathways within 18 weeks

RTT performance remained relatively stable throughout 2018-19 with full year performance at 84.8%. This has been delivered against increased GP referrals of 2.3%, the majority of which have been fast track referrals which have created pressure on the total waiting list and first outpatient attendances activity.

The specialties with the greatest pressures on the capacity have remained the same during 2018-19 as in 2017, with continued work to transform ophthalmology, dermatology and colorectal pathways which would address any backlogs and ensure services are more sustainable in the future.

The CCG has also mobilised the programme of work around the front end of the outpatients pathway (Rapid Expert Input), building on the demand management platform supported by the local Referral Support Service (RSS) and enabling our local primary and secondary care clinicians to come together to consider how to best manage accessing expert opinion around their patients. This large-scale transformation programme will continue throughout the next two years and will support the local system in reducing face to face attendances and optimising elective capacity.

The CCG has had a total of 85 52-week breaches in the full year 2018-19. Across the year the CCG have had 76 breaches at Leeds Teaching Hospitals NHS Trust, five at York Teaching Hospital NHS Foundation Trust, two at Bradford Teaching Hospitals Foundation Trust and two at North Lincolnshire and Goole Foundation Trust. The vast majority of breaches were at Leeds Teaching Hospitals NHS Trust related to complex adult spinal patients; the North of

England team and NHS Improvement is aware of the situation and are working together with CCGs to see what capacity is available across the North to be able to offer further choice to new and current patients.

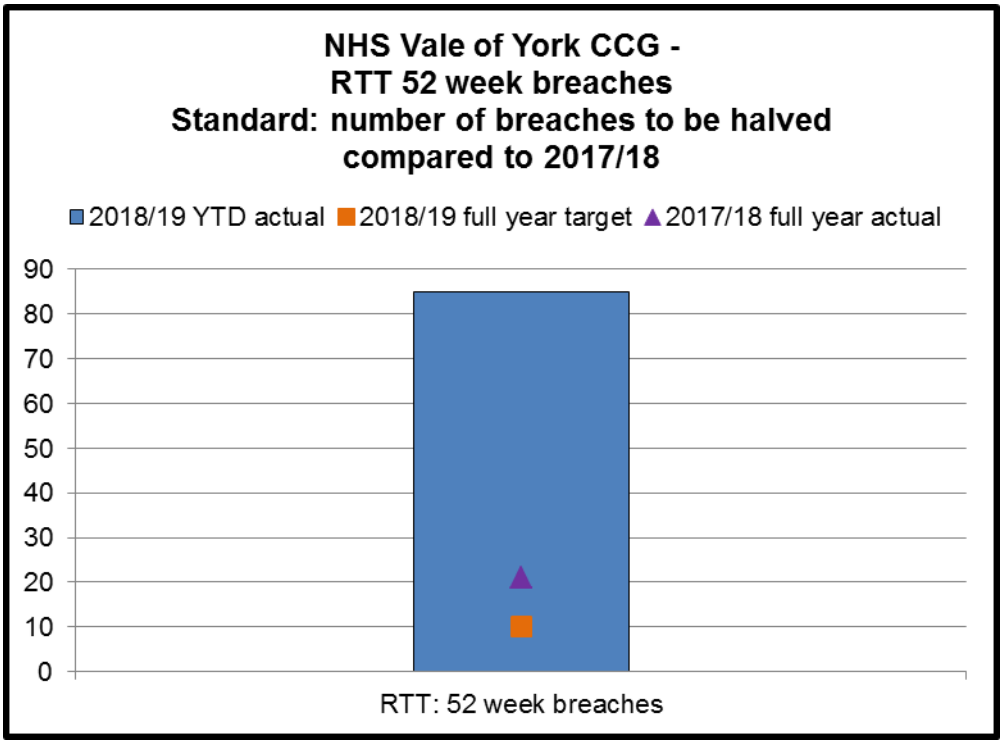
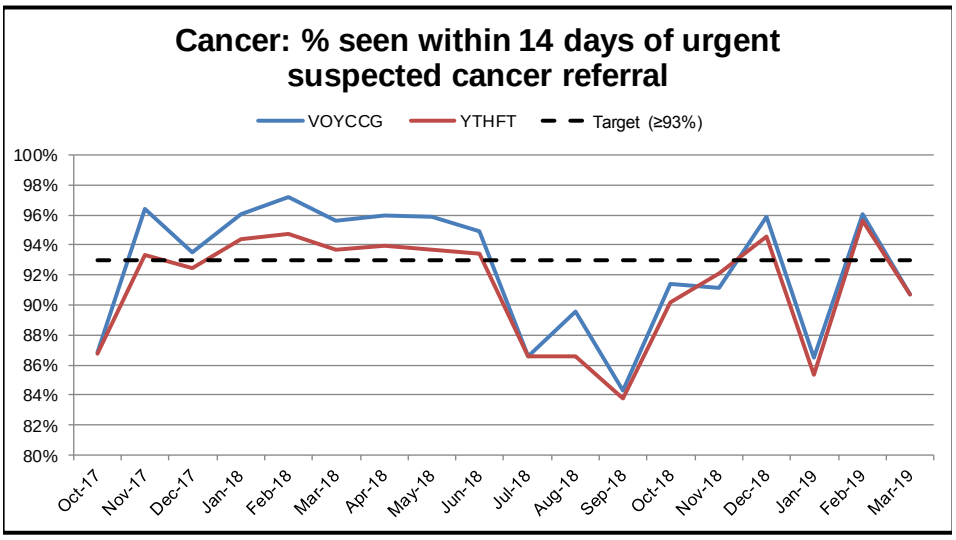


Table 9 – Referral to treatment 52 week breaches

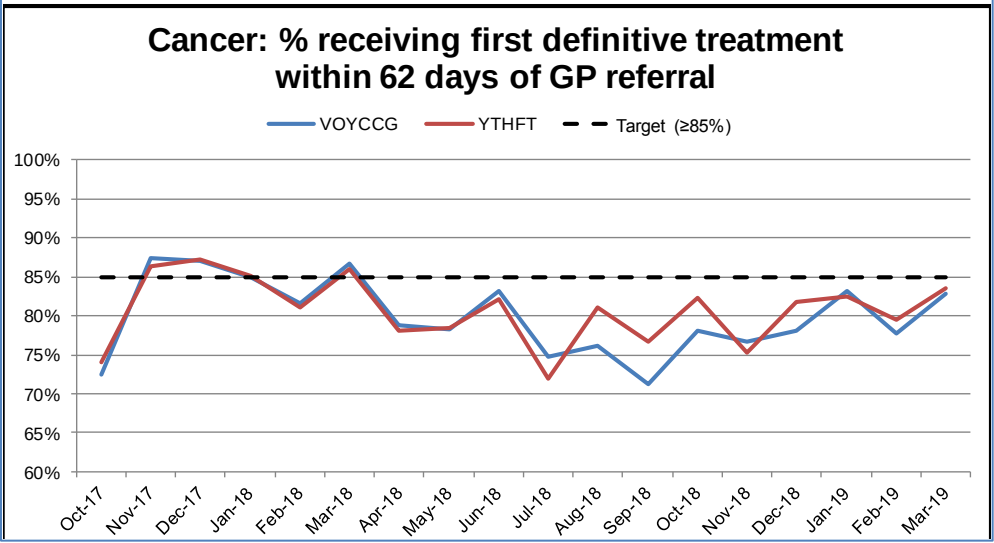
1.4.8 Cancer performance

Cancer: % 2WW referrals seen within 14 days (Target ≥93%)					
Vale of York CCG			York Trust		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
96.1%	90.7%	⇩	95.7%	90.7%	⇩



Tumour Type	VOYCCG: Total Referrals	Number of 2WW breaches	VOYCCG: % within 14 days
Lung	20	0	100.0%
Haematological Malignancies	8	0	100.0%
Other Cancer	5	0	100.0%
Childrens	5	0	100.0%
Lower Gastrointestinal	239	6	97.5%
Urological Malignancies	144	5	96.5%
Gynaecological	79	3	96.2%
Head and Neck	136	6	95.6%
Breast	229	22	90.4%
Upper Gastrointestinal	73	8	89.0%
Skin	161	52	67.7%
Brain/Central Nervous System	0	0	N/A
Testicular	0	0	N/A
Sarcoma	0	0	N/A
Grand Total	**1099**	**102**	**90.7%**

Cancer: % treated within 62 days of urgent GP referral (Target ≥85%)					
Vale of York CCG			York Trust		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
77.8%	82.8%	↑	79.4%	83.5%	↑



Tumour Type	VOYCCG: Total Treated	VOYCCG: 62 day breaches	VOYCCG: % within 62 days
Testicular	2	0	100.0%
Upper Gastrointestinal	4	0	100.0%
Skin	19	0	100.0%
Gynaecological	5	0	100.0%
Haematological (Excluding Acute Leukaemia)	2	0	100.0%
Head and Neck	1	0	100.0%
Lower Gastrointestinal	17	1	94.1%
Breast	12	2	83.3%
Urological (Excluding Testicular)	29	9	69.0%
Lung	8	5	37.5%
Sarcoma	0	0	N/A
Acute Leukaemia	0	0	N/A
Brain/Central Nervous System	0	0	N/A
Other	0	0	N/A
Grand Total	**99**	**17**	**82.8%**

Tables 10 A-F - Cancer performance

The CCG and Humber, Coast and Vale Health and Care Partnership's Cancer Alliance failed to meet the 62 Day Cancer target in 2018-19 though the CCG remains the highest performing CCG in the Humber, Coast and Vale Health and Care Partnership. The CCG has continued to work with local provider partners and the Cancer Alliance to deliver priority programmes of work to transform cancer pathways and improve the time to diagnosis and in turn to drive further improvement in the one year survival rates for our local population diagnosed with cancer.

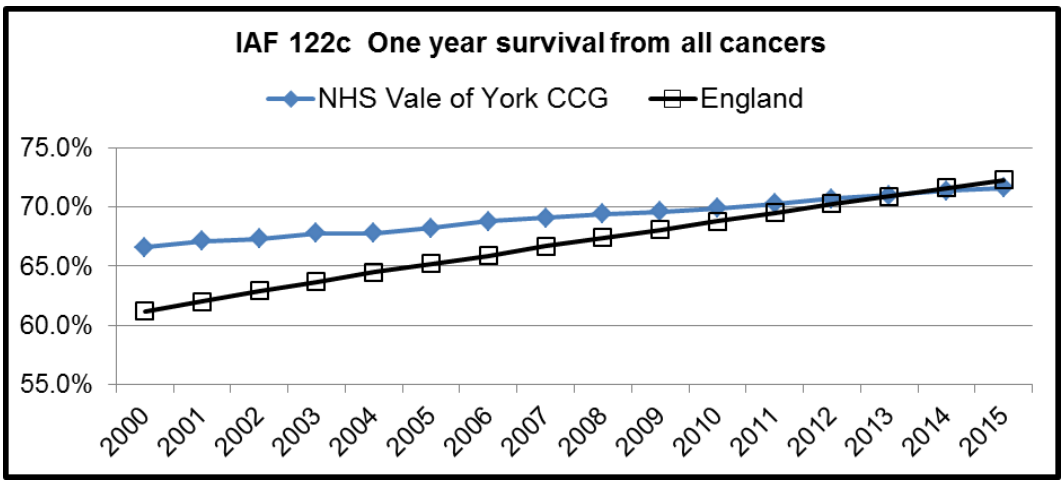


Table 11 - One year cancer survival rate

The majority of the 62 day breaches were for Urology patients and were due to diagnostic delays with MRI, CT and PET scans.

Workforce shortages also impacted on capacity as acute trusts in Yorkshire and Humber have been unable to recruit to fill Consultant vacancies in Dermatology and Oncology and have had to redesign clinical pathways in order to manage the increased patient demand.

Prostate, Colorectal and Lung cancer pathways continue to be priority areas for the Humber, Coast and Vale Health and Care Partnership's Cancer Alliance and in November 2018 York Teaching Hospital NHS Foundation Trust secured £242,000 of additional funding for diagnostics capacity to improve 62 Day performance.

The Trust have utilised the funding to provide hundreds of additional scans and endoscopy procedures. £2.9m funding has been agreed for the Humber, Coast and Vale Health and Care Partnership's Cancer Alliance for 2019-20 and priority actions are to implement the networked radiology and pathology systems and improve 62 Day Cancer performance across Yorkshire and the Humber.

In addition, £1.4m has been allocated to Hull for the Lung Check Programme which will support the whole Humber, Coast and Vale Health and Care Partnership's work.

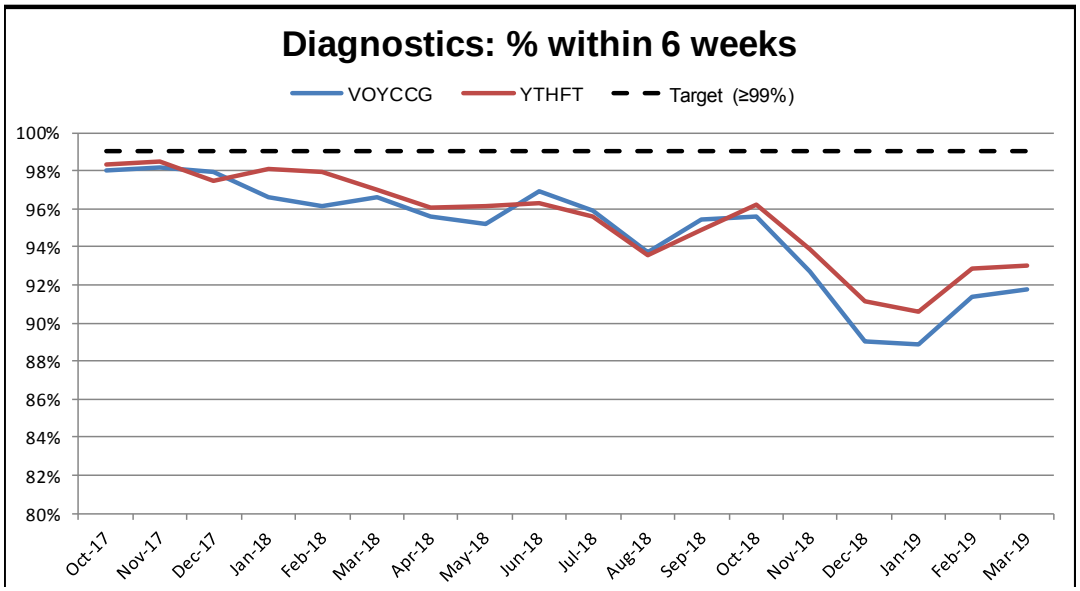
Two week wait cancer fast-track performance has been more consistent in meeting the 93% target but has been adversely impacted by the number of skin referrals and lack of outpatient capacity to see these patients. The provision of dermatoscopes for general practice to support

provision of quality images for skin urgent referrals has resulted in improvements in two week performance in dermatology.

The CCG is working with local providers to develop sufficient diagnostic capacity in radiology and endoscopy to support moving all fast track referrals from 14 day to seven days as a further step towards delivering the 28 day cancer definitive diagnosis performance target and the new cancer waiting time system from April 2020.

1.4.9 Diagnostics

Diagnostics: % within 6 weeks (Target ≥99%)					
NHS Vale of York CCG			YTHFT		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
91.4%	91.8%	⇧	92.9%	93.0%	⇧



Diagnostic Type	Total VOYCCG Waiting List	Total >6 weeks	% within 6 weeks
PERIPHERAL_NEUROPHYS	58	0	100.0%
AUDIOLOGY_ASSESSMENTS	323	0	100.0%
URODYNAMICS	21	0	100.0%
CT	511	8	98.4%
CYSTOSCOPY	62	1	98.4%
DEXA_SCAN	110	5	95.5%
MRI	832	45	94.6%
NON_OBSTETRIC_ULTRASOUND	987	56	94.3%
BARIUM_ENEMA	12	1	91.7%
FLEXI_SIGMOIDOSCOPY	112	15	86.6%
ECHOCARDIOGRAPHY	249	39	84.3%
COLONOSCOPY	215	45	79.1%
GASTROSCOPY	506	108	78.7%
SLEEP_STUDIES	31	8	74.2%
ELECTROPHYSIOLOGY	0	0	N/A
Grand Total	**4029**	**331**	**91.8%**

Tables 12 A-C Diagnostic % within six weeks

The CCG achieved full year performance in 2018-19 of 93.5% against the 99% target for patients waiting less than six weeks for a Diagnostic Test.

There are particular local pressures in Endoscopy, Echo CT and MRI and MRI under General Anaesthetic (MRI GA) and the CCG has continued to work with the main acute provider to develop the additional endoscopy capacity required and to start reviewing how MRI capacity can be better utilised so that current capacity is optimised.

The new endoscopy unit at York Teaching Hospital NHS Foundation Trust is close to completion and will provide a significant increase in local capacity in order to meet some of the growth and help deliver the bowel screening programme in 2019.

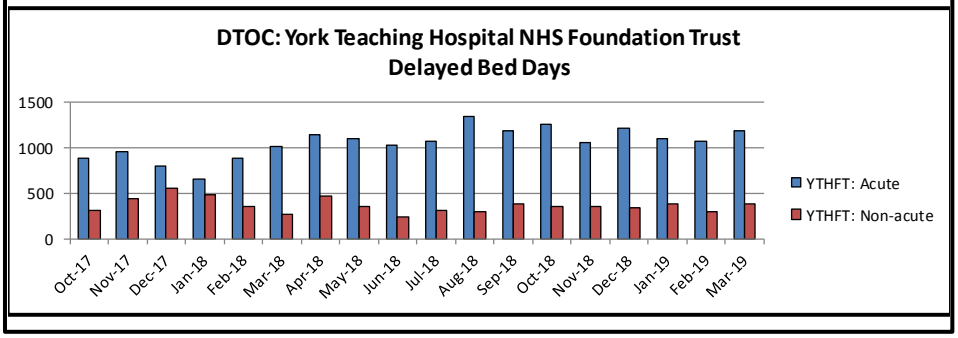
Echo-cardiographs have been affected by staff shortages and the service is reviewing actions to mitigate the pressures, repeated attempts at recruitment have so far been unsuccessful.

Nationally there is a shortage of radiographers to undertake the diagnostic tests and Radiologists to report the outcomes. Humber, Coast and Vale Health and Care Partnership's Cancer Alliance has procured a new networked radiology system which will be implemented in 2019 and help to increase capacity and speed up reporting of test results.

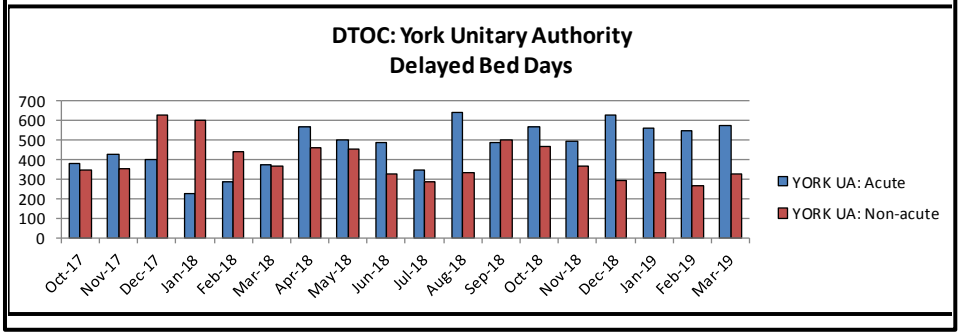
Hull University Teaching Hospitals NHS Trust also experienced delays with PET scans due to equipment failures but this has now been resolved.

1.4.10 Delayed Transfers of Care (DToC)

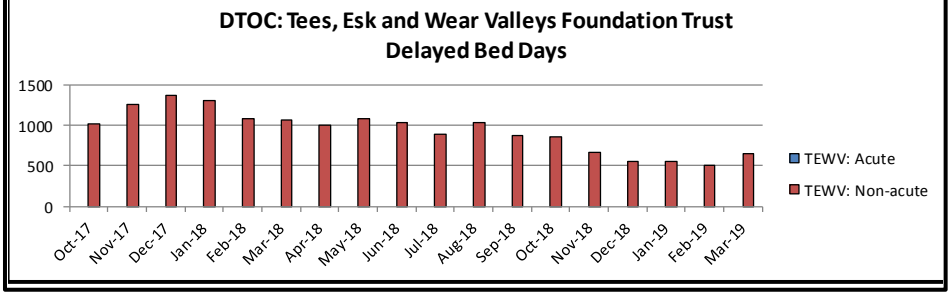
DTOC: YTHFT Delayed Bed Days					
Acute			Non-acute		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
1067	1178	⇧	295	377	⇧



DTOC: York UA Delayed Bed Days					
Acute			Non-acute		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
546	574	⇧	267	328	⇧



DTOC: TEWV Delayed Bed Days					
Acute			Non-acute		
Feb-19	Mar-19	DoT	Feb-19	Mar-19	DoT
N/A	N/A	N/A	506	657	↑



Tables 13 A – F Delayed Transfers of Care and Bed days

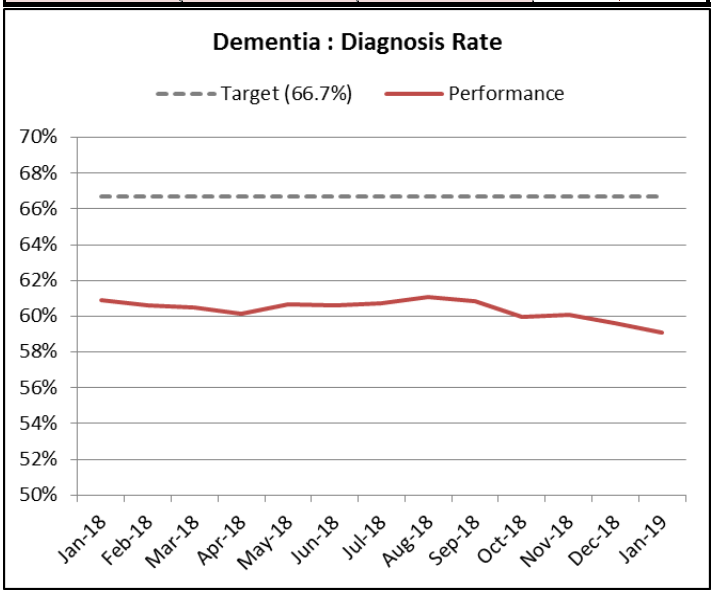
The number of bed days for acute Delayed Transfers of Care at York Teaching Hospital NHS Foundation Trust was 1,178 as at March 2019 with 377 bed days for non-acute Delayed Transfers of Care.

There were significant numbers of bed closures due to infection during December 2018 to February 2019 with on average eight wards and 96 beds being partially or fully closed to admissions each day, and peaking at 13 wards and 180 beds on the 31st January. Additionally two care homes were closed during 2018 and there is an on-going shortage in the availability of packages of home care; all of which have had an impact over the winter period.

All partners have continued to work together through the Complex Discharge Group to deliver programmes of work which support patients being cared for in the right place, and address the key factors causing patients to be waiting in acute hospital beds when they should be at home or in a more appropriate care setting.

1.4.11 Dementia diagnosis

Dementia			
Diagnosis Rate			
Jan-19	Feb-19	Mar-19	DoT
59.1%	58.7%	58.6%	↓



Tables 14 A-B Dementia diagnosis rate

Dementia diagnosis coding rates in primary care continue to prove to be a challenge.

In July 2017, the Intensive Support Team from NHS England-NHS Improvement conducted a review of the Vale of York dementia pathway and services. This gave commissioners, providers and the wider system key areas to focus on and a joint action plan was developed to tackle the areas identified.

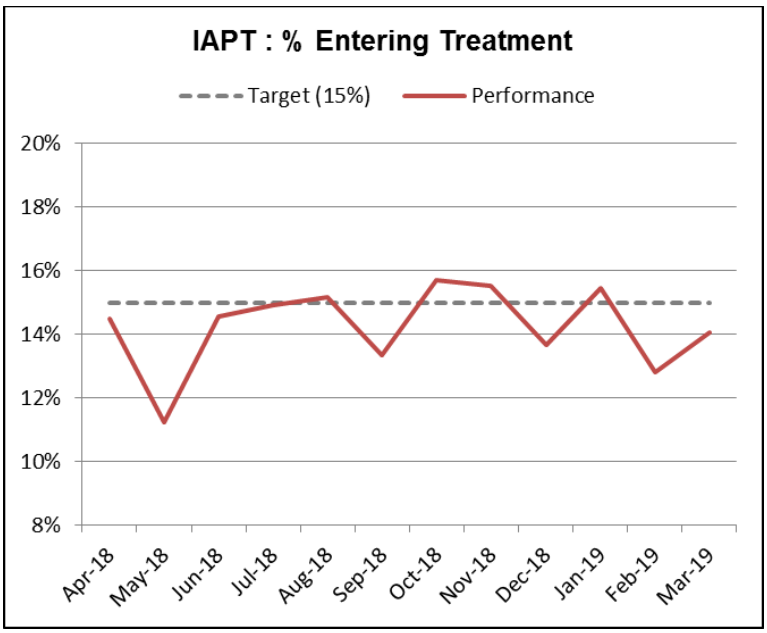
Significant support has been provided to the CCG from the local Clinical Network with a view to raising the coding rates and this had some success. A recent follow up analysis from the Clinical Network and NHS England has again been helpful

The CCG has provided resource to run the toolkit, where required, and clinical direction to improve the coding rate in practices. Prior to the year end, a package of financial assistance was offered to practices to increase their coding rates.

Several practices have achieved the national target; however the Humber, Coast and Vale Health and Care Partnership's ambition is to reach 72% and this will need a greater push to be achieved consistently.

1.4.12 Improved Access to Psychological Therapies (IAPT)

IAPT			
Prevalence			
Jan-19	Feb-19	Mar-19	DoT
15.4%	12.8%	14.1%	↑



Tables 15 A-B IAPT Treatment

Following the NHS England-NHS Improvement Intensive Support Team review of the Vale of York's IAPT service in February 2017, Tees, Esk and Wear Valleys NHS Foundation Trust and the CCG worked on a combined action plan to clear the backlog and develop a new assessment and treatment pathway. Given the scale of the challenge, NHS England

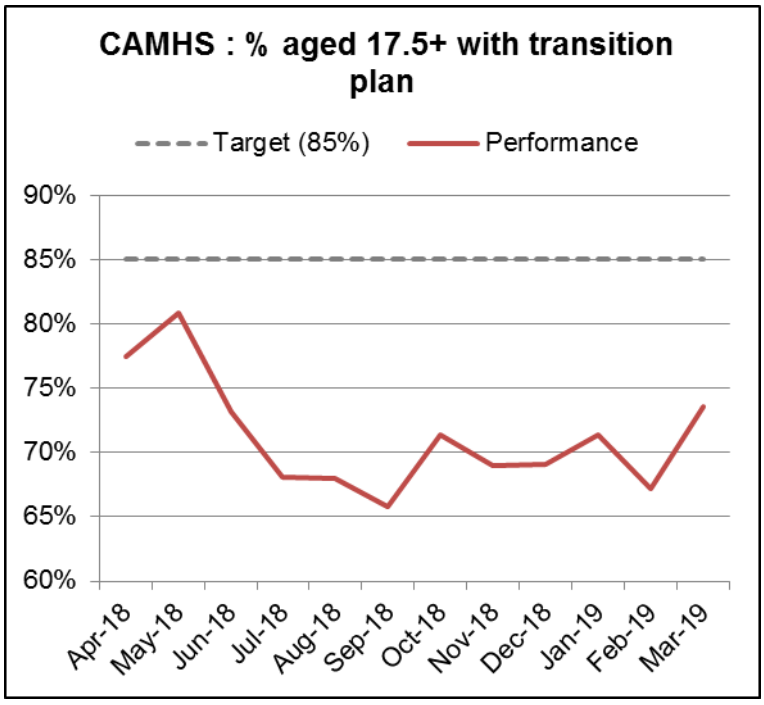
consented to the CCG's access target being 15% during Quarter 4 rather than the national expectation of 16.8%.

The backlog has been systematically worked through to ensure that all patients were offered access to the assessment treatment service or were referred to other services, as appropriate. Tees, Esk and Wear Valleys NHS Foundation Trust enlisted the assistance of a voluntary sector organisation, Mental Health Matters, to give them additional capacity in the service.

The CCG has now received a business case from Tees, Esk and Wear Valleys NHS Foundation Trust to review the size and scale of investment required over the next few years to reach the national access target of 25% during 2020-21. This will be considered by the CCG Executive over the coming months.

1.4.13 Children's and Adolescents' Mental Health Services (CAMHS)

CAMHS			
% aged 17.5+ with transition plan			
Jan-19	Feb-19	Mar-19	DoT
71.4%	67.2%	73.5%	↑



Tables 16 A-B CAMHS Performance

Demand for services continues to increase across the range of services and especially for eating disorder and autism assessments resulting in long waiting lists to access services. This may potentially impact on the patient experience with delays in assessment and diagnosis leading to delays in treatment and support options.

A capacity and demand gap analysis received by the CCG indicates a need for greater investment, and is under review. The CCG is working with local authority colleagues to better

understand the pressures into the range of services and how to both prioritise and de-escalate these.

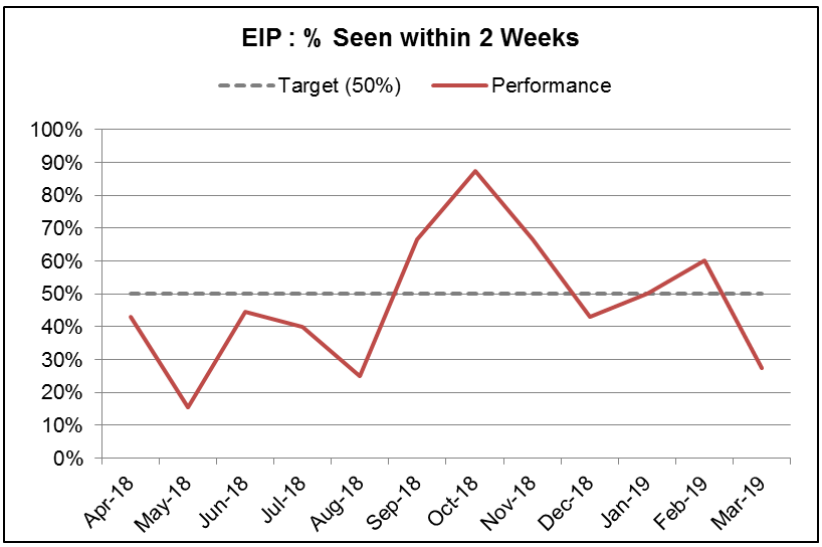
A further meeting with Tees, Esk and Wear Valleys NHS Foundation Trust and NHS England has been held to resolve procedural issues around Community Eating Disorders that should lead to improved reporting. Once complete a true gap analysis can be performed to establish the actual difference in performance.

Internal waiting lists for Children's and Adolescents' Mental Health Services (CAMHS) treatment remain long and are under discussion in connection with the capacity and demand within the service.

Tees, Esk and Wear Valleys NHS Foundation Trust has funded additional assessments for autism long waiters, whilst Executive Committee is reviewing options for short term measures to ensure a robust autism diagnostic process following the decision by York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust to split diagnostic pathways. The autism performance data is being reviewed with Tees, Esk and Wear Valleys NHS Foundation Trust to assure the CCG that it is fully validated.

1.4.10 Early Intervention in Psychosis (EIP)

EIP			
% seen within 2 Weeks			
Jan-19	Feb-19	Mar-19	DoT
50.0%	60.0%	27.3%	↓



Tables 17 A-B EIP Performance

The national target for Early Intervention in Psychosis (EIP) programmes should offer patients experiencing a first episode psychosis who commence a NICE concordat package of care within two weeks of referral. The position over the year has deteriorated and has been challenging for the provider because of a combination of recruitment pressures and an

increase in demand for this level of service. The provider reports increased numbers of referrals.

The CCG has worked very closely with Tees, Esk and Wear Valleys NHS Foundation Trust as the provider and the NHS England clinical network to develop an action plan to address the issues. Whilst progress has been made there remain some actions outstanding to improve access to family therapy and Cognitive Behaviour Therapy within the service model.

1.4.11 Learning Disabilities and Autism

1.4.11.2 Learning Disability Annual Health Check

The CCG aims to promote health equality and better health outcomes for people with learning disabilities (LD). Adults and young people aged 14 or over with a learning disability on the GP practice LD register should be invited to attend an annual health check**.** Annual health checks promote early identification of health issues to allow for appropriate and timely care and also provide opportunity to explain the national cancer screening programmes.

At the request of the LD Screening and Taskforce group, base line data for LD and cancer was collated in January 2018 via a questionnaire sent to all 26 GP practices across the Vale of York. 16/26 GP practices responded, which accounted for 80% of the patient population. This study found evidence of a discrepancy in cancer screening (bowel, breast and cervical) between the LD and non LD population in the Vale of York.

An LD clinician training event for all practices was recently delivered in March 2019 and a carer event will be supported at the LD forum in the summer 2019. A newly commissioned LD Support Team in York is led by a GP Partner from Haxby Group Practice. The LD Support team with the LD population and other stakeholders will produce a healthcare service that is accessible and appropriate to meet the specific needs of the LD community.

Improving access for LD patients will increase the number of health checks completed with the aim of improving health outcomes. Specific goals include: develop a team able to signpost resources for LD patients and carers, advise practices about clinical coding and registers, roll out a new template and easy to read invite documents across all practices, improve the number and quality of annual health checks, improve screening uptake rates, reduce late cancer presentations, reduce early mortality. The team will gather data to evidence an improved healthcare service for the local LD population.

1.4.11.3 Reliance on Inpatient Care for Individuals with a Learning Disability and / or Autism

The CCG has worked within the Transforming Care Partnership (TCP) across North Yorkshire and York and supports the development of the Forensic Outreach Team in order to assist and secure community placements. Undertaking timely Care and Treatment Reviews across the TCP area has proved a challenge due to availability of appropriately skilled individuals. This has now improved and recruitment has been successful.

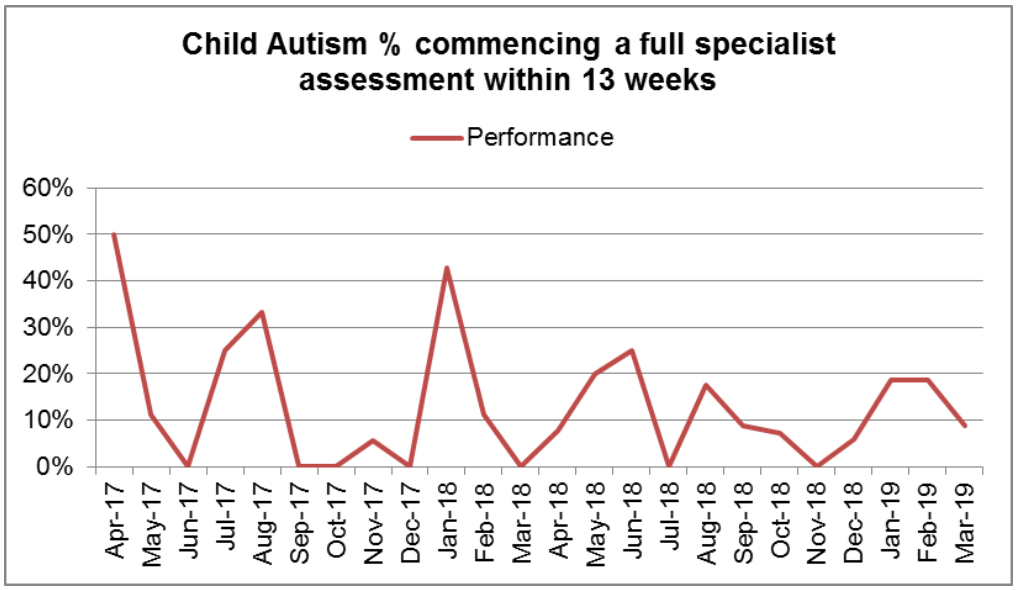
We anticipate the launch of the Enhanced Community Framework across the Yorkshire and Humber area which has been awarded to a number of providers and was built upon a quality

framework will offer a much improved and streamlined pathway into community care for those whose behaviour can challenge. Transitioning from extremely long in patient stays can take time but this is occurring for a number of individuals now.

1.4.11.4 Autism waits for children

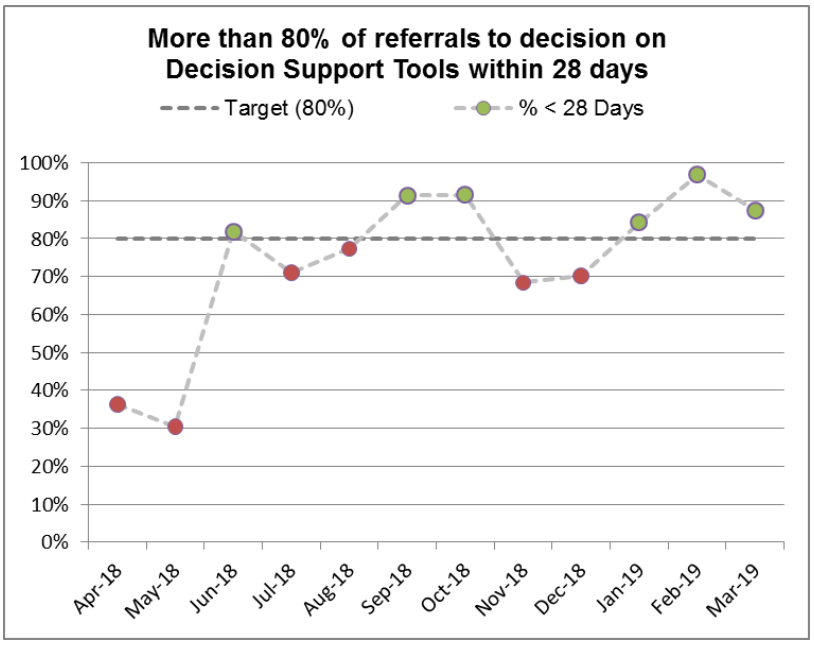
Following investment in year into this service and support from a third party provider to enhance the workforce the waiting times are now starting to decrease. The CCG has focussed its efforts in year to invest both recurrently and where possible non-recurrently into its highest rated service risk of Children's Mental Health.

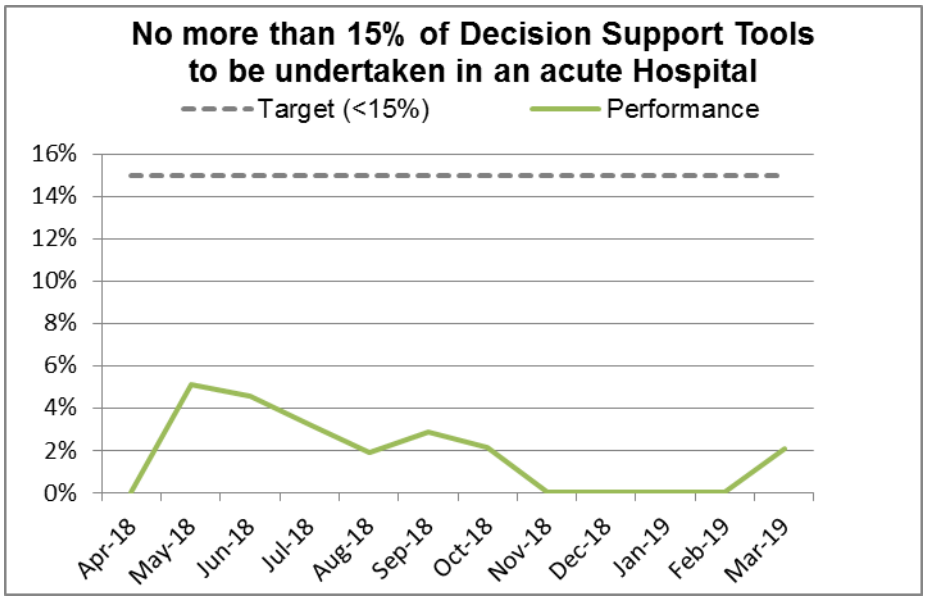
Child Autism			
% commencing full specialist assessment < 13 wks			
Jan-19	Feb-19	Mar-19	DoT
18.8%	18.5%	8.7%	↓



Tables 18A-B Child Autism waits

1.4.12 Continuing Health Care (CHC)





Tables 19 A-B: Decision Support Tool performance

The two key performance areas for Continuing Health Care (the 28 day referral to decision on Decision Support Tool assessments and no more than 15% of Decision Support Tool assessments undertaken in an acute hospital) are now performing at target.

The CCG has implemented a new Continuing Health Care system in 2018 to manage an end to end service including referral management, clinical information related to assessments, Continuing Health Care decision making and the subsequent management of the financial flows to support care. Further developments will be rolled out in 2019 with regards to referrals module, assessors' module, panel app, scheduling tool and performance dashboard. All of this is with a view to digitising the Continuing Health Care service, ensuring compliance with the

national framework and provide the necessary assurances around the robustness of the information held by the CCG.

In order to address the workforce challenges relating to Continuing Health Care staff and in order to meet the drive for improved productivity to deliver at target, the team has successfully diversified its professional mix to include Allied Health Professionals.

The discharge to assess process to support Decision Support Tool assessments being undertaken out of the Acute Hospital has been reviewed and joint work continues to refine the pathway in line with patient need and the local challenges faced by access to capacity within the care home market.

The Continuing Health Care service improvement is supported by an end to end programme and has developed key interfaces within the CCG with finance, performance and business intelligence. This programme is aligned to the National NHS England Continuing Health Care Strategic Improvement Programme.

1.5 Sustainable Development

1.5.1 Introduction

Sustainable development can be defined as “Development that meets the needs of the present without compromising the ability of future generations to meet their own needs." While the CCG is not a large employer in itself, the CCG has considerable influence over the local health and social care system in ensuring that the services it commissions are meeting their share of sustainability targets.

The national Sustainable Development Unit makes an annual collection of sustainability data from NHS organisations, which it publishes, as well as providing the Sustainable Development Assessment Tool which replaces the former Good Corporate Citizen assessment. The CCG had completed the assessment using the results to inform its Sustainable Development Management Plan. The CCG’s Sustainable Development Management Plan for 2016-2020 is published at http://www.valeofyorkccg.nhs.uk-about-us-sustainability-and-commissioning-for-sustainable-development/ .

1.5.2 Premises

The CCG occupies a repurposed historic building in the centre of York, the former railway station, which has been renovated to be a model of sustainable architecture. The overall environmental design was conceived to work with redevelopment of the existing building, using existing features to reduce energy demand.

The heavy masonry walls of the existing building that now form part of the internalised space provide the thermal mass required for the building to be largely naturally ventilated. Low-carbon heating technologies and heat recovery, for example from server rooms, also form part of this strategy, as well as photovoltaic panels on south-facing roof surfaces.

Rainwater harvesting and water saving controls are all integrated into a building management system which allows all aspects of building services to be remotely monitored. A gas fired

combined heat and power unit acts as the lead boiler and generates electricity. The basement also houses biomass boilers. Most of the heat demand is provided by bio mass boilers which deliver thermal energy with a minimal carbon footprint. Gas fired boilers are also installed to meet the peak demands and to provide backup. The peak summer cooling loads are provided by a chilled water system that is generated by an absorption chiller. Passive ventilation and de-stratification fans are also integral to the internal environmental control.

As a tenant of part of this environmentally conscious building, the CCG benefits from state-of-the-art energy efficiency measures, but it is difficult to calculate the CCG's share of recyclable waste since recycling bins are shared across multiple organisations. Waste paper, cans, bottles and batteries have allocated recycling points. The CCG's share of energy consumption is calculated on a square footage basis, and as energy efficiencies have already been maximised, it is now challenging to set further efficiency targets.

1.5.3 Travel

The City of York prides itself on being a 'Cycling City' and has an extensive network of cycle lanes. The CCG encourages its staff to make use of the building's facilities for cycling, as well as offering access to one of the national Cycle to Work schemes. Facilities for sustainable travel include secure bike sheds constructed from reclaimed train platform canopies, and shower and changing facilities, together with events run in conjunction with the police on bike security and bike marking. Close proximity to train station and bus services, as well as on site meeting facilities, help to reduce the need for car travel.

In the 2016-17 staff travel survey, 76% of staff responding to the survey travelled via public transport, on foot or cycle to work. The CCG has recently installed an E-expenses system to improve monitoring of business-related travel.

The CCG supports the use of teleconferencing facilities to reduce the need for travel, as well as remote working technology to enable staff to work from home. Car-sharing for business travel purposes is encouraged.

To improve air quality in the locality, one of the CCG's main providers, York Teaching Hospital NHS Foundation Trust, has recently arranged for the main hospital site to have its own Park and Ride bus route, reducing the need for car travel to the site.

1.5.4 Commissioning

Commissioning for sustainable development is the process by which commissioners improve both the sustainability of an organisation, and the way it provides services and interacts with people in the community. It is about striking the right balance between the three key areas of financial, social and environmental sustainability when making commissioning decisions. It also saves money and resources which benefits both patients and staff.

The CCG is committed to ensuring that sustainability forms a key part of its commissioning arrangements with partner organisations. Sustainability Impact Assessments form a mandatory component of decision-making and are developed to estimate the likely sustainability implications of the introduction of a new policy, project, or function; or the implementation of an existing policy, project, or function within the organisation.

When sustainability implications are identified, steps can be taken to amend the proposed policy, project or function or amend the way in which it is implemented. This helps to make sure that the implications are fully understood and that any adverse consequences are considered and mitigated against.

1.5.5 Carbon reduction targets of CCG providers

Details of the environmental targets for the CCG's main providers, York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust, are published with the national metrics at https://www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx. York Teaching Hospital NHS Foundation Trust has published details of its carbon reduction targets at https://www.yorkhospitals.nhs.uk/about-us/reports-and-publications/. Tees, Esk and Wear Valleys NHS Foundation Trust has published information at https://www.tewv.nhs.uk/about-us/how-we-do-it/caring-for-the-environment/.

1.5.6 Pharmaceutical prescriptions

In its effort to reduce wastage in unwanted medication, the CCG continues to work with GPs and pharmacists to ensure that regular reviews of medication take place.

1.5.7 Staff wellbeing

The CCG has an active Staff Engagement Group, which has supported and promoted a number of wellbeing initiatives, including taking a regular temperature check survey of staff. The group supports and promotes a number or initiatives, such as staff wellbeing and fitness groups including the healthy weight club, on-site yoga classes, badminton and, in July 2018, the 1,000 miles initiative when staff collectively walked, cycled or ran over 1,000 miles as part of the NHS70 celebrations.

1.5.8 Global sustainability goals

The CCG is supportive of the United Nation's 17 Global Goals for Sustainable Development, and while it contributes directly to Goal 3, Good Health and Wellbeing, it is also working to reduce inequalities (Goal 10) and forming part of a sustainable city (Goal 11).

Figure 2 - The United Nation's Global Goals for Sustainable Development

The CCG is a signatory to the One Planet York environmental initiative. Details about this are published at https://www.york.gov.uk/info/20252/one_planet_york/1846/one_planet_york.

1.5.9 Certificate of excellence for sustainability reporting

The CCG was proud to receive a commendation for its sustainability reporting in 2017-18 and to receive a certificate of excellence from the Sustainable Development Unit, NHS Improvement and the Healthcare Financial Management Association.

High quality reporting on sustainability is recognised as a fundamental way in which organisations can demonstrate their commitment to embedding environmental, social and financial sustainability.

Good sustainability reporting includes:

- Leadership and engagement – Board level, staff and community
- Resources - such as energy, water and waste
- Travel - including staff travel, patient transport, business travel
- Procurement – including local, community and ethical procurement
- Adaptation and transformation
- New models of care

1.6 Improving quality

1.6.1 Introduction

The CCG's focus on quality and safety is managed by the Quality and Nursing Team. The team actively seeks patient feedback on health services and engages with all sections of the population with the aim of improving services. It also supports primary medical and pharmacy services to deliver high quality primary care services.

The team's work is overseen by the Quality and Patient Experience Committee, a subcommittee of the Governing Body. The committee's objective is to ensure that commissioned services are safe, effective and provide a good patient experience. It also focuses on continuous improvement in line with the NHS Constitution (2011) and the CCG's Quality and Assurance Strategy.

The committee's membership includes four Governing Body members – the Clinical Chair, the Executive Director of Primary Care and Population Health, the Chief Nurse and a Secondary Care Doctor. The committee's report, which is discussed at the Governing Body meeting, describes how the CCG's Quality and Nursing Team identify and seek assurance on key components to support quality improvement. These include:

- Quality in Primary Care
- Infection prevention and control
- Serious incidents
- Maternity
- Patient experience
- Patient engagement
- Regulatory inspection assurance

- Adult and children safeguarding
- Quality in care homes
- Mental health
- Cancer
- End of life care

1.6.2 Monitoring quality

All services are reviewed in line with the NHS England's Quality Monitoring and escalation process and services are reviewed dependant on whether they are under enhanced or routine surveillance.

As part of the CCG's quality, risk and assurance monitoring the CCG uses a suite of documentation in its decision making. This includes a Quality Impact Assessment which may include a Patient and Public Participation Assessment, and an Equality Impact Assessment. This process has been shared and embedded with neighbouring CCG's

The CCG acts on local intelligence and provides swift, effective support. Intelligence is gathered from many sources, one of which is the recently established Quality and Safety Group with NHS York Hospital NHS Foundation Trust. The group focuses upon quality improvement and assesses the impact of services and any clinical risk as appropriate. Intelligence also supports the CCG in its work to develop future models of assurance and continuous improvement, and its strategies for delivering care.

1.6.3 Quality intelligence

CCG staff also led Primary care intelligence meetings to ensure that any intelligence about GP Practices is proactively used to direct support

The CCG also proactively works with partners to gather local intelligence. This comes from a number of sources which includes robust monitoring of patient complaints and feedback as well as responding to soft intelligence gathered from the CCG's soft intelligence platform (YorInsight) and from partnership working. The CCG also works closely with the Care Quality Commission, Healthwatch, local authority partners, the Police and voluntary sector to ensure that early warning signs are captured and responded to.

Feedback from patients and the public is discussed at each Quality and Patient Experience Committee. For each of the committee meetings the Head of Engagement provides an update about patient and public involvement. She discusses recent engagement activity and how this impacts upon commissioning work and decisions. The most recent reports can be found here: https://www.valeofyorkccg.nhs.uk/get-involved/how-we-involve-the-public-in-governance/

1.6.4 Working with our Primary Care colleagues

The CCG Quality and Nursing Team recognised the requirement to support practices with CQC Inspection preparation.

In response to this the CCG introduced a Care Quality Commission process of self-assessment for all practices to support them in preparing for Care Quality Commission visits.

All practices that contributed to the self-assessment and have been inspected by the CQC, were assessed as good or outstanding.

The CCG worked proactively with its partners to ensure there was an adequate flu vaccination supply for people aged 65 and over. A high patient uptake of the vaccination was achieved and examples of good practice were shared in the few areas where initial uptake was not as high.

In response to the identification of a patient in a catchment cohort not having being offered Meningitis A, C, W and Y vaccination by primary care, the CCG worked with member practices to support invitations to vaccination and uptake increased significantly.

The CCG has been successful in bidding for a Clinical Leadership Fellow due to start in August 2019 who will support quality improvement with a focus on the identification and management of sepsis in primary care.

1.6.5 Working with our Partners in Care

The Quality and Nursing Team also supports the local nursing and care workforce. This work includes education and skills improvement through initiatives such as the Practice Nurse 10 Point Plan, the React to Red Pressure Ulcer Reduction Programme, the Care Home Capacity Tracker and the Enhanced Care in Care Homes Framework. To date the CCG has trained 91% of care home staff, with 72% of homes having 100% of their staff trained on the React to Red (pressure ulcer) programme. Information about the CCG's work with care homes and domiciliary care agencies is published at https://www.valeofyorkccg.nhs.uk/care-homes-our-partners-in-care-1/react-to-red-skin-stop-pressure-ulcers/ .

The CCG has also developed pilot work around the care of deteriorating residents which has resulted in improved outcomes for patients and increased capability of care home staff to care for patients who become ill. This led to a successful bid for a project nurse to roll out this work out across all our care homes. It has also allowed the CCG to participate and showcase the work at various national and regional conferences through presentations and posters. Lessons learned bulletins have been developed for care homes in response to adverse incidents as well as sharing of good practice. Bulletins have also been developed for primary care colleagues.

The CCG has significantly improved its performance over the past year against the target of '28 days from referral to verification' for Decision Support Tool (DST) assessments and anticipate meeting this indicator fully in in the last quarter of 2019-20. A further requirement is to ensure that no more than 15% of patients have their DST assessment in an acute hospital. The CCG has been achieving this indicator all year through the development and use of Discharge to Assess beds (step down into either a community bed, home or a care environment). In addition the CCG CHC programme led a whole system audit of fast track processes which has resulted in agreed actions in assessing and planning care at the time of efficiencies and subsequent efficiencies in packages. The outcome of this work will support improved experiences for patients requiring care at the end of life and their families.

1.6.6 Palliative Care and End of Life Care services

As part of the on-going improvements for patients in receipt of palliative and end of life care the CCG arranged a number of sessions during Autumn 2018 with clinicians, carers, care homes,

service users and the public about their experiences. The CCG spent a day at the St. Leonard's Hospice Sunflower Centre, talking to patients with a life limiting illness, their families, people who have recently lost loved ones and volunteers. In addition the CCG held a public facing event on 22 November, chaired by the CCG Clinical Lead (GP) for End of Life Care. This information was used to shape the End of Life Care Strategy and will help to create a soon to be published Citizen's Charter that aims to improve and further develop end of life care and support services.

1.6.7 Research and development

The CCG has further developed its response to its duty to support and develop research by establishing the Research Partnership Group which is a subgroup of the Clinical Effectiveness Advisory Group. The CCG's Research and Development Manager has developed the CCG website to include a section on 'Research, Evaluation and Innovation'. The website will enable the CCG to showcase research that is undertaken in general practice, celebrate the work of their research staff within practices and CCG led innovations. It will also provide and promote information to patients who may be interested in taking part in research and provide clarity of who to approach locally as well as containing useful information about new research studies and links to useful websites for researchers.

1.6.8 Patient insight and feedback

The Engagement and Patient Relations Teams meet each month to analyse patient insight to identify key themes of feedback. A strong example from December 2018 includes feedback about the Accessible Health Standards where, at a visit to MySight York, the Head of Engagement was made aware that some of its members had recurrent issues around receiving accessible format information from a local provider. The CCG's Patient Relations Team investigated further and concerns were shared with the provider which resolved the immediate issue for this patient cohort and put in place plans to overcome the issue for other patients.

Another example, recorded through the CCG's Patient Relations Team and the CCG's work with local carers groups, allowed for the capture of feedback about a change in continence products in June 2018. On investigation, the provider had procured a new supplier and some service users and carers raised concerns about the product. The CCG's Deputy Chief Nurse liaised with the provider about these issues and arranged an event hosted by the provider listen to patients and their carers. Learning about better communication with patients and involving them more in the process was taken from this event.

1.6.9 Patient stories

Patient stories are an important part of presenting patients views and ensuring that the Governing Body are sighted on the experiences of those for whom they commission services. Following the story presented by a service user undergoing the Continuing Health Care assessment process, the Deputy Chief Nurse and Head of Engagement met with the Continuing Health Care nursing team. They presented the feedback from the Quality and Patient Experience Committee patient story to ensure that the experience was shared with those delivering care. They have continued to meet with the carer and his mother on a regular

basis to understand their experiences during different stages of the process. More information can be viewed here: https://www.valeofyorkccg.nhs.uk/get-involved/patient-stories/ .

1.6.10 Delivering training and learning opportunities

The CCG's Governing Body comprises of local GPs who represent the population in their locality as commissioners. This has led to a cultural change in conversations and actions being clinically led. Examples of this is the safeguarding training for the Governing Body members in January 2019, quality improvement in medicines management and service improvements for out of hospital care in February 2019.

The CCG has established quarterly Protected Learning Time events for its primary care colleagues. The events were led by the Clinical Chair and Chief Nurse with workshop session topics that were selected in partnership with primary care, geared towards quality improvement and in line with key local priorities.

1.7 Engagement and involvement

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

The CCG follows and implements a set of guidance issued by NHS England which outlines best practice for enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services.

1.7.1 The CCG's engagement principles

The CCG has a set of engagement principles based on its core values. As part of this the CCG works hard to:

- hold open, clear, informed and collaborative conversations
- ensure engagement is core to planning, prioritising and commissioning activities
- develop innovative and interactive approaches to holding engagement conversations
- seek and listen to views of partners, patients, carers and local citizens
- be honest and transparent in offering opportunities and discussing constraints and challenges to the delivery of services

During 2018-19 the CCG began to review its engagement principles as part of the refresh of its engagement and communications strategy to ensure that they reflected the needs and expectations of the community. Following a number of public forum events, the CCG's population said that building trust and relationships, regular communications, listening and providing timely feedback, being honest, inclusive and accessible are important principles and that they would like to see these embedded within the CCG's future strategy.

1.7.2 Patient and public involvement in governance

Public engagement and patient experience is formally reported through the Quality and Patient Experience Committee. This committee meets bi-monthly and focuses on quality of services

within the Vale of York and patient engagement and experience. Minutes and key actions feed into the Governing Body through a standing item on the agenda presented by the Chief Nurse.

At the start of each meeting the committee hears a patient story to ensure that the service user voice is at the heart of every meeting. A representative from Healthwatch sits on the committee which is chaired by a Governing Body Lay member.

1.7.3 Engagement with our population

Over the last year the CCG has focused its attention on the needs of the local population. During 2018-19 it held thousands of conversations with its communities and facilitated hundreds of events and meetings with partners and the public to help gather views about what is important to them to keep them healthy and well. This rich source of feedback has formed the foundations of the CCG's priorities. It has also proved an essential tool in raising awareness of health prevention messages and involving patients and the public in the review of services and providing feedback to improve services.

Working in partnership with health colleagues, local authority partners, voluntary organisations and the wider community is vital for helping to achieve best outcomes for the local population. The CCG could not engage with and care for its residents without the continued support of the community and voluntary sector partners and the CCG would like to thank all of the organisations that have supported vulnerable members of the population to be involved.

1.7.4 Engaging our staff

The CCG's Staff Engagement Group forms an integral part of the CCG's engagement and employee involvement process and underpins its organisational development work. The group meets on a monthly basis and has a representative from each area of the organisation. The Deputy Chief Nurse and Head of Engagement are present at each meeting to ensure that the Staff Engagement Group acts as a mechanism to inform the Executive Team on all key areas of staff opinion. Whilst areas for discussion vary, they include:

- supporting organisational objectives
- CCG culture (values and behaviours)
- internal communications including how we continuously improve staff engagement
- social and charitable calendar for the organisation
- staff recognition and achievement
- staff satisfaction
- supporting staff development and opportunities

During 2018-19 the Staff Engagement Group was responsible for reviewing new policies and procedures, developing local staff opinion surveys, reviewing the CCG's organisational values, promoting health and wellbeing opportunities and delivering NHS70 engagement events.

1.7.5 Key engagement activities during 2018-19

During 2018-19 the CCG worked with its population on a number of key projects. These include:

Fig 3 – Key engagement activities in 2018-19

1.7.5.1 CCG's commissioning intentions for 2019-20

The CCG's commissioning intentions for 2019-20 reflect the views of local people and key community stakeholders with whom the CCG has been in conversations with over the last year.

During the summer of 2018, the CCG team spoke to hundreds of people and partners within the Vale of York about what they would like to help keep them healthy and well. The CCG's priorities for 2019-20 build on work that has been carried out in 2018-19 while moving towards longer-term planning.

1.7.5.2 Working with local Healthwatch and forums

The CCG works closely with colleagues at Healthwatch York, North Yorkshire and East Riding of Yorkshire to seek the views of patients, carers and service users. Its role is to provide a single point of contact for people to report their experiences, concerns or their compliments about health and social care. The CCG receives copies of the feedback and uses these to work with providers in primary care, acute care and community services to improve the experience for patients. The CCG regularly attends local Healthwatch Assembly meetings and has presented on several occasions during 2018-19. The CCG accesses number of forums and channels where patients and members of the public are represented. These groups help assure the CCG's public involvement work, such as the Maternity Voices Partnership, a group of women and their families, commissioners and providers e.g. midwives and doctors that work

together to review and contribute to the development of local maternity care and increase the voice of the service user.

Date	Activities with Healthwatch partners
April 2018	The CCG's Executive Director for Primary Care and Population presented the CCG's commissioning intentions. The CCG's Senior Quality Lead talked about the work that is taking place within care homes and the training and support that is offered to staff working with some of the most vulnerable patients in our community to recognise deteriorating residents, to improve safety and to raise awareness of pressure ulcers.
October 2018	The Executive Director for Primary Care and Population Health gave an update about how the CCG is performing against its priorities of GP services, mental health and cancer services.
January 2019	CCG's Head of Engagement provided an update on areas of patient feedback and where these helped to shape the commissioning intentions for 2019-20. A table top exercise was conducted to gather views to feed into the CCG's communications and engagement strategy and formulate its engagement principles.

Table 20 – Key Healthwatch engagement activities in 2018-19

1.7.5.3 NHS 70 celebrations

The National Health Service turned 70 on 5 July 2018. The CCG embraced the celebrations not only as a CCG, but across the Vale of York community to reflect on the history and achievements of one of the nation's most loved institutions.

During June and July 2018 the CCG organised over 20 events in collaboration with local communities, health partners, local authorities, businesses, libraries and voluntary sector. These events focused on acknowledging the good work of the NHS and its staff, whilst raising awareness around key priorities of self-care, mental health and tackling loneliness and isolation.

Date	NHS 70 activities
Community health bus tour on the 1, 15 and 18 June 2018	The CCG boarded a double-decker bus to visit various sites across its patch in York, Selby and Easingwold, and members of the public were invited to hop-on board and receive healthcare advice, learn more about health check-ups and sign health pledges. The aim of the tour was to take the celebrations and engagement into some of the most deprived and rural areas of the community in partnership with health, voluntary sector and local authority colleagues.

Involving local employers in helping to improve the health and wellbeing of their staff June and July 2018	Over 50 organisations in York sent representatives along to a business briefing, held in partnership with the CCG, the City of York Council's Public Health team and the local MPs to work with local employers and look at how they can help support the health and wellbeing of their workforce. Many signed up to give health checks to their employees and took leaflets and advice about vaccinations, healthy work place and carers' information. London North Eastern Railway (LNER), formerly Virgin Trains East Coast, was the first organisation to take the opportunity to join forces with the CCG, hosting an event at York Station where staff members signed pledge cards and wrote goodwill messages in the CCG's giant NHS70 birthday card. Staff from the CCG also pledged to donate thousands of miles to the NHS this year, by taking part in regular physical activity throughout 2018 as a collective birthday present to the NHS.
NHS 70 giant birthday card tour **June and July 2018**	The CCG created a 4ft high birthday card to mark the occasion. In the weeks leading up to the 70th birthday, the birthday card toured all four corners of the Vale of York so people could sign their names or write their messages to express what the NHS means to them and their families. Communities were encouraged to have a conversation about how to keep their communities healthy and well.
1940s themed tea-party celebrations 5 July 2018	The CCG held a 1940s-themed event to celebrate 70 years of the NHS on 5 July and everyone was invited to celebrate and become involved in raising awareness around self-care, tackling loneliness and isolation and supporting those with a mental and physical health condition. These conversations with the community across the Vale of York helped feed into a number of campaigns and the CCG's latest commissioning intentions

Table 21 – NHS 70 engagement activities in 2018-19

1.7.5.3.1 Using the community's feedback to shape our work

We used all of the feedback and pledges from conversations with the community at the NHS 70 events to influence areas of our work and to guide our future planning.

Fig 4 – Examples of the community's feedback that has shaped our work in 2018-19

1.7.5.4 Working with the carer community

The CCG is committed to hearing the voice of the carer and their families and this is most notable through its engagement work. The CCG regularly attends the Carers' Advisory Groups (CAG) and other forums such as York Parent Carers forum. These groups are run by carers and professionals to represent the needs of carers.

In 2018-19 the CCG has led on the following pieces of work with carers through these forums:

- Understanding the view of carers who use patient transport.
- Raising concerns about the change in continence product provider, and working with the hospital Trust to convene a focus group to understand issues of the new product and involving the most vulnerable patients in the process.
- Involvement in developing the City of York's new Carers' Strategy.
- Providing training around recognition and support for carers within GP surgeries in partnership with York Carers Centre and members of the East Riding of Yorkshire Carers Advisory Group.
- Supporting GP surgeries to become carer friendly employers.
- Training with carers to recognise pressure ulcers and deterioration of family members.
- Review of transition services to support parents of young people with special educational needs and disability (SEND) on moving into adulthood.
- Autism pathway review with York Parent Carer Forum (Parents of children with autism).

1.7.5.5 Improving access to General Practice

Between February and April 2018 the CCG gave its population the opportunity to think about what their needs are and then tell the CCG how they would like evening and weekend general practice appointments to be delivered. This was conducted through an online survey and face-to face events in railway stations, colleges and supermarkets to target those who may need appointments outside of normal working hours.

The CCG received 1,043 responses through a mixture of online surveys and paper questionnaires. In developing the new model of care, the CCG has listened to its population and set up services based on what the population has said they want. This included the days and times they preferred, as well as offering telephone appointments and sessions via the internet through an app called 'PushDoctor'.

1.7.5.6 Hearing the patient story

As part of commitment to ensuring the patient, carer and public voice is heard within the organisation, the CCG has now embedded a patient story as a regular item at the start of each Quality and Patient Experience Committee.

Patient stories bring experiences to life and make them accessible to other people. They encourage those that work in health and social care to focus on the patient as a whole person rather than just a clinical condition or as an outcome. The CCG invites real patients, carers and family members to tell their experience of using those services with the aim of understanding what the organisation needs to do better.

Within the 2018-19 year the CCG heard a patient story from a family member of a resident of a care home who was part of the Continuing Health Care assessment, how it felt to access mental health services in times of crisis, the experience of end of life care services, feedback on child and adolescent mental health services and two stories related to opiate prescribing.

1.7.5.7 Clinical engagement

In the past year there has been a great focus on clinical engagement across the Vale of York, in particular with colleagues from Primary Care. In early 2019 the CCG, in partnership with Hull and York Medical School, introduced quarterly Protected Learning Time . These peer-led sessions set aside dedicated time for Primary Care colleagues to learn and share best practice. These events will be the key to forging relationships and building clinical networks over the coming years.

We were delighted that over 330 GPs, Registered Nurses, Health Care Assistants, Allied Health Professionals and Physician Associates from across the Vale of York attended the inaugural session in January 2019. Workshops included a focus on resilience, children's mental health and dementia, end of life care, reducing opiate usage, safeguarding and innovation and workforce.

Feedback was hugely positive and colleagues from across primary care have had the opportunity to shape future events.

1.7.5.8 Embedding engagement in all projects

The CCG has designed a toolkit to provide staff with resources to help them to assess the level of public and patient engagement that is needed within any project large or small. The CCG uses the NHS England patient and public engagement statutory guidelines to assist with decision making. This process includes tools such as a stakeholder mapping process, guidance for equality impact assessments and a template to address if the legal duty needs to be applied.

The CCG wants to be sure that the decisions it takes make a real, positive difference to its population. To ensure that participation activity reaches diverse communities and groups with distinct health needs the CCG uses a Quality and Equality Impact Assessment tool to assess and measure the potential impact of proposed service changes or reviews, as well as the need for patient and public involvement.

1.7.5.9 Tackling health inequalities

The CCG takes a proactive approach towards the use of engagement in addressing health inequalities, and has undertaken a number of activities designed to increase its reach to all groups of people. This has ranged from working with people in our community with a learning disability to understand any barriers they may experience to accessing healthcare. It also includes our work with the Parent Carer Forum to review the autism pathway through to taking a bus into some of our most rural and deprived communities to reach people in locations where the CCG has not historically had a presence. As a result, the CCG has been able to engage with new audiences and gain additional views as to where services are most needed.

The CCG provides regular updates to staff to emphasise the importance of involving patients and public in its work. The sessions increased awareness of the legal duty to involve, encouraged staff to incorporate communications and engagement throughout any project cycle

and looked to increase understanding and knowledge of the connection between equality, engagement and health inequalities duties within the NHS.

1.8 Reducing health inequalities

Health inequalities are “the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs” (Public Health England). For example, people in more deprived areas have a shorter life expectancy than those who live in less deprived areas. Inequalities also exist between population groups with other characteristics such as gender, ethnic background, disability and sexual orientation.

Tackling health inequalities is a long-term process, but with the strength of partnership working we can shape joint plans for the coming years around the need to promote self-care and prevention work to help people improve their health and wellbeing.

That is why, in addition to offering tailored and individual support services, the CCG works 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 makes healthier choices easier. The CCG takes a holistic approach to reducing health inequalities by:

- considering the impact on health inequalities in every decision we make and every policy we deliver;
- allocating resources to where they are needed most;
- working in an integrated way for individuals and communities who suffer poorer health outcomes;
- working with individuals / communities to develop community based solutions to improving the health and wellbeing of our population.

You can find out more about this work, including the CCG’s and City of York Council’s joint Health and Wellbeing Strategy at https://www.york.gov.uk/info/20139/health_and_wellbeing_partnerships/973/health_and_wellbeing_board/1

As part of the Health and Wellbeing Board we use the Joint Strategic Needs Assessment to help identify the health and wellbeing needs of our local population and to inform the development of services to reduce health inequalities.

There is a dedicated website for York’s Joint Strategic Needs Assessment to help to make sure the information in the Joint Strategic Needs Assessment is more widely accessible. Go to http://www.healthyork.org./

North Yorkshire County Council publishes a Vale of York summary as part of their Joint Strategic Needs Assessment and the latest update (2019) can be found at http://hub.datanorthyorkshire.org/dataset/north-yorkshire-jsna-2019-vale-of-york-ccg-profile

The current East Riding of Yorkshire Joint Strategic Needs Assessment priority areas are:

- Parenting
- Unpaid carers
- Isolation and loneliness
- Mental and emotional health across the life course

Further information about the East Riding of Yorkshire Joint Strategic Needs Assessment can be found at: http://dataobs.eastriding.gov.uk/jsna/jsnahome.

1.8.1 The NHS Long Term Plan

In January 2019 the NHS published its Long Term Plan. The plan makes commitments relating to some clinical priorities, chosen for their impact on the population's health and where outcomes lag behind those of other similar advanced health systems. These include cancer, cardio-vascular disease, maternity and neonatal health, mental health, stroke, diabetes and respiratory care. There is also a strong focus on children and young people's health.

The plan also commits to a "more concerted and systematic approach to reducing health inequalities," with a promise that action on inequalities will be central to everything that the NHS does. In the next section are listed the key health inequalities in the CCG area along with actions in response.

1.8.2 Health inequality in the Vale of York

Much of the information in the following table has been sourced from the North Yorkshire Joint Strategic Needs Assessment 2019 Vale of York CCG profile. Other information comes from the York Health and Wellbeing website.

Inequality	Action taken / planned in response
Life expectancy is higher than England. For 2011-2015, female life expectancy in the Vale of York is 83.6 years (England 83.1) and male life expectancy is 80 years (England: 79.4) However, there is a difference in healthy life expectancy between people living in the most and least deprived areas of our CCG.	The CCG has been developing its work in line with the requirements of the NHS Long Term Plan. Neighbourhood profiles have been produced in preparation for the adoption of a Primary Care Network model of local service commissioning / provision. These highlight variations in local populations and their health needs within the CCG so that commissioning and services can be tailored and targeted to address inequalities.

Inequality	Action taken / planned in response
There is a high proportion of older people and the proportion is increasing. In 2017, 19.6% of the population was aged 65 and over (68,900 people), higher than national average (17.3%). Over 9,100 people (2.6%) were age 85+, compared with 2.3% in England.	GPs in the north of the CCG area (Pickering and Helmsley) are working jointly to identify patients who are most at risk of needing hospital care and then to provide them with support and care at home / in the community. The opportunity to employ a community geriatrician to join this team is currently being explored.
A significant proportion of **older adults** in York are **socially isolated**. When asked in a York survey, about a third of older adults say they go out socially only every few months or less often, and a similar proportion say they do not get as much social contact as they would like.	A directory of services for older people was developed by Healthwatch York. The Healthwatch Ways to Wellbeing Social Prescribing Service connects people to local community support.
The Quality and Outcomes Framework used by GP practices shows the **dementia** prevalence in our CCG area is 0.8% (same as national prevalence). Given the increasing proportion of older people in our area, this is an important priority for us.	Work within primary care has focused on narrowing the gap in diagnosis between the modelled prevalence and declared prevalence.
In the CCG there is a higher proportion of the population who are **15-24 years old** compared with both England and the Yorkshire and Humber region. This is probably linked to the people in this age group who are students at the four Higher York institutions – University of York, York St John University, Askham Bryan and York College.	The CCG has been working to support Unity Health (GP practice that mostly caters for University of York) following a poor Care Quality Commission rating. A more recent Care Quality Commission inspection showed that quality at this practice has improved and it is now rated “Good.” As part of this work a Student Health Needs Assessment was carried out to identify health needs of this particular group. It also describes actions that are being taken in response.

Inequality	Action taken / planned in response
There are areas of deprivation. Within the CCG seven lower super output areas (out of a total of 206) rank within the 20% most deprived in England and one of these (Selby West) is amongst the 10% most deprived in England. The other deprived areas are in Westfield, Clifton and Guildhall in York and in Selby east ward. Almost 12,000 people live in these areas.	As part of the CCG's NHS 70 celebrations we held a double-decker bus tour of various sites in York, Selby and Easingwold, and members of the public were invited to come along to receive healthcare advice, signposting and health check-up. In Selby we worked in partnership with Inspiring Healthy Lifestyles.
There is significant crossover between areas of deprivation and unplanned hospitalisations There are around 950 **complex patients**, typically with 3 different conditions, resident in the CCG area who are admitted to hospital on average 6 times a year. Almost half (44%, 417 patients) are aged over 75 and these patients are more likely to live in deprived areas.	A Proactive Health Coaching service has been trialled with 700 of these patients with good results. Amongst these patients there has been a reduction of 30% in non-elective hospital admissions, 36% of A&E attendances and 21%of elective admissions. In addition, patients have reported marked improvements in their quality of life. For example a 26 year old man has travelled abroad, gained a qualification and returned to work, a 69 year old woman has started driving again and is getting out of her house much more and a 67 year old man has moved from one word monotone answers to having conversations and has rebuilt his relationships with his wife and daughter.
Child poverty is lower than the national and regional index; in 2015, 11.2% of children aged 0-15 lived in low income families, compared with 19.9% in England. However, the North Yorkshire Child Poverty Needs Analysis, compiled in 2011, shows that child poverty in Vale of York is most prevalent around urban areas like Selby. Child poverty is also found in some rural locations, most particularly in Central Ryedale, and the southernmost area of the Selby locality. York also has the highest level of hospital admissions for unintentional or deliberate injuries in children in Yorkshire – significantly higher than the national average.	Work is carried out to reduce child poverty jointly with local authority partners and updates are made available in the local Joint Strategic Needs Assessments.

Inequality	Action taken / planned in response
The census in 2011 showed 54,300 people living **with a long term health problem or disability** (15.8% compared to 17.6% in England).	In response to feedback from parents of children with autism, the autism pathway is now under review. Engagement with the York Parent Carer Forum showed difficulties with the transition for disabled children into adult services. Information leaflets have been improved and shared and a workshop on transitions will take place in March 2019. Working with children, young people and families has led to improvements in our Child and Adolescent Mental Health Service including reduced waiting times, services in new venues, rapid support at times of crisis and easy to access online support. The CCG is also working to ensure that support for children, for example the oral health service which is currently being developed is open and accessible to disabled children and those with complex health needs.
Nationally **people with a learning disability** are four times more likely to die of something which could have been prevented than the general population. They are also less likely to receive a good education or to get a good job which will affect their future health.	Engagement with people with learning disabilities living in our CCG area showed that their priorities are to improve access to annual health checks and to Easy Read information. Two learning disability nurses are currently being employed to work in the Central York locality.
The highest reported rates of ill health are from**:** hypertension (13.4%); obesity (9.8%); depression (9%), asthma (6.1%) and diabetes (5.6%) these figures are taken from the Quality and Outcomes Framework used by GP practices. 13.4% of the CCG population has **hypertension** as recorded in the Quality and Outcomes Framework.	More than 46,000 people in our CCG area are affected by high blood pressure, yet around 1 in 10 (34,000 people) have undiagnosed high blood pressure. Detecting and treating hypertension is part of our Healthy Hearts initiative.
The Public Health Outcomes Framework (survey based data) describes **adult obesity** prevalence in the CCG at 24.6% and **child obesity** (year 6) at 15.5%. 2016-17 data describes 63.5% of Selby district population as overweight or obese compared to 60.4% in York.	The North Yorkshire County Council area is one of 13 places in the country to recently receive Public Health England funding for discovery activity looking at how to reduce child obesity in Selby.

Inequality	Action taken / planned in response
There are more than 26,300 people with a record of **depression** in the CCG area, with a lower rate than seen in England. Overall, the data shows that fewer people enter IAPT (talking therapies) in York than in other parts of the country, but the situation improved in 2017 compared to previous years.	Additional investment has been made into mental health services to increase access to services.
A significantly lower proportion of **diabetes** patients meet the three treatment targets around cholesterol, blood pressure and HbA1c than in similar CCGs (31.8% locally compared with 36.3% across similar CCGs).	Following NHS England funding the CCG has had access to a Diabetes Specialist Outreach team which specialises in finding hard to reach and poorly managed diabetes patients (based on the three treatment target criteria) and offering them specialist, psychological and social support in order to ensure they will re-engage with services as these patients are at highest risk of developing a diabetes related complication. The Diabetes local enhanced scheme has been re-drafted this year which will commence 1 April 2019 which includes two KPIs which asks practices to improve the number of diabetic patients achieving the three treatment targets and care processes. The CCG has also employed a Primary Care Nurse one day a week to support practices and reduce variation across the Vale of York practices.
Binge drinking is a significant issue for the area with 28.8% of the adult population estimated as binge drinkers compared with 20% nationally. A greater proportion of 15 year olds in York report having ever consumed an alcoholic drink than the national average. York has significantly above average hospital admissions for alcohol-related conditions in both men and women, and for admissions for mental and behavioural disorders due to use of alcohol (rates in Selby and rest of North Yorkshire are not as high).	Work to reduce harmful drinking and alcohol abuse is carried out jointly with the local authorities and updates are made available in the local Joint Strategic Needs Assessments.

Inequality	Action taken / planned in response
Quality and Outcomes Framework prevalence figures for 2017-18 give the CHD prevalence of **Coronary Heart Disease (CHD)** in the Vale of York as 3.4%, above national average (3.1%). The cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check (2013-14-2017-18) is lower than national average (44.3%) across Vale of York. There is an additional inequality between those in York and those in North Yorkshire – in York on 27.5% received a check, compared to 41.4% in North Yorkshire (source - PHE Fingertips)	The CCG's Healthy Hearts project aims to reduce the number of people who die from cardiovascular disease by at least 10% in the next five years. The work focuses on three main areas: **Reducing cholesterol** – By ensuring patients are on the most effective statin to lower blood cholesterol levels, which helps to reduce their risk of having a heart attack or stroke. **Detecting high blood pressure (hypertension)** – High blood pressure can lead to heart attacks and strokes if untreated, so it's particularly important to detect those who do not know they have it. Patients already identified with high blood pressure will be treated with the most effective medication available. **Atrial fibrillation and heart failure** – Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. Better treating patients with atrial fibrillation will help to reduce the number of strokes.
The CCG has a lower rate of **smoking** prevalence (13%) compared to England (17%). However, smoking quit rates (at four weeks) are also significantly worse than in similar CCGs (480 per 100,000 locally compared to 818 per 100,000 across similar CCGs) or England (868 per 100,000). The proportion of pregnant women who smoke at the time of their delivery is greater in York than any of York's statistical neighbours, and has recently risen above the national average for the first time in five years.	Smoking cessation is commissioned by our local authority partners. Information about local work is available in the local Joint Strategic Needs Assessments.

Inequality	Action taken / planned in response
Although the total number of **BME people** identified in the Census is lower than the UK average, the report *Mapping rapidly changing minority ethnic populations: a case study of York by the Joseph Rowntree Foundation,* reports that York has a very diverse BME population with 78 different first languages spoken by its residents. York also attracts a large number of international students making up 17% of their student population and this diversity needs to be considered by the CCG in its decision making process.	The particular set of health challenges experienced by international students are set out in the local Student Health Needs Assessment.
42.7% of the population within the Vale of York lives in areas defined as rural, of which 5.7% live in areas that are sparsely populated. In **rural areas** it is generally more difficult to access services.	The engagement plan for patient transport review includes rural communities. The CCG has made links with Community First, which is an amalgamation of two Rural Action Groups.
In September 2018 Healthwatch York published a report about **Lesbian, Gay, Bisexual and Transgender community's** experience of using local health services	Information has been shared with GP practices and there is a plan to provide LGBT awareness training as part of the GP Protected learning Time programme for 2019-20.

Table 22: Health inequalities

1.8.3 Equality and diversity

The CCG is committed to reducing health inequalities and to promoting equality and diversity and sees this important subject forming an integral part of its work to reduce health inequalities.

This section of our annual report highlights the work the CCG has undertaken and provides evidence of how it is meeting its public sector equality duties under the Equality Act 2010, and includes updates on ensuring that opportunities to improve equality and diversity as part of the CCG's day to day work are not missed, how the CCG responds to national initiatives such as the Equality Delivery System and the Workforce Race Equality Standard and how the CCG supports local NHS provider trusts to perform well in terms of equality, diversity and inclusion.

In publishing this report Vale of York CGG is providing assurance and demonstrating that it works proactively to improve equality as required by the Public Sector Equality Duty which is part of the Equality Act, 2010.

1.8.4 Considering equality and diversity as part of our work

The CCG's Equality, Diversity and Human Rights Strategy sets out its approach to equality and diversity and provides more detail on the legal requirements of the Equality Act 2010. The CCG's strategy is published at https://www.valeofyorkccg.nhs.uk/data/uploads/about-us/equality/equality-strategy-2017-21.pdf.

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

The CCG recognises the importance of leadership in driving forward the equality agenda and that this is critical to its success as commissioners of local NHS services. During 2018- 19 two equality and diversity training sessions were delivered to a range of CCG staff to explore the principles and practice of embedding equality and diversity throughout the work of the CCG and of maximising opportunities to contribute to the reduction of health inequalities.

The CCG plans to use the Care Quality Commission's Equally outstanding: Equality and human rights – good practice resource 2017 to help it embed equality into its mainstream work. Although the report is primarily focused on provider trusts, the human rights principles of fairness, respect, equality, dignity and autonomy at the heart of good care provision is equally applicable to commissioning services that meet local need, focus on health improvement and reduce health inequalities.

The report identifies the following factors for success:

- Leadership committed to equality and human rights
- Putting equality and human rights principles into action
- Developing a culture of staff equality
- Applying equality and human rights thinking to improvement issues
- Putting people who use services at the centre
- Using external help and demonstrating courage and curiosity.

The Equality Act 2010 requires public bodies such as the CCG to prepare and publish one or more specific and measurable equality objectives, which they believe will support them to achieve the aims of Public Sector Equality Duty.

In line with this requirement, the CCG has reviewed its equality objectives and used the Care Quality Commission factors above as its new equality objectives 2018-2022. To support the delivery of our Equality, Diversity and Human Rights Strategy and take forward our equality objectives, the CCG has developed an action plan. This is published at http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/equality/voy-equality-objectives-for-web.pdf

In March 2019 the CCG produced an update report to describe the progress it has made in implementing the equality objectives. This is published at https://www.valeofyorkccg.nhs.uk/data/uploads/about-us/equality/equalities-objectives-update-march-2019.pdf

For example, in response to what local people have told us, the CCG is working with parents of disabled children to improve the transition from children's disability services to adult services, has made improvements to our Child and Adolescent Mental Health Services and is improving the uptake of annual health checks by people with learning difficulties and the provision of Easy Read information.

As part of its commitment to reducing health inequalities the CCG uses Equality Impact Assessments to measure the impact of its decisions and how they affect the local population, particularly protected groups. This helps it to identify any action needed to reduce or remove any negative impacts. As part of this process the CCG considers and analyses a range of information and data including any engagement activity and this informs its decision making both as a commissioner and as an employer.

Further information about the CCG polices and Equality Impact Assessments is published at http://www.valeofyorkccg.nhs.uk/publications/policies/.

The CCG has been using the Equality Delivery System 2. This framework was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system to help NHS organisations improve the services they provide for their local communities and provide better working environments; free of discrimination, for those who work in the NHS while meeting the requirements of the Equality Act 2010. The Equality Delivery System was developed by and for the NHS, and took inspiration from existing work and good practice.

Further information about the Equality Delivery System 2 is available published at https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf.

In November 2017, the CCG and York Teaching Hospital NHS Foundation Trust held a workshop that brought together key stakeholders including the voluntary and community sector to review progress against their Equality Delivery System 2 priorities. The workshop looked at progress against existing shared priorities and also focused on progress and gaps against the Equality Delivery System 2 goal of 'Better Health Outcomes'. The table below provides an update on progress made since that workshop:

Shared joint equalities priority	Key achievements in 2018-19
Improve the transition from children's to adult services for	Over the summer of 2018 the CCG had a series of five

Shared joint equalities priority	Key achievements in 2018-19
disabled children	seminars with the York Parent Carer Forum. These workshops described a lack of information about physical health checks and screening for children and young people and concerns about communication from hospital clinics when transferring to adult services. New improved information leaflets have been drafted.
Information sharing	The CCG and Trust have shared areas of interest and good practice via two clinical summits (GP's and hospital staff).
Gather information about health inequalities in different neighbourhoods in the CCG area	This year the CCG has been developing a new approach to its work in line with the requirements of the NHS Long Term Plan. Neighbourhood profiles have been produced in preparation for the adoption of a Primary Care Network model of local service commissioning / provision. These highlight variations in local populations and their health needs within the CCG so that commissioning and services can be tailored and target to address these inequalities.
Minimise any negative impact of leaving the European Union on NHS staff	Staff kept up-to-date on the arrangements for gaining settled status. The CCG had offered to pay the fees for settled status prior to government cancellation of these fees.
Develop options for improved representation and communication about EDS3	Nationally EDS is being significantly revised and a new EDS3 is due to be published and piloted in 2019. This new framework and associated guidance will inform our joint work in the future.

Table 23 – Shared joint equalities priorities and achievements

1.8.5 Monitoring NHS provider organisations

In addition to working jointly with York Teaching Hospital NHS Foundation Trust and community organisations, as the local commissioner of health care, the CCG has a duty to ensure that all of its local healthcare service providers are meeting their statutory Public Sector Equality Duties under the Equality Act 2010. To this end, the CCG provided feedback to York Teaching Hospital NHS Foundation Trust on their 2018 Workforce Race Equality Standard report and associated action plan. The data for each indicator have been calculated in line with the technical guidance and then presented clearly. However, the data do not seem to have been analysed in terms of any gaps between black and ethnic minority (BME) and white staff

and the actions in the plan seem to focus on improving the situation for staff and job applicants in general rather than on reducing any race inequalities that the data reveal. The CCG has requested that in next year's report the trust identifies any ethnic inequalities and that actions focus on reducing the most important inequalities.

1.8.6 Workforce equality

To ensure that staff members do not experience discrimination, harassment and victimisation the CCG has a range of policies to support staff including flexible working, bullying and harassment, employing disabled people, home working and retirement. All of the CCG's policies are published at http://www.valeofyorkccg.nhs.uk/publications/policies/.

The implementation of these policies, along with occupational health support, ensures the continuation of employment - and provision of appropriate training - to any employee who becomes disabled. They ensure access for all their employees, including disabled staff members to training, career development and promotion opportunities.

1.8.6.1 Equality Impact Assessment

All relevant policies have been subject to an Equality Impact Assessment. The CCG recognises that in order to remove the barriers experienced by disabled people, it will need to make reasonable adjustments for disabled employees. The CCG does this on an individual basis and involves occupational health services as appropriate. The CCG has signed up for level one of the new Disability Confident Employer scheme which is the replacement of the Two Ticks scheme.

1.8.6.2 NHS Workforce Race Equality Standard

The CCG has welcomed the national focus on the NHS Workforce Race Equality Standard and as described above provided feedback to the local teaching hospitals trust to help them ensure that they are using Workforce Race Equality Standard as effectively as possible. Further information is published at https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/. Due to the small number of staff within the CCG and the risk of breaching confidentiality, the CCG is not required to publish statistical data for the Workforce Race Equality Standard. However, the CCG is collecting and analysing this data to inform the ongoing development of its action plan. In addition, any issues identified are also taken to the Staff Engagement Group.

1.8.6.3 NHS Workforce Disability Equality Standard

The NHS Workforce Disability Equality Standard was launched in early 2019 with the requirement for provider trusts to publish their data for the ten Workforce Disability Equality Standard indicators by August 2019 along with an action to address any inequalities identified. Further information on the Workforce Disability Equality Standard is published at https://www.england.nhs.uk/about/gov/equality-hub/wdes/.

1.8.7 Accessible Information Standard

The Accessible Information Standard was made mandatory in July 2016. The aim of the standard is to make sure people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support they might need. This includes making sure people get information in different formats, for example large print, Braille, Easy Read and support such as a British Sign Language interpreter, deafblind manual interpreter or an advocate. Although the CCG is exempt from delivering the standard, it is required to pay due regard and will make sure that when it communicates with the public it considers the requirements of the standard. The CCG is required to seek assurance from provider organisations of their compliance with the standard, including evidence of how they meet, or plan to meet the standard. As the CCG now commissions Primary Care services, this includes GP practices.

1.9 Health and wellbeing strategies

The Chair of the CCG is the vice-chair of the York Health and Wellbeing Board, and the CCG is an active member of two neighbouring health and wellbeing boards in North Yorkshire and the East Riding of Yorkshire. The Chair has led Health and Wellbeing Board workshops, for example on ageing.

The formal Health and Wellbeing Board meetings are themed around the priorities in the Joint Health and Wellbeing Strategy. The CCG is asked for its input into these updates and contributes where appropriate, for example by presenting on progress with the “Future in Mind” children and adolescents mental health programme.

The CCG are asked to contribute to the Health and Wellbeing Board’s Annual Report which details progress against delivering the Joint Health and Wellbeing Strategy; the CCG are asked for information to include and are consulted widely on the content.

Each of the themes in the Joint Health and Wellbeing Strategy have a lead Health and Wellbeing Board member attached to them; until recently the CCG representative was the lead for the mental health theme and the CCG were instrumental in developing the Board’s All Age Mental Health Strategy 2018-2023 which expands on the mental health theme of the Joint Health and Wellbeing Strategy.

The CCG is always represented at the informal workshops which are frequently focused around the Joint Health and Wellbeing Strategy. A number of CCG representatives are members of a variety of partnership boards leading on the delivery of the Joint Health and Wellbeing Strategy.

The CCG are active members of the Health and Wellbeing Board Steering Group which ensures the Board delivers against its statutory functions.

1.10 Financial performance

1.10.1 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.

1.10.2 Accounting policies

The CCG prepares the accounts under International Financial Reporting Standards (IFRS) and in line with the Group Accounting Manual issued by the Department of Health and Social Care 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.

1.10.3 Financing transactions

There have been no financing transactions undertaken by the CCG.

1.10.4 Cash

The CCG delivered its key financial statutory duty to have a cash balance at the year-end within 1.25% of the monthly cash draw down or £250k, whichever is lower.

The CCG also has its own internal key financial measures which include maintaining a month-end cash balance within 1.25% of the monthly cash draw down. This was delivered throughout 2018-19.

1.10.5 Summary of expenditure

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

1.10.5.1 Programme costs

A funding allocation is 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.

The CCG's in-year allocation for programme costs was £461.7m in 2018-19 and total expenditure against this allocation was £481.0m.

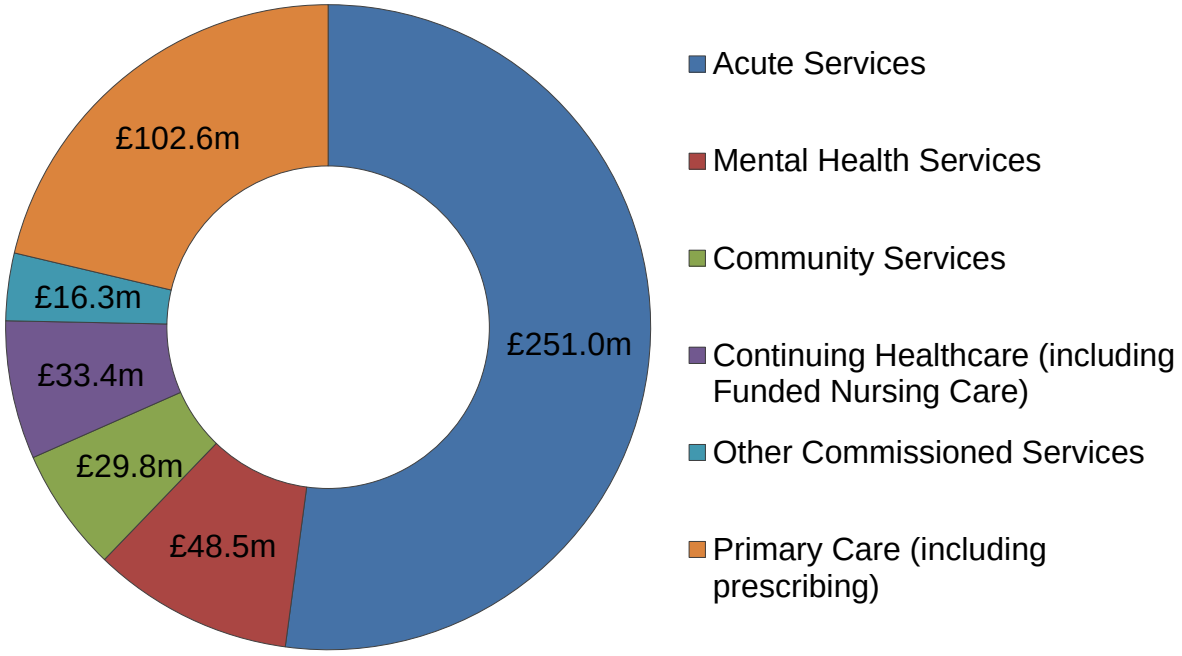


Figure 5: An analysis of 2018-19 programme expenditure

1.10.5.2 Running costs

Payment is allocated to CCGs based on £21.75 per head of the Office for National Statistics' population to pay for non-clinical management and administrative support, including commissioning support services.

The CCG's allocation for running costs was £7.6m in 2018-19 and total expenditure against this allocation was £7.0m.

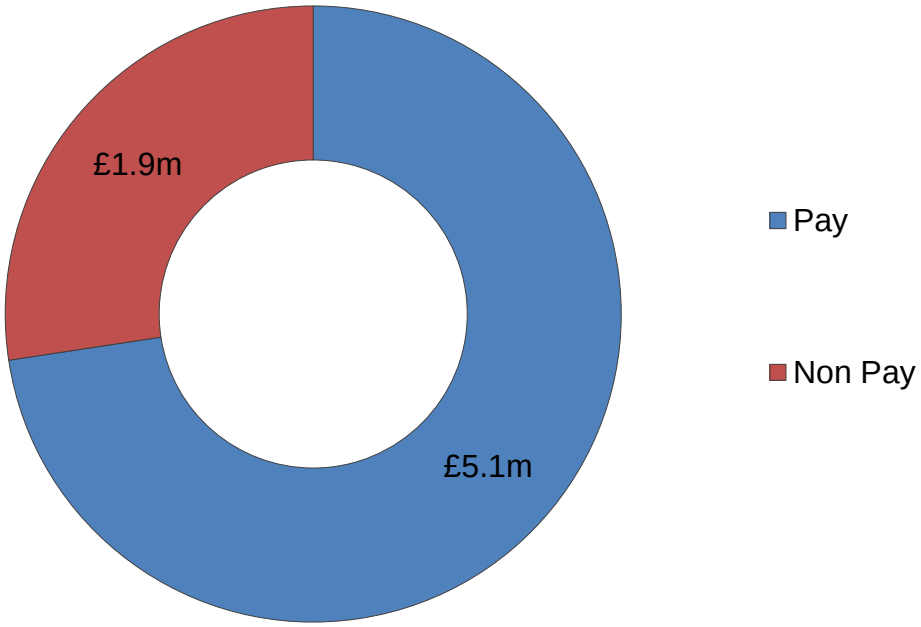


Figure 6: An analysis of 2018-19 running costs expenditure

1.10.6 Underlying recurrent position

Excluding the effect of all non-recurrent elements in in the 2018-19 position, and including the recurrent full year impact of 2018-19 Quality, Innovation, Productivity and Prevention programme schemes, the CCG has an underlying recurrent deficit of £20.5m as it moves into 2019-20, having started the year with an underlying deficit of £21.7m.

1.10.7 Quality, Innovation, Productivity and Prevention

In 2018-19 the CCG delivered savings of £7.8m through its Quality, Innovation, Productivity and Prevention programme. In addition to this, the schemes delivered in 2018-19 will have a full year impact in 2019-20 of £4.0m. Therefore, the recurrent value of Quality, Innovation, Productivity and Prevention programme savings delivered in 2018-19 totals £11.8m. However, the CCG has not been able to deliver against all of its planned schemes identified at the start of 2018-19.

Three significant initiatives that have contributed significantly towards in-year savings are:

- Demand Management in planned care through Health Optimisation and via the Referral Support Service (RSS) - £2.4m
- Clinical review of Continuing Healthcare packages - £2.1m
- Prescribing savings and cost avoidance through a variety of targeted projects - £1.4m

These initiatives have laid a firm foundation for the CCG to continue delivery of savings in prescribing and Continuing Health Care in 2019-20. The CCG is working collaboratively with York Teaching Hospital NHS Foundation Trust and NHS Scarborough and Ryedale CCG on a number of demand management initiatives which are targeted to mitigate increased cost in the acute sector as a result of demand growth. Additionally, the CCG delivered £5.2m of further savings as a result of the Financial Recovery Plan which is the most significant financial improvement plan the CCG has delivered to date.

1.10.8 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 documents. 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.

1.10.9 Data quality

The CCG received a business intelligence service from the Commissioning Support Team at eMBED Health Consortium. This team checked and validated data internally. The Governing Body and the CCG's committees raised no concerns regarding the quality of data supplied by eMBED Health Consortium in 2018-19.

1.10.10 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 in the tables below for 2018-19.

Non-NHS invoices						
Month	Total invoices paid	Invoices paid on time	% Paid within target	Total value paid (£)	Value paid on time (£)	% Paid within target
Apr-18	748	724	96.79	9,564,670.52	9,424,157.22	98.53
May-18	843	809	95.97	7,135,477.18	6,895,943.67	96.64
Jun-18	965	929	96.27	14,108,173.25	13,458,610.94	95.40
Jul-18	851	827	97.18	8,473,705.80	8,349,579.41	98.54
Aug-18	893	864	96.75	9,686,984.85	9,522,451.51	98.30
Sep-18	726	691	95.18	9,513,483.93	9,322,756.64	98.00
Oct-18	1,135	1,082	95.33	8,892,533.68	8,724,711.68	98.11
Nov-18	963	930	96.57	9,802,546.03	9,592,230.76	97.85
Dec-18	823	789	95.87	10,480,723.10	10,380,613.66	99.04
Jan-19	793	746	94.07	11,773,600.96	11,708,444.48	99.45
Feb-19	804	777	96.64	11,049,110.65	10,976,261.51	99.34
Mar-19	854	807	94.50	9,899,577.04	9,787,696.12	98.87
Totals	**10,398**	**9,975**	**95.93**	**120,380,586.99**	**118,143,457.60**	**98.14**

Table 24: Payment of Non-NHS invoices in 2018-19

NHS invoices						
Month	Total invoices paid	Invoices paid on time	% Paid within target	Total value paid (£)	Value paid on time (£)	% Paid within target
Apr-18	351	343	97.72	25,965,170.48	25,943,604.71	99.92
May-18	175	169	96.57	24,577,796.42	24,507,616.72	99.71
Jun-18	305	297	97.38	24,949,270.34	24,863,796.65	99.66
Jul-18	388	386	99.48	25,666,325.98	25,662,318.90	99.98
Aug-18	279	273	97.85	28,776,205.46	28,735,712.95	99.86
Sep-18	235	231	98.30	25,768,509.87	25,763,605.45	99.98
Oct-18	268	262	97.76	25,509,736.85	25,415,723.79	99.63
Nov-18	311	306	98.39	27,969,725.42	27,968,974.59	100.00
Dec-18	341	328	96.19	27,367,920.25	27,271,981.44	99.65
Jan-19	165	163	98.79	25,423,296.31	25,348,727.09	99.71
Feb-19	355	345	97.18	26,158,471.84	26,140,528.36	99.93
Mar-19	452	443	98.01	32,052,503.23	32,040,079.40	99.96
	3,625	**3,546**	**97.82**	**320,184,932.45**	**319,662,670.05**	**99.84**

Table 25: Payment of NHS invoices in 2018-19

Section two

Accountability Report

PHIL METTAM

Accountable Officer

24 May 2019

2. Members' Report - The CCG's Council of Representatives meetings

The Chair's review is presented at the beginning of this report. The Council of Representatives met on 11 occasions during 2018-19 and details of practice involvement are given below.

Practice	20 April	18 May	15 June	20 July	21 Sept	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	15 Mar
Beech Tree Surgery	PM (m)+ GPR m)	Y(m) + GPR (m)	Y(m) + GPR (m)	Y(m)	Y(m) + GPR (m)	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(m)
Dalton Terrace Surgery	Y (m)	PM (m)	PM (m)	N	A	PM (m)	PM (m)	Y(m)	Y(m)	Y(m)	Y(m)
East Parade Medical Practice	N	A	A	N	N	N	N	N	N	N	N
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)	Y(f)	Y(f)	Y(f)	PM (f)	PM (f)	Y(f)	Y(f)	PM (f)	Y(f)
Front Street Surgery	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Haxby Group Practice	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Helmsley and Terrington Surgeries	Y(m) + PM (m)	Y(m)+ PM (m)	A	A	Y(m)	Y(m)	N	Y(m)	Y(m)	Y(m)	A
Jorvik Gillygate Practice	Y(m)	Y(m)	Y(m)	N	Y(m)	Y(m)	Y(m)	APM (f)	Y(m)	Y(m)	APM (f)
Kirbymoorside Surgery	Y(m)	Y(m)	Y(m)	Y(m)	A	N	A	N	A	Y(m)	Y(m)
Millfield Surgery	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	N	Y(f)	Y(f)
MyHealth	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	N	Y(m)	A	Y(m)
Old School Medical Practice	A	Y(f)	Y(f)	A	A	A	A	N	A	A	A
Pickering Medical Practice	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m) +Y(f)	Y(m)
Pocklington Group Practice	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	A	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)	A	Y(m) + GPR(f)
Priory Medical Group	Y(f)	Y(f)	Y(f)	Y(f) +PM (m)	Y(f)	Y(f)	A	A	Y(f)	Y(f)	Y(f)
Scott Road Medical Centre	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	PM (m)	A	Y(f)	Y(f)
Sherburn Practice	PM (f)	A	PM (f)	PM (f)	Y(m)	Y(m)	N	N	Y(m)	Y(m)	Y(f)
South Milford Surgery	PM (f)	PM (f)	A	A	Y(m)	N	A	PM (f)	N	Y(m)	N
Stillington Surgery	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	N
Tadcaster Medical Centre	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Tollerton Surgery	A	Y(f)	Y(f)	Y(f)	Y(f)	A	Y(f)	N	Y(f)	N	Y(f)
Unity Health	Y(m)	A	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
York Medical Group	Y(m)	Y(f) + PM (m)	Y(f) +Y (m) +Y(f)	Y(f) +Y(f)+ PM (m)	Y(f) +Y (m)+ PM (m)	Y (m)+ PM (m)	Y(f) +Y (m)+ PM (m)	Y(f) +Y (m)	PM(m)	PM(m)	Y(m)
Dr Stuart Calder, Training Programme Director – Deputy Chair	Y	Y	A	Y	Y	A	A	A	Y	A	A

Key
Y = Attended
GPR = GP Registrar attended
A = Apologies
m = male, f = female
N = Neither attended nor sent apologies

Table 26: Council of Representatives and attendances

PM / APM = Practice Manager / Assistant Practice Manager represented Practice / attended with member

2.2 The Governing Body

The Governing Body met eight times in public and was quorate on each occasion. A Governing Body workshop was held for members to take part in risk training relating to policy, phasing and mitigation and the respective Designated Professionals delivered a Safeguarding Children and Safeguarding Adults sessions for members.

Additionally there were five workshop sessions when discussion included: resilience and Winter planning for 2018-19; developing a medium-term financial recovery plan and 2019-20 Aligned Incentive Contract framework with York Teaching Hospital NHS Foundation Trust; acute transformation plans; York-Scarborough System Performance Month 7 (pre-Winter), the priorities for 2019-20 and planning for 2019-20.

There was also a joint meeting with members of NHS Scarborough and Ryedale CCG Governing Body and an informal meeting with the Chief Executive, Finance Director / Deputy Chief Executive and Chief Operating Officer of York Teaching Hospital NHS Foundation Trust.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Dr Nigel Wells	CCG Clinical Chair	7/8
Michael Ash-McMahon (from 30 April to 31 July 2018)	Acting Chief Finance Officer	2/2
Simon Bell (from 30 July 2018)	Chief Finance Officer	4/5
David Booker	Lay Member and Chair of Finance and Performance Committee	8/8
Michelle Carrington	Executive Director of Quality and Nursing / Chief Nurse	8/8
Dr Helena Ebbs	North Locality GP Representative	7/8
Phil Goatley (from 3 July 2018)	Lay Member and Audit Committee Chair	5/6
Dr Andrew Field (to 6 September 2018)	Central Locality GP Representative	3/4
Dr Arasu Kuppuswamy (to 30 March 2019)	Secondary Care Doctor Member - Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust	6/8
Phil Mettam	Accountable Officer	7/8
Denise Nightingale	Executive Director of Transformation, Complex Care and Mental Health	8/8
Tracey Preece (to 27 April 2018)	Chief Finance Officer	1/1
Keith Ramsay	Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and the Remuneration Committee	6/8

Dr Kevin Smith	Executive Director of Primary Care and Population Health	6/8
Dr Ruth Walker	South Locality GP Representative	7/8
Attendees – Non voting		
Dr Aaron Brown / Dr Chris Stanley	Local Medical Committee Liaison Officer, Selby and York	5/8
Sharon Stoltz	Director of Public Health, City of York Council	6/8

Table 27 - Governing Body membership and attendances

2.3 The Governing Body membership in 2018-19

Dr Nigel Wells
Clinical Chair and Chair of the Council of Representatives

Nigel joins the CCG team from Beech Tree Surgery, Selby. He moved to York in 1998 after qualifying in medicine at Dundee University. He trained in Leeds and York and started work as a GP in 2003. Nigel worked as a locum GP in York for three years. He was a GP partner in Consett Medical Centre Co. Durham before joining Beech Tree Surgery in 2008.

He is a GP trainer and has an interest in finance, management and service provision. Nigel has set up alternative NHS services in podiatry and community ultrasound within the Vale of York and other CCGs.

Phil Mettam
Accountable Officer

Phil joined the CCG in October 2016. Phil joined the NHS from industry and has held a number of senior and Board level positions across the East Midlands and Yorkshire. These have involved positions in both Strategic Health Authority and Primary Care Trusts (PCTs). Most recently Phil led the establishment of 'outstanding' Bassetlaw CCG, and was involved in the formation of the early wave South Yorkshire Integrated Care System (ICS).

Phil believes commissioning can make a real difference, but only when aligned with clinical insight and involving service users. Phil is a chartered secretary by profession and is a sport and music enthusiast with a passion for the beauty of the natural world.

Michelle Carrington
Executive Director of Quality and Nursing

Michelle is a registered nurse with over 30 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.

Michelle joined the CCG in September 2014 as Head of Quality Assurance and has been the Executive Director of Quality and Nursing since March 2015.

Denise Nightingale
Executive Director for Transformation, Complex Care and Mental Health

Denise joins us from NHS Bassetlaw CCG where she was the Chief Nurse. Previously she has worked as an Executive in an acute setting. She has led a hospital re-provision and has undertaken significant service re-configurations. Denise has held roles in the Department of Health and within a Strategic Health Authority implementing the Choice and Independent Treatment Centre agendas.

Denise believes her current role in the CCG offers a real opportunity to deliver targeted improvements through working closely with local partners.

Dr Kev Smith
Executive Director of Primary Care and Population Health

Kev's expertise and leadership skills are charted throughout his career in senior roles including Principal Adviser to NHS England for Yorkshire and the Humber and as the national Medical Adviser for Specialised Services and Screening in the Department of Health. Kevin was also the head of the Healthcare team in Public Health England Yorkshire and the Humber where he has supported three local STP areas in their work to develop future models of health and care. Before working in public health, Kev worked in clinical medicine.

Kev was a Senior Lecturer at the School of Health and Related Research at Sheffield University, one of the largest and most dynamic Schools of health research in the UK. He continues to teach at universities in York, Leeds and Sheffield.

Dr Helena Ebbs
GP Representative for the North Locality

Helena has been a GP partner at Pickering Medical Practice since 2012. After graduating from Sheffield Medical School in 2003 she spent her first few years working in South Yorkshire in hospital medicine, before moving to North Yorkshire to train as a GP. She has an interest in mental health, frailty and rural general practice.

Dr Ruth Walker
GP Representative for the South Locality

Ruth graduated from Edinburgh Medical School in 1999 and came to York to complete her GP training. She has worked at Scott Road Medical Centre in Selby since 2004, initially as a salaried GP before becoming a partner in 2013. Ruth has special interests in mental health and health inequalities and enjoys her role teaching third-year medical students at Hull York Medical School.

Dr Andrew Field
GP Representative for the Central Locality to 6 September 2018

Andrew is a GP at York Medical Group.

Simon Bell
Chief Finance Officer from 30 July 2018

Simon joins the team from NHS Kernow CCG in Cornwall. He is a qualified accountant and graduate of the NHS Finance Management Training Scheme. He has worked in the NHS for more than twenty years across a number of provider and commissioning organisations including Chief Finance Officer roles in CCGs based in the South West of England.

Michael Ash-McMahon
Acting Chief Finance Officer from 30 April to 31 July 2018

Michael joined the NHS in 2001 through the NHS Financial Management Training Scheme, graduating in 2004. He spent two years working within Ernst and Young's healthcare consultancy team, working on large scale NHS projects with a range of organisations across the country.

Michael has built up nearly 18 years of NHS finance experience and has held several positions in acute provider organisations in the North West. Most recently Michael has been the CCG's Deputy Chief Finance Officer. He is a member of the Chartered Institute of Public and Finance and Accountancy.

Tracey Preece
Chief Finance Officer to 27 April 2018

Tracey joined the CCG as Chief Finance Officer in November 2013. She has almost 16 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.

David Booker
Lay Member and Chair of the Finance and Performance Committee

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, David helps to ensure the CCG is efficient and responsive and listens to the views of local stakeholders.

David has a special interest in promoting mental health services for children.

Keith Ramsay
Lay Member and Chair of the Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration 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.

As the lead for Patient and Public Involvement, Keith's role is to ensure that in all aspects of the CCG's business, the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG.

Phil Goatley
Lay Member and Chair of the Audit Committee from 3July 2018

Phil joined the CCG in July 2018 after serving as Humberside's Police Assistant Chief Officer between 1999 and 2017. During his 18 years at Humberside Police, Phil was responsible for all non-operational services.

Prior to that Phil briefly worked in banking before joining the public sector - joining the Audit Commission, where he specialised in value-for-money studies with a focus on policing. Phil has been committed to public services for most of his career and wanted to continue to put something back into the community following his retirement from Humberside Police in 2017. He has been married for 25 years and has a teenage son.

Dr Arasu Kuppuswamy
Secondary Care Governing Body Member to 30 March 2019

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.

Members in attendance

Sharon Stoltz
City of York Council Director of Public Health

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 National Midwifery Council.

Dr Aaron Brown
Local Medical Committee Liaison Officer for Selby and York

Aaron is a GP with the York Medical Group. He has been a member of YORLMC, the only statutory body with a duty to represent GPs at a local level. He became a member whilst a GP Registrar and was elected as Liaison Officer of the Vale of York Division in 2017.

Table 28: Governing Body Members

2.4 NHS Vale of York CCG Governance Structure

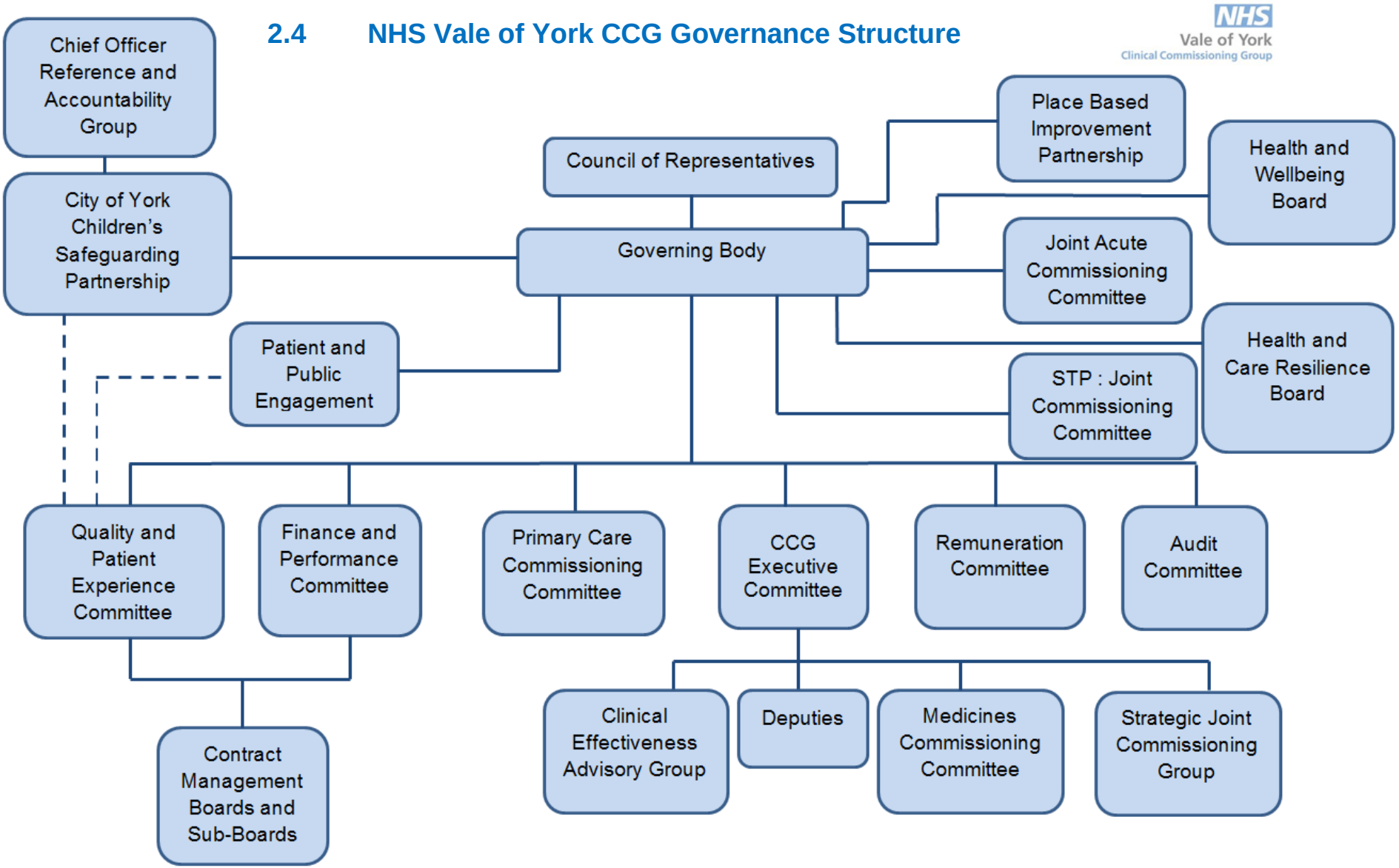


Figure 7 – NHS Vale of York CCG Governance Structure March 2019

2.5 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. Performance / highlights for each Committee are also captured in the table below.

Strategic committees	
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 through critically reviewing the CCG's financial reporting and internal control principles and ensuring an appropriate relationship with both internal and external auditors is maintained. 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 including counter fraud and security management and financial reporting. The Committee met six times in 2018-19 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, Audit Committee Chair to 31 May 2018 Phil Goatley, Lay Member and Audit Committee Chair from 3 July 2018 David Booker, Lay Member and Chair of Finance and Performance Committee Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member to 30 March 2019 **Performance / highlights** Review of Committee terms of reference and work plan Regular updates on key financial policies and progress against Financial Recovery Plan Regular updates on the Aligned Incentive Contract with York Teaching

	Hospital NHS Foundation Trust Review of draft Annual Report and Annual Accounts Regular assurance from internal and external audit on reports issued to management Approving internal audit and external audit plans Monitoring the implementation of audit recommendations Annual review of Internal Audit Charter and Working Together Protocol Review of Assurance Framework and Risk Register processes Development of a Board Assurance Framework (BAF) for implementation in early 2019-20 Review of Information Governance assurance Regular updates on counter fraud and security including approval of annual work plan and review of the organisation's annual self-assessment against NHS Counter Fraud Authority's Standards for Commissioners Review of primary care commissioning assurance Processes for review of Committee effectiveness, internal audit effectiveness, counter fraud and security effectiveness, and external audit effectiveness
Remuneration Committee	The Remuneration Committee makes recommendations to the Governing Body on: terms and conditions of employment for the CCG's Governing Body members; pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG; recruitment and retention premia and 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'; policies and instructions relating to remuneration; and any significant amendments to the terms and conditions of employment which affects all employees of the CCG generally (for example changes to the Agenda for Change terms and conditions). The Committee convened eight times in 2018-19 and was quorate on each occasion. **Members** Keith Ramsay, Lay Member and Chair of Remuneration Committee, Primary Care Commissioning Committee and Quality and Patient Experience Committee David Booker, Lay Member and Chair of Finance and Performance Committee

	Phil Goatley, Lay Member and Audit Committee Chair (from 3 July 2018) **Performance / highlights** Remuneration for appointment of Chief Finance Officer and arrangements for Acting Chief Finance Officer Changes relating to establishment of a clinically led Governing Body including Clinical Lead pay and performance Agenda for Change Pay Award 2018 and Implications Review of Executive Directors' remuneration and objectives Review of Committee terms of reference Remuneration for appointment of Executive Director of Primary Care and Population Health
Finance and Performance Committee	The paramount role of the Committee, which met 12 times in 2018-19 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. **Members** David Booker, Lay Member and Committee Chair Michael Ash-McMahon, Acting Chief Finance Officer (from 30 April to 31 July 2018) Simon Bell, Chief Finance Officer (from 30 July 2018) Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse Phil Mettam, Accountable Officer Denise Nightingale, Executive Director of Transformation, Complex Care and Mental Health Tracey Preece, Chief Finance Officer (to 27 April) Keith Ramsay, Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee Dr Kevin Smith, Executive Director of Primary Care and Population Health **In attendance** Caroline Alexander, Assistant Director of Delivery and Performance, for performance related items Phil Goatley, Lay Member and Audit Committee Chair (from 3 July 2018) Jon Swift, Director of Finance, NHS England North (or deputy) Dr Nigel Wells, CCG Clinical Chair

	Performance / highlights Monthly Financial Performance Report Development of and progress against the Financial Recovery Plan and towards a system approach Review of Committee terms of reference Progress reports towards and the establishment of an Aligned Incentive Contract with York Teaching Hospital NHS Foundation Trust Monitoring of progress against NHS constitutional targets including Child and Adolescent Mental Health Services, Improving Access to Psychological Therapies, dementia coding and cancer Monitoring of concerns relating to Continuing Health Care, Transforming Care and Section 117 Winter and resilience planning Recommendations for Primary Care Estates Capital Bids Procurements including Improving Access to GP Services and Anticoagulation Warfarin Monitoring and Management Service Promoting the role of the CCG as a key collaborative partner within the NHS regional system
Quality and Patient Experience Committee	The Quality and Patient Experience Committee, which meets bi-monthly, met six times in 2018-19 and was quorate on each occasion. 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. In line with the NHS Constitution, this also includes actively seeking patient feedback on health services and engaging with all sections of the population with the intention of improving services and, as a membership organisation, working with NHS England, to support primary medical and pharmacy services to deliver high quality primary care, including patient experience. **Membership** Keith Ramsay, Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee Jenny Brandom, Deputy Chief Nurse / Deputy Executive Director of Quality and Nursing Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse (Director with responsibility for quality and patient experience) Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire

	Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member to 30 March 2019 Dr Kevin Smith, Executive Director of Primary Care and Population Health Dr Nigel Wells, CCG Clinical Chair **In attendance** Victoria Binks, Head of Engagement Abigail Combes, Head of Legal and Governance Barry Dane, Healthwatch representative Karen Hedgley, Designated Nurse Safeguarding Children Christine Pearson, Designated Nurse Safeguarding Adults Gill Rogers, Patient Experience Officer Debbie Winder, Head of Quality Assurance and Maternity Co-opted member of Scarborough Ryedale CCG as required **Performance / highlights** Patient stories Quality and Patient Experience Report Safeguarding Adults and Children updates Review of patient experiences during winter Review of Committee terms of reference Draft Patient and Public Participation Annual Report Quality Assurance Strategy 2018-2021 The role of Medicines Management in supporting the CCG Quality Strategy Children and Young People's Mental Health Services Dementia Services District Nursing – Large Scale Change Special School and Children's Community Nursing Transformation Plan The Vale of York and Scarborough Ryedale CCG Infection Prevention Strategy Terms of Reference for the Vale of York End of Life and Palliative Care Group
Primary Care Commissioning Committee	The Primary Care Commissioning Committee met six times in public and was quorate on each occasion. **Membership** (from the CCG unless otherwise stated) Keith Ramsay, Lay Member and Chair of Primary Care Commissioning

	Committee, Quality and Patient Experience Committee and Remuneration Committee Michael Ash-McMahon, Acting Chief Finance Officer (from 30 April to 31 July 2018) Simon Bell, Chief Finance Officer (from 30 July 2018) David Booker, Lay Member and Chair of Finance and Performance Committee Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse (to May 2018) Chris Clarke, Senior Commissioning Manager, NHS England North Region (Yorkshire and the Humber) (from 1 March) Phil Goatley, Lay Member and Audit Committee Chair (from 3 July 2018) Heather Marsh, Head of Locality Programmes, NHS England – North (Yorkshire and the Humber) (to 24 January 2019) Phil Mettam, Accountable Officer Tracey Preece, Chief Finance Officer (to 27 April 2018) Dr Kevin Smith, Executive Director of Primary Care and Population Health **In attendance** Nigel Ayre, Healthwatch North Yorkshire representative Kathleen Briers / Lesley Pratt, Healthwatch York representative Dr Aaron Brown / Dr David Hartley, Selby and York Local Medical Committee representative Shaun Macey, Head of Transformation and Delivery Sharon Stoltz, Director of Public Health, City of York Council Standing attendees (non-voting) also include up to two GPs from each locality and a Practice Manager, the latter has not attended to date. **Performance / highlights** Regular updates on General Practice visits and engagement Approved plans from Central and North Localities for 2018-19 Personal Medical Services premium and £3 / head transformation funding Updates and assurance relating to the Care Quality Commission Unity Health Inspection Report Primary Care Estates Capital Bid North Yorkshire and York Screening and Improvement Plan General Practice Health and Social Care Network migration and General Practice public access WiFi updates Local Enhanced Services review Updates on Improving Access to General Practice services at evenings and weekends

	Primary Care Commissioning Committee Annual Chair's Report GP Patient Survey Results – Data collected between 2 January 2018 to 6 April 2018 from patients aged 16+ registered with a GP Practice in England Review of Committee terms of reference Establishment of protected learning time for clinical General Practice staff Primary Care update from NHS England North

Table 29 - Committee roles and performance

2.6 Remuneration Committee

Name	Role	Membership from	Attendance
Keith Ramsay	Lay Member and Chair of Remuneration Committee, Primary Care Commissioning Committee and Quality and Patient Experience Committee	1 April 2018	8/8
David Booker	Lay Member and Chair of Finance and Performance Committee	1 April 2018	8/8
Phil Goatley	Lay Member and Chair of Audit Committee	3 July 2018	4/6

Table 30 - Remuneration Committee membership

2.6.1. Non Remuneration Committee member attendances

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

Holly Tetley, Human Resources Business Partner, eMBED Health Consortium, attended seven meetings in the capacity of external adviser.

Stacey Oglesby, Human Resources Manager, eMBED Health Consortium, attended three meetings in the capacity of external adviser.

Helen Darwin replaced Holly Tetley as Human Resources Business Partner, eMBED Health Consortium from 20 February 2019 and attended one meeting in the capacity of external adviser.

Holly Tetley, Helen Darwin and Stacey Oglesby also provided a range of general HR advice to the CCG during the 2018-19 financial year. They were employed by eMBED Health Consortium who 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.

Phil Mettam, Accountable Officer, attended all but two meetings.

Dr Kevin Smith, Executive Director of Primary Care and Population Health, attended one meeting for a specific item.

Abigail Combes, Head of Legal and Governance, attended one meeting.

2.7 Register of Interests

All CCG staff are required to complete a declaration of interests form on an annual basis. Should their circumstances change and a conflict arise, they are asked to complete a new form within 28 days of becoming aware of the conflict. The CCG's registers of interest are reviewed monthly and published at http://www.valeofyorkccg.nhs.uk/about-us/our-registers-of-interest/ .

2.8 Personal data related incidents

There has been one data security incident that has been reported to the Information Commissioner's Office, relating to the inadvertent release of the names and addresses of 13 patients to another patient. The information received in error was immediately destroyed.

2.9 Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report;

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

2.10 Modern Slavery Act 2015

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

2.11 Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England appointed the Accountable Officer, Phil Mettam as the Accountable Officer for NHS Vale of York CCG.

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, and subject to the disclosures set out below), 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.

Disclosures:

- The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2018-19 expenditure performance is £18.6m 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 January 2019 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.

2.12 Governance Statement

2.12.1 Introduction and context

NHS Vale of York CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).
The clinical commissioning group'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.

As at 1 April 2018, the clinical commissioning group is subject to directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 as follows: The CCG was placed under legal directions in 2016 with a number of provisions including the appointment of an Accountable Officer, changes to governance arrangements and the stabilisation of the financial position. The full text of the directions can be seen on the NHS England website: https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions/

While the CCG has met the requirements of the directions with regard to the appointment of an Accountable Officer and the governance arrangements, the deficit total required under the directions forms part of a longer-term financial recovery plan.

2.12.2 Scope of responsibility

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

2.12.3 Governance arrangements and effectiveness

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

Further details of the work of the CCG's Governing Body and its Committees, as well as it Council of Representatives (membership body) can be found in the Members Report on page 82.

2.12.4 UK Corporate Governance Code

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

2.12.5 Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

2.12.6 Risk management arrangements and effectiveness

The CCG has a Risk Management Strategy which includes a risk appetite statement set by the CCGs Governing Body. Risks are grouped into four areas which enable staff to understand and monitor those areas which the organisation highlights as significant areas of risk for the organisation:

- finance
- quality and safety
- compliance
- service delivery

This focuses the minds of the CCG officers when identifying risks. The risks are described and rated according to likelihood and impact and given an overall score. The CCG has historically used those high scoring risks as an escalation matrix ensuring that the highest

scoring risks are presented regularly to committees and ultimately Governing Body. In 2019 the CCG is moving to a different scheme of escalation where the risks will be escalated when there is a requirement for intervention from the committees.

An example of how the new process will be different relates to a risk which has been on the register for a long period of time that the CCG will not make a financial surplus this financial year. This is currently reported through to finance and performance committee as a result of the score which it receives. In reality there is very little that finance and performance committee can do to mitigate this risk and simply being aware of it is not sufficient for pro-active risk management. For that reason all risks relating to finance (including this one) will be seen twice a year however those going to committee will be with a request for the committee to take some action. This will enable the committees to actively manage the risks reported to them and empower staff to manage the risks that are not.

Risk is identified by individual officers with reference to the strategy. The evaluation and control is done by the individual in conjunction with an Executive Director, their line manager and the CCG's governance team.

Risk is also proactively managed through the CCG's impact assessment work. A Quality Impact Assessment, Equality Impact Assessment and Privacy Impact Assessment are carried out on all business cases for change. These documents are completed by those with the expertise to complete them and highlight and identify risks as a working document and early enough to inform decision making about how much risk the organisation is prepared to tolerate.

The CCG's risk appetite was determined by working through a number of scenarios with the CCGs Governing Body members to assess their tolerance as a group. This was then described and the description was approved by the Governing Body. This will be reviewed and renewed in May 2019.

Where a business case suggests a change of approach in the CCG, the CCG will assess whether public consultation is required in accordance with legislation and NHS Engand guidance. Where consultation is required the CCG will engage public stakeholders by describing the changes including identified risks and seeking views on these. This would include alternative ideas.

The CCG is moving to consider where choice is to be offered to patients in accordance with their constitutional rights and where policies might change the choice available (for example, the issue relating to the treatment of wet AMD in the North Eastern CCG areas) the CCG will need to provide information to the public attached to that policy to enable them to understand the risks and benefits of those choices and make decisions accordingly. NHS Vale of York CCG anticipates taking this approach going forward.

2.12.7 Capacity to handle risk

The CCG risk management process requires that an Executive Director is assigned to each risk contained on the register. Risks are currently escalated according to the score they receive and the escalation process is to committee and ultimately to Governing Body. The reporting lines and accountability are clearly set out in both the Risk Management Strategy and the Terms of Reference for each of the Committees.

Staff training was provided in 2017-18 in relation to Risk following the production of the Risk Appetite Statement and Strategy. This will be refreshed in July – September 2019 following revision of the statement and changes to process. Staff will also be encouraged to attend Committees to seek support on managing risks themselves rather than a paper report being the primary means of communicating risk with a committee.

The CCG Governance Team will take a more proactive role in the day to day oversight of risk and the decisions regarding escalation and reporting. The Governance Team will provide guidance and advice to staff to support them in the process of managing risk and to identify and learn from both good and bad practice.

2.12.8 Risk assessment

The CCG has improved its risk profile and management of risk over the last twelve months, including a programme of actively archiving risks which have not been proactively managed for some time and have remained consistent in terms of the rating which they have been given.

The major risks to governance include decisions made out with the scheme of delegation in a period of extreme pressure such as decisions regarding acute commissioning made by groups which have no formal delegation but are made by senior individuals who would on their own have the appropriate delegation to make decisions.

The CCG officers still require support and advice in relation to the reporting and management of risk and this is a role which the Governance Team are performing. Risks should be escalated where the escalation is required for additional support and this will be the case in the new system. The CCG works on a programme of action plans for the most significant risks which staff are supported to work through, this has resulted in a number of risks being archived successfully this financial year.

Key risks as at March 2018-19 include:

- Risk of failure to deliver 1% in-year surplus;
- Risk of failure to maintain expenditure within allocation;
- Waiting times for children’s and adolescents’ mental health services and children and young people’s eating disorder services;
- Waiting times for autism assessments.

2.12.9 Other sources of assurance

2.12.9.1 Internal control framework

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

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

The CCG has assigned both internal and external auditors to provide the Governing Body with independent assurance of its process of internal control and to assure itself of the validity of this Governance Statement.

Throughout the year a series of audits continue to be undertaken to review the effectiveness of governance systems. The finalised reports and agreed action plans from these audits are submitted to the Audit Committee. All audit reports contain action plans of work required as a result of the review findings. All actions are assigned to a senior manager with responsibility to complete within the designated timescales.

2.12.9.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs 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 its annual internal audit review of conflicts of interest and received the view that substantial assurance can be given to the CCG's arrangements. Some minor changes to the format of reporting templates are required as well as ensuring that one declaration was updated.

2.12.9.3 Data quality

The CCG receives a business intelligence service via eMBED Commissioning Support, with data checked and validated internally. The Governing Body and Committee reports were reviewed during 2018-19 and no concerns have been raised regarding data quality. The format of reporting is reviewed on a regular basis to ensure that data is reported to the levels of detail required.

2.12.9.4 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. This year, the former IG Toolkit has been replaced by the Data Security and Protection (DSP) Toolkit and the CCG has met the standards required.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit.

The CCG has ensured all staff undertook annual information governance training and has implemented a staff information governance suite of policies to ensure that staff are aware of their information governance roles and responsibilities.
There are processes in place for incident reporting and investigation of serious incidents. The CCG is developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.12.9.5 Business Critical Models

The CCG has reviewed the MacPherson report on government analytical models and has concluded that it does not currently create any analytical models that fit the criteria within that report and would therefore need to be notified to the Analytical Oversight Committee.

2.12.9.6 Third party assurances

The CCG requests service auditor's reports from its third party providers for those providers it engages with directly. Where contracts are managed nationally by NHS England the Service Auditor's Reports are made available to CCGs via the NHS England SharePoint site. The Service Auditor's Reports are also made available to the CCGs external auditors as part of the year-end audit.

2.13 Control issues

The CCG did not meet its requirement to ensure that expenditure in-year before Commissioner Sustainability Funding is no worse than an overspend of £14m. The CCG agreed a financial plan and control total to deliver no worse than a £14m deficit. However, at Month 6 it became clear that this was not achievable, and the position deteriorated by £6m to an £18.6m forecast outturn deficit (as actual expenditure was in line with plan at Q1, CSF at £1.4m was earned). The CCG has since undertaken and delivered a number of actions to ensure this position was maintained through the year and has delivered this as at the end of the financial year.

- The CCG has ensured that NHS England has been fully involved throughout the year, as has the CCG's Finance and Performance Committee, Audit Committee, Executive Committee and Governing Body.
- An external review of the Aligned Incentive Contract was undertaken in order to explore areas for development in future planning.
- Additional Financial Recovery Actions were put in place to ensure the delivery of the revised forecast deficit and have been monitored on a regular basis.
- The CCG has implemented a new system for the management, monitoring and reporting of Continuing Health Care, Funded Nursing Care, Personal Health Budgets, mental health aftercare and neurological rehabilitation. Further updates to this system will be rolled out during 2019-20.
- A number of changes have been made to internal processes around planning, internal control, and forecasting.
- The CCG continues to manage the financial consequences of the final financial reconciliation work previously undertaken by the Partnership Commissioning Unit hosted by NHS Scarborough and Ryedale CCG with regard to delivering Continuing Health Care operations to the CCG up to February 2018. This was a significant part of the Month 6 financial deterioration in the CCG's forecast financial position related to unpaid bills identified by NHS Scarborough and Ryedale CCG following the closure of the Partnership Commissioning Unit that impacted across the four North Yorkshire CCGs. The impact on this CCG was £1m. The mitigations described above impact on this area as well and build on the CCG's decision to in-house this service completely rather than outsourcing to other organisations.
- The CCG continues to work through the resolution of historic operational issues from the Partnership Commissioning Unit hosted by the Scarborough and Ryedale CCG with regard to delivering Continuing Health Care operations to the CCG up to February 2018 in terms of compliance with national guidelines and processes, performance management and delivery of the Continuing Health Care Assessment Tool requirements. The CCG has taken a number of significant steps to resolve this

which will impact at various points in the future, although there may continue to be some historic impact to this as the CCG implement the improvements, in particular:

- The CCG has in-housed this service to ensure it is closer to the control of operational and performance management.
- The CCG has established a project-team to deliver a comprehensive service improvement programme.
- The CCG has implemented a new iQA+ software system for the management of packages of care in a fit for purpose way.
- The CCG is recruiting to and supporting the training and development of the Continuing Health Care administrative and nursing teams.

2.14 Review of economy, efficiency and effectiveness of the use of resources

During 2018-19 the CCG's overall financial performance, including the key statutory financial duties measures, was monitored and managed on a regular basis by 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.

The CCG has continued to deliver its duties in relation to finance, delivery and governance throughout 2018-19 without any external intervention from NHS England and the CCG's leadership team has continued to achieve improved financial stability with a year-end deficit of £18.6m, an improvement on the 2017-18 deficit of £20.1m.

The CCG's financial plan was an in-year deficit of £14.0m and several financial pressures materialised in year leading to an increased deficit. These additional financial pressures were identified, quantified and reported through the CCG's financial governance process and a series of Financial Recovery Actions were agreed and implemented by the CCG's Executive Committee. Delivery against each of these recovery actions was reported to the Finance and Performance Committee each month.

The CCG's opening underlying position for 2018-19 was a deficit of £21.7m and the exit underlying position has improved to a deficit of £20.5m which is included within the financial plan for 2019-20. This is the second year of improvement in the underlying position which demonstrates the impact of stabilising the CCG's financial position.

The CCG implemented a joint Financial Recovery Board with NHS Scarborough and Ryedale CCG during 2018-19 in order to closely monitor delivery against the Quality, Innovation, Productivity and Prevention programme. The CCG has delivered 54% of its planned Quality, Innovation, Productivity and Prevention programme, equating to savings of £7.8m in-year.

The CCG's internal audit function has carried out annual audits covering contract management, budgetary control and reporting and key financial controls. At the time of writing the audit outcomes are to be finalised. The CCG received 'significant assurance' in all of these areas in 2017-18 and anticipates the same level of assurance in 2018-19.

Additionally, the CCG Leadership team is jointly developing a five-year financial recovery plan with NHS Scarborough and Ryedale CCG and provider partners across the Vale of York and Scarborough and Ryedale footprint. This should provide a strong foundation to bring the local health economy back into financial balance by 2022-23.

The published CCG quality of leadership indicator for 2017-18 was 'Requires Improvement' and this remains the same throughout 2018-19 until the 2018-19 annual Quality of Leadership assessment is reviewed and formal notification given. This is expected by end of Q1 (July 2019).

The results for the Quality of Leadership indicator will be available from July 2019 at https://www.nhs.uk/service-search/performance/search

2.15 Delegation of functions

The CCG has not delegated any of its functions during the 2018-19 financial year.

2.16 Counter fraud arrangements

The CCG has an accredited Counter Fraud Specialist that is contracted to undertake counter fraud work proportionate to identified risks. In January 2019, NHS Counter Fraud Authority issued Standards for commissioners – fraud, bribery and corruption to Counter Fraud Specialists and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. The work plan for 2018-19 followed the format of these standards and described the tasks and outcomes which informed anti-fraud activity during 2018-19. The standards are listed below.

- Strategic governance – sets out the requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-crime measures are embedded at all levels across the organisation.
- Inform and Involve - this sets out the requirements in relation to raising 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 - this sets out the requirements in relation to discouraging individuals who may be tempted to commit crime against the NHS and ensuring that opportunities for crime to occur are minimised.

- Hold to Account – sets out the requirement in relation to detecting and investigating crime, prosecuting those who have committed crime and seeking redress.

The Chief Finance Officer is proactively and demonstrably responsible for tackling fraud, bribery and corruption. In November 2018 the Audit Committee requested an effectiveness review of the CCGs internal audit and counter fraud functions. The effectiveness survey is intended to help the CCG to ensure counter fraud resources are used effectively and to test perceptions of the CCG's overall arrangements for preventing and detecting fraud and corruption. The outcome will be reported back to the Audit Committee.

The CCG's counter fraud arrangements are in compliance with NHS Counter Fraud Authority's Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the appointment of accredited local counter fraud specialists, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud.

The CCG's Audit Committee reviews and approves an annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Chief Finance Officer and Audit Committee.

The Counter Fraud Team also completes an annual self-assessment of compliance against the NHS Counter Fraud Authority Standards for commissioners: fraud, bribery and corruption, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to NHS Counter Fraud Authority. The 2017-18 assessment was completed and submitted in March 2018 with an overall assessment of green and this task will be undertaken in April 2019 for counter fraud work undertaken in 2018-19.

2.17 Head of Internal Audit Opinion

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

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 2019

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 the 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.

My opinion is set out as follows:

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

My **overall opinion** is that

- ***Significant assurance*** **can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some 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.

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

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

A risk update report is presented to each meeting of the Governing Body to provide assurance that risks are strategically managed, monitored and mitigated. 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. In 2018/19 the CCG put in place a Board Assurance Framework and a redesign of their Risk Register reporting.

Internal Audit reviewed the CCG's governance arrangements during 2018/2019 and gave it significant assurance. The audit found that the CCG implemented governance arrangements that support accountability, transparent decision making, management of potential conflicts of interest and management of risk. An effective framework had been developed for providing assurance to the Governing Body on the management of risk to its objectives.

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

The 2018/19 Internal Audit Plan was approved by the Audit Committee on 7th March 2018. The work of Internal Audit continues to focus on the design and embedding of core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

- Governance and Risk Management
- Quality and Safety
- Commissioning
- Stakeholders and Partnerships
- Financial Governance
- Information Governance

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

Opinion Level	Opinion Definition	Guidance on Consistency
HIGH (STRONG)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.	The system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. Controls are operating effectively and consistently across the whole system. There are likely to be core controls fundamental to the effective operation of the system. A High opinion can only be given when the controls are working well across all core areas of the system. For example with 'Debtors' the controls over identifying income, raising debt, recording debt, managing debt, receiving debt, etc. are all working effectively – there are no serious concerns. Note this does not mean 100% compliance. There could be some minor issues relating to either systems design or operation which need to be addressed (and hence the report may include some recommendations) – however these issues do not have an impact on the overall effectiveness of the control system and the delivery of the system's objectives.

Opinion Level	Opinion Definition	Guidance on Consistency
SIGNIFICANT (GOOD)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.	The system is generally well designed - but there may be weaknesses in the design of the system that need to be addressed. In addition most core system controls are operating effectively – but some may not be. Whilst any weaknesses may be significant they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.
LIMITED (IMPROVEMENT REQUIRED)	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.	The system is operating in part but there are notable control weaknesses. There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved. In terms of what differentiates a borderline Significant Opinion to a borderline Limited opinion – the main factors are the scale and potential impact of weaknesses found. Multiple weaknesses across a range of core areas would suggest a Limited Opinion level is applicable. However it also true that ONE weakness can suggest a Limited Opinion if it is fundamental enough to mean that a number of core system objectives will not be achieved.

Opinion Level	Opinion Definition	Guidance on Consistency
LOW (WEAK)	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 system's objectives.	The audit has found that there are serious weaknesses in either design or operation that may mean that the overall system objectives will not be achieved and there are fundamental control weaknesses that need to be addressed. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses. The report will clearly state if 'No Assurance' is actually more applicable than low assurance.

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 Follow Up Section is included within our Progress Report 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. No advisory work was requested during 2018/19.

The outcome of the assurance audit reports as at 15 May 2019 from the 2018/2019 audit plan are summarised below.

Audit Area	Assurance Level
Conflicts of Interest	Significant
Governance Arrangements/ Risk Management	Significant
Quality Impact Assessment	Significant
Safeguarding	Significant
Community Paediatrics Commissioning	Limited
Acute Transformation/Joint Commissioning	Limited
Contract Management	Draft (Significant assurance)
Financial Recovery & QIPP	Draft (Significant assurance)
Budgetary Control, Financial Reporting and Key Financial Systems	High
Data Security & Protection Toolkit	Significant

Taking into account the internal audit work completed, all of my findings and the CCG's actions to date in response to my recommendations, areas of control weakness to be noted are:

Joint Commissioning Audit

- In Summer 2018 NHS Scarborough and Ryedale Clinical Commissioning Group, NHS Vale of York Clinical Commissioning Group, NHS East Riding of Yorkshire Clinical Commissioning Group and York Teaching Hospital NHS Foundation Trust (YTHFT) signed a variation agreement putting in place an Aligned Incentive Contract (AIC). This York – Scarborough recovery and transformation programme worked across the place-based strategies of the respective CCG systems and the acute transformation programme across the planning footprint of YTHFT.

- An audit took place in 2018/19 which reviewed the new AIC governance arrangements with an objective to provide assurance on the arrangements in place to support this acute system transformation. The audit found that key governance arrangements had not been fully implemented. These audit findings will remain relevant for subsequent development planning between the CCGs and the Trust in 2019/20.

Community Paediatrics Commissioning

- The CCG commissioning arrangements for the Children's Community Nursing and Specialist School Nursing services require strengthening by establishing a service specification in collaboration with York Teaching Hospital Foundation Trust (YTHFT), with agreed service outcomes and quality measures.
- Currently no final up to date version of a service specification is in place at the CCG, which outlines service delivery requirements.
- No assurance mechanisms are in place to demonstrate that legislation and standards are being met.
- Commissioning arrangements in place with YTHFT for Children's Community Nursing and Specialist School Nursing so not outline clear measurable outcomes for delivery
- No monitoring and reporting arrangements are in place to provide assurance to the CCG on the quality of service delivery
- There is currently no established reporting of quality assurance to the CCG Quality and Patient Experience Committee

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
15 May 2019

Section three

Remuneration and Staff Report

Phil Mettam

Accountable Officer

24 May 2019

3.1 Remuneration Committee

Details of the work and membership of the remuneration committee can be found in the members report at page 82.

3.1.1 Policy on the remuneration of senior managers

The policy for the remuneration of senior managers was operated in accordance with Agenda for Change and it is intended to continue with this policy for future years. The pay for chief officers is in accordance with national guidance and is benchmarked nationally.

3.1.2 Remuneration of Very Senior Managers

Very Senior Managers' pay rates are set by taking into account the guidance from NHS England on the Pay Framework for Very Senior Managers in CCGs. Independent HR advice has been provided to the Remuneration Committee from an HR Director contracted from eMBED Health Consortium.

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, the account taken of the prevailing financial position of the wider NHS and the need for pay restraint by 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 2018-19

Table 31 - Senior Manager Remuneration (including salary and pension benefits) 2018-19

2018-19						
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
Dr N Wells - Clinical Chair - see (a)	110-115	0			0	110-115
P Mettam - Accountable Officer	125-130	0			105-107.5	230-235
T Preece - Chief Finance Officer (to 27 April 2018)	10-15	0			0	10-15
M Ash-McMahon - Acting Chief Finance Officer (from 30 April 2018 to 31 July 2018)	20-25	0			5-7.5	25-30
S Bell - Chief Finance Officer (from 30 July 2018)	75-80	0			12.5-15	90-95
M Carrington - Executive Director of Quality and Nursing	85-90	0			45-47.5	135-140
D Nightingale - Executive Director of Transformation	65-70	0			20-22.5	85-90
Dr K Smith - Executive Director of Primary Care and Population Health (to 31 March 2019) - see (b)	130-135	0			190-192.5	320-325
K Ramsay - Lay Member and Governing Body Chair	10-15	0			0	10-15
D Booker - Lay Member and Finance and Performance Committee Chair	10-15	500			0	10-15
S Powell - Audit Committee Chair (to 31 May 2018)	0-5	0			0	0-5
P Goatley - Lay Member and Audit Committee Chair (from 3 July 2018)	5-10	0			0	5-10
Dr A Kuppuswamy - Secondary Care Doctor Governing Body Member (to 30 March 2019) - see (c)	5-10	0			0-2.5	10-15
Dr H Ebbs - North Locality GP Governing Body member - see (a)	5-10	0			0	5-10
Dr A Field - Central Locality GP Governing Body Member (to 6 September 2018) - see (a)	0-5	0			0	0-5
Dr R Walker - South Locality GP Governing Body member - see (a)	10-15	0			0	10-15

NB all senior managers are continuing except where stated.

(a) Dr N Wells, Dr H Ebbs, Dr A Field and Dr R Walker are engaged under contract for services arrangements. Under this arrangement they are afforded Practitioner status for pension purposes. The amount included in the salary column above includes the CCG's employer pension contributions. These engagements are paid through the CCG's payroll with taxation and national insurance deducted at source.

(b) Dr K Smith is in post on a secondment arrangement from Public Health England.

(c) Dr A Kuppuswarmy was employed by the CCG via secondment arrangements from other NHS organisations on a part time basis. The remuneration values above relate to his role at the CCG and have been prepared on a pro-rata basis.

(d) The expenses payments disclosed above relate to travel expenses.

(e) Co-opted members of the governing body are non voting members and do not receive remuneration for their role. Co-opted members have therefore been excluded from the table above, however they appear in the 2017-18 comparator table.

(f) All figures in the table above are pro-rata where the senior manager has not been in post for the full year.

(g) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

3.3 Senior Manager Remuneration 2017-18

2017-18						
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
K Ramsay - Chair	15-20	0			0	15-20
P Mettam - Accountable Officer	120-125	0			20-22.5	145-150
T Preece - Chief Finance Officer	95-100	0			17.5-20	115-120
R Potts - Executive Director of Planning and Governance (to 30 September 2017)	35-40	0			0	35-40
M Carrington - Executive Director of Quality and Nursing	80-85	0			47.5-50	130-135
D Nightingale - Executive Director of Transformation and Delivery (from 10 July 2017)	50-55	0			45-47.5	95-100
K Smith - Executive Director of Primary Care and Population Health (from 1 October 2017) - see (c)	0	0			0	0
E Wyllie - Interim Executive Director of Joint Commissioning (to 5 April 2017) - see (a)	0-5	0			0	0-5
Dr S O'Connell - Joint Medical Director	130-135	0			45-47.5	180-185
Dr A Phillips - Joint Medical Director	130-135	0			25-27.5	155-160
Dr T Maycock - Clinical Director (to 31 August 2017)	25-30	0			5-7.5	30-35
Dr E Broughton - Clinical Director	60-65	0			12.5-15	70-75
Dr L Barker - Clinical Director	65-70	0			25-27.5	90-95
S Powell - Lay Member and Audit Committee Chair	10-15	400			0	10-15
D Booker - Lay Member and Chair of Finance and Performance Committee	10-15	200			0	10-15
Dr P Evans - GP, Council of Representatives Member	10-15	0			42.5-45	55-60
Dr A Calder - GP, Council of Representatives Member	5-10	0			0	5-10
Dr A Kuppuswamy - Secondary Care Doctor Governing Body Member - see (d)	10-15	0			2.5-5	10-15
Dr J Lethem - Local Medical Committee Liason Officer, Selby and York (Co-opted) (to 2 September 2017) - see (b)	0	0			0	0
Dr A Brown - Local Medical Committee Liason Officer, Selby and York (Co-opted) (from 3 September) - see (b)	0	0			0	0
S 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) E Wyllie was engaged through an off payroll arrangement with her remuneration paid through a contract with a corporate body. Remuneration shown above reflect 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 K Smith is in post on a secondment arrangement from Public Health England on a part time basis, and remuneration shown above reflects the gross payments to that body. The CCG did not receive his closing pension figures in line with the required timescales, and his pension related benefits are currently shown as zero.

(d) A Kuppuswamy was employed by the CCG via a secondment arrangement from another NHS organisation on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer. The CCG did not receive details of his employee pension contributions in line with the required timescales, and therefore his pension related benefits are shown gross of these contributions.

Table 32 - Senior Manager Remuneration (including salary and pension benefits) 2017-18

3.4 Pension benefits as at 31 March 2019

Table 33 - Pension benefits as at 31 March 2019

2018-19								
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019) (bands of £5,000	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
P Mettam - Accountable Officer	5-7.5	15-17.5	40-45	125-130	756	184	981	0
T Preece - Chief Finance Officer (to 27 April 2018)	0	0	25-30	55-60	347	43	402	0
M Ash-McMahon - Acting Chief Finance Officer (from 30 April 2018 to 31 July 2018)	0-2.5	0-2.5	15-20	40-45	248	3	277	0
S Bell - Chief Finance Officer (from 30 July 2018)	0-2.5	0	40-45	95-100	604	62	727	0
M Carrington - Executive Director of Quality and Nursing	2.5-5	7.5-10	30-35	100-105	537	109	674	0
D Nightingale - Executive Director of Transformation	0-2.5	2.5-5	40-45	130-135	947	0	0	0
Dr K Smith - Executive Director of Primary Care and Population Health (to 31 March 2019) - see (b)	7.5-10	10-12.5	45-50	60-65	435	182	649	0
Dr A Kuppuswamy - Secondary Care Doctor Governing Body Member (to 30 March 2019) - see (c)	0-2.5	0	20-25	40-45	262	46	331	0

(a) Dr N Wells, Dr H Ebbs, Dr A Field and Dr R Walker are engaged under contract for services arrangements. Under this arrangement they are afforded Practitioner status for pension purposes and the pension disclosures above do not apply to their role with the CCG.

(b) Dr K Smith is in post on a secondment arrangement from Public Health England.

(c) Dr A Kuppuswarmy was employed by the CCG via secondment arrangements from other NHS organisations on a part time basis. The pension benefits above relate to the total employment contract with the host employer.

(d) The pension benefits and related CETVs disclosed in the above table do not allow for a potential future adjustment arising from the McCloud judgement.

3.5 Pension benefits as at 31 March 2018

Table 34 - Pension benefits as at 31 March 2018

2017-18								
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019) (bands of £5,000	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
P Mettam - Accountable Officer	0-2.5	5-7.5	35-40	105-110	676	73	756	0
T Preece - Chief Finance Officer	0-2.5	0	20-25	55-60	303	36	342	0
R Potts - Executive Director of Planning and Governance (to 30 September 2017) - see (d)	0-2.5	0-2.5	40-45	125-130	799	0	0	0
M Carrington - Executive Director of Quality and Nursing	2.5-5	7.5-10	30-35	90-95	456	76	537	0
D Nightingale - Executive Director of Transformation and Delivery (from 10 July 2017)	0-2.5	5-7.5	40-45	120-125	842	70	947	0
K Smith - Executive Director of Primary Care and Population Health (from 1 October 2017) - see (c)	0	0	0	0	0	0	0	0
Dr S O'Connell - Joint Medical Director	2.5-5	0-2.5	20-25	45-50	309	50	363	0
Dr A Phillips - Joint Medical Director	0-2.5	5-7.5	15-20	45-50	267	48	317	0
Dr T Maycock - Clinical Director (to 31 August 2017)	0-2.5	0	10-15	25-30	172	21	194	0
Dr E Broughton - Clinical Director	0-2.5	0-2.5	15-20	45-50	228	16	247	0
Dr L Barker - Clinical Director	0-2.5	0-2.5	10-15	20-25	116	19	136	0
Dr P Evans - GP, Council of Representatives Member	0-2.5	0-2.5	15-20	35-40	234	34	270	0
Dr A Calder - GP, Council of Representatives Member	0	0	0	0	0	0	0	0
Dr A Kuppuswamy - Secondary Care Doctor Governing Body Member - see (b)	0-2.5	0	20-25	40-45	236	2	262	0

(a) E Wyllie was engaged through an off payroll arrangement is not a current member of the NHS Pension scheme.

(b) A Kuppuswarmy was employed by the CCG via a secondment arrangement from another NHS organisation on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer.

(c) Dr K Smith is in post on a secondment arrangement from Public Health England on a part time basis, and remuneration shown above reflects the gross payments to that body. The CCG did not receive his closing pension figures in line with the required timescales, and his pension related benefits are currently shown as zero.

(d) R Potts retired on 30 September 2017 and claimed pension benefits. There is no closing Cash Equivalent Transfer Value to disclose.

3.6 Cash equivalent transfer values

A cash equivalent transfer value 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 cash equivalent transfer value 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 cash equivalent transfer value 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. Cash equivalent transfer value s are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

3.6.1 Real increase in cash equivalent transfer value

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

3.6.2 Compensation on early retirement or for loss of office

The CCG made payments for loss of office to two senior managers in 2018-19. The details of these payments are shown below.

Payment (£)	Basis for payment value
129,155	Payment of pension benefits in accordance with statutory NHS Pensions Scheme regulations as a result of compulsory redundancy.
16,575	Redundancy payment in line with individual's contract of employment based on reckonable service.

Table 35 - Compensation for loss of office

3.6.3 Payments to past members

There have been no payments to past members in 2018-19.

3.6.4 Pay multiples

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

The banded remuneration of the highest paid director in the CCG in the financial year 2018-19 was £175k - £180k (2017-18: £165k – 170k). This was 5.34 times (2017-18: 5.28) the median remuneration of the workforce, which was £33,222 (2017-18: £31,697).

The movement in the highest paid director's remuneration for 2018-19 was as a result of the Governing Body restructure which came into effect from 1 April 2018.

In 2018-19, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £15k - £20k to £130k - £135k (2017-18: £10k - £15k to £130k - £135k).

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

Pay band	Total
Band 8a	9
Band 8b	8
Band 8c	3
Band 8d	5
Band 9	0
VSM	3
Governing body	6
Any other Spot Salary	2

Table 36 - Senior managers by band

3.7.2 Staff numbers and costs

	2018-19			2017-18
	Permanently employed Number	Other Number	Total Number	Total Number
Total	**115**	**6**	**121**	**116**
Of the above: Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

Table 37 - Staff numbers

3.7.3 Salaries and wages

	2018-19		
	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	4,732	434	5,166
Social security costs	477	0	477
Employer contributions to NHS Pension scheme	597	0	597
Apprenticeship Levy	6	0	6
Termination benefits	87	0	87
Total employee benefits expenditure	**5,899**	**434**	**6,333**

Table 38 - Salaries and wages

3.7.4 Staff composition

Gender	Total (Female)	Total (Male)
Band 8a	6	3
Band 8b	5	3
Band 8c	3	0
Band 8d	3	2
Band 9	0	0
VSM	1	2
Governing body	2	4
Any other Spot Salary	0	2
All other employees (including apprentice if applicable)	0	0
Total	**20**	**16**

Table 39 - Staff composition

3.7.5 Sickness absence data

Level of absence for last 12 months (days)	%	Full Time Equivalent of Days Lost
2,416	**5**	**2026.9**

Table 40 - Sickness absence

3.7.6 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. The CCG has a range of HR policies and processes in place to support this.

The following HR policies were reviewed or developed through to approval by the Social Partnership Forum (SPF) in 2018-19.

Policy name	SPF Approval Date
Maternity, Maternity Support, Adoption and Parental Leave	2 April 2018
Professional Registration	2 April 2018
Statutory and Mandatory Training	17 May 2018
Other Leave Policy	27 September 2018
Probationary Periods Policy	5 November 2018
Flexible Working Policy	6 November 2018
Disciplinary Policy	12 December 2018
Grievance Policy	12 December 2018
Bullying and Harassment Policy	12 December 2018
Recruitment and Selection Policy	17 January 2019

Table 41 – Staff policies reviewed in 2018-19

3.7.6 Other employee matters

The CCG is a Disability Confident Committed employer.

The CCG recognises the benefits of partnership working and has been an active member of the North Yorkshire, Humber and Leeds Social Partnership Forum. The aim of the Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Unions to discuss and debate issues in an environment of mutual trust and respect.

The CCG undertook a staff survey in 2018-19 and had a response rate of 59%. The overall satisfaction for 2018-19 was 53.7%.

The CCG held an HR and Learning and Development roadshow for staff on 18 October 2018

Under the terms of the Trade Union (Facility Time Publication Requirements) Regulations 2017, public sector bodies employing more than 49 people are expected to publish the amount of time that employees with trade union responsibilities spend on trade union

activities (facility time). The tables below reflect the requirements set out in Schedule 2 of the Regulations:

3.7.7 Relevant union officials

Number of employees who were relevant union officials during 2018-19	Full-time equivalent employee number
0	0

Table 42 - Relevant union officials

3.7.8 Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	0
51%-99%	0
100%	0

Table 43 - Percentage of time spent on facility time

3.7.9 Percentage of pay bill spent on facility time

Total cost of facility time	0
Total pay bill	0
Percentage of the total pay bill spent on facility time	0

Table 44 - Percentage of pay bill spent on facility time

3.7.10 Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	0

Table 45 - Paid trade union activities

3.7.11 Expenditure on consultancy

There was no expenditure on consultancy during 2018-19.

3.8 Off-payroll engagements

There were no off-payroll engagements during 2018-19.

3.8.1 Exit Packages Agreed in the Financial Year

	2018-19							
	Compulsory redundancies		Other agreed departures		Total exit packages		Departures where special payments have been made	
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	1	2,492	0	0	1	2,492	0	0
£10,001 to £25,000	2	36,464	0	0	2	36,464	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	1	129,155	0	0	1	129,155	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Total	**4**	**168,111**	**0**	**0**	**4**	**168,111**	**0**	**0**

Table 46 - Exit packages

Redundancy and other departure cost 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 in this note are the full costs of departures agreed in the year. Where the CCG has agreed early retirements, the additional costs are met by NHS Vale of York CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

3.9 Parliamentary Accountability and Audit Report

NHS Vale of York CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Notes 13.1 and 20 to the accounts. An audit certificate and report is also included in this Annual Report at the beginning of the annual accounts..

Part two

Annual accounts

Phil Mettam

Accountable Officer

24 May 2019

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

Opinion on the financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Qualified opinion on regularity

In our opinion, with the exception of the matters described in the 'Basis for qualified opinion on regularity' paragraph, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported a deficit of £18.6 million in note 19 of its financial statements for the financial year ended 31 March 2019, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of the Health and Social Care Act 2012, to ensure revenue resource use does not exceed the amount specified in the Direction.

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

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

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

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

We have nothing to report in this regard.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

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

Matters on which we are required to report by exception
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014
We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
On 24 January 2019, we issued a report to the Secretary of State for Health under section 30(a) 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 2018/19; 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.

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

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

Qualified conclusion – Adverse
On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, we are not satisfied that, in all significant respects, NHS Vale of York CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion
The CCG reported a deficit of £18.6 million in its financial statements for the year ending 31 March 2019, 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 been unable to agree a financial plan for 2019/20 which aligns with those of its key partners.
These issues are evidence of weaknesses in proper arrangements for 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.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller

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

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

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

Certificate
We certify that we have completed the audit of NHS 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

Mazars LLP
5th Floor
3 Wellington Place
Leeds
LS1 4AP

24 May 2019

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The Primary Statements

Notes to the Accounts

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

	Note	2018-19 £'000	2017-18 £'000
Revenue from services	2	(716)	(2,222)
Other operating revenue	2	(1,180)	(149)
Total operating revenue		**(1,896)**	**(2,371)**
Staff costs	4	6,333	6,088
Purchase of goods and services	5	483,299	471,067
Depreciation	5	76	76
Provision expense	5	22	124
Other operating expenditure	5	135	87
Total operating expenditure		**489,865**	**477,442**
Net operating expenditure		**487,969**	**475,071**
Total net expenditure for the financial year		**487,969**	**475,071**
Of which:			
Administration revenue and expenditure			
Employee benefits	4	5,056	4,466
Operating expenses	5	2,089	2,512
Operating revenue	2	(153)	(668)
Net administration expenditure		**6,992**	**6,310**
Programme revenue and expenditure			
Employee benefits	4	1,277	1,622
Operating expenses	5	481,443	468,842
Operating revenue	2	(1,743)	(1,703)
Net programme expenditure		**480,977**	**468,761**
Comprehensive expenditure for the financial year		**487,969**	**475,071**

The notes on pages 5 to 30 form part of this statement.

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets			
Property, plant and equipment	8	302	378
Total non-current assets		**302**	**378**
Current assets			
Trade and other receivables	9	5,296	2,371
Cash	10	130	95
Total current assets		**5,426**	**2,466**
Total assets		**5,728**	**2,844**
Current liabilities			
Trade and other payables	11	(28,394)	(23,787)
Provisions	12	(22)	(124)
Total current liabilities		**(28,416)**	**(23,911)**
Assets less liabilities		**(22,688)**	**(21,067)**
Financed by taxpayers' equity			
General fund		(22,688)	(21,067)
Total taxpayers' equity		**(22,688)**	**(21,067)**

The notes on pages 5 to 30 form part of this statement.

The financial statements on pages 1 to 30 were approved by the Audit Committee on behalf of the Governing Body on 23 May 2019 and signed on its behalf by:

Phil Mettam
Accountable Officer

Statement of Changes In Taxpayers' Equity for the Year Ended 31 March 2019

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19		
Balance at 1 April 2018	**(21,067)**	**(21,067)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating expenditure for the financial year	(487,969)	(487,969)
Net funding	486,348	486,348
Balance at 31 March 2019	**(22,688)**	**(22,688)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18		
Balance at 1 April 2017	**(14,967)**	**(14,967)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18		
Net operating expenditure for the financial year	(475,071)	(475,071)
Net funding	468,971	468,971
Balance at 31 March 2018	**(21,067)**	**(21,067)**

The notes on pages 5 to 30 form part of this statement.

Statement of Cash Flows for the Year Ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(487,969)	(475,071)
Depreciation	5	76	76
(Increase)/decrease in trade and other receivables	9	(2,925)	547
Increase/(decrease) in trade and other payables	11	4,607	5,358
Provisions utilised	12	(124)	(73)
Increase/(decrease) in provisions	12	22	124
Net cash outflow from operating activities		**(486,313)**	**(469,039)**
Net cash outflow before financing		**(486,313)**	**(469,039)**
Cash flows from financing activities			
Grant in aid funding received		486,348	468,971
Net cash outflow from financing activities		**486,348**	**468,971**
Net increase/(decrease) in cash	10	**35**	**(68)**
Cash at the beginning of the financial year		**95**	163
Cash at the end of the financial year		**130**	95

The notes on pages 5 to 30 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 and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group (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.

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.
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 the going concern basis.
Although Note 19 shows that in 2018-19 the Clinical Commissioning Group 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 2019-20 there is no material uncertainty regarding the Clinical Commissioning Group'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

The Clinical Commissioning Group has entered into three pooled budget arrangements with partner organisations in accordance with section 75 of the Health Care Act 2006. Under the arrangement, funds are pooled for the management of commissioning health and social care 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). Note 16 Joint Arrangements - Interests in Joint Operations provides details of the income and expenditure.

The Clinical Commissioning Group has entered into pooled budgets with North Yorkshire County Council, City of York Council, East Riding of Yorkshire Council and the following Clinical Commissioning Groups:
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
NHS Cumbria CCG

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 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 agreements.

Notes to the Financial Statements

1.4 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

The Clinical Commissioning Group receives most of its income from Parliament and does not have any other material income sources.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Clinical Commissioning Group accesses funds from the Government's apprenticeship service is recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

The Clinical Commissioning Group has assessed the impact of IFRS 15 and there is no transitional change required for disclosure.

1.5 **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.

1.5.1 **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: Leeds Teaching Hospitals NHS Trust, Harrogate and District NHS Foundation Trust, North Lincolnshire and Goole Hospitals NHS Foundation Trust, Ramsay Health Care UK and Nuffield Health.

Notes to the Financial Statements

- **Transforming Care Programme**

NHS Vale of York CCG is part of the North Yorkshire and York Transforming Care Partnership (TCP). The four CCGs within the North Yorkshire and York TCP (NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG) have entered into a risk share arrangement whereby the net cost relating to patients discharged under the Transforming Care Programme is split between parties on the basis of raw population. The risk share has been entered into due to the programme involving a small patient cohort with high cost variability of placements. Details of the net costs and the split across the four North Yorkshire CCGs is shown below. The risk share is a new arrangement for 2018-19 therefore no prior year comparators are shown.

NHS Hambleton, Richmondshire and Whitby CCG 18% £212,349
NHS Harrogate and Rural District CCG 21% £239,839
NHS Vale of York CCG 45% £521,267
NHS Scarborough and Ryedale CCG 15% £177,138

- **Gross/Net Accounting Arrangements for Hosted Services**

There are four Clinical Commissioning Groups in the North Yorkshire region: NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG. Collaborative arrangements exist whereby one of the Clinical Commissioning Groups hosts certain services on behalf of the other Clinical Commissioning Groups. Details of these hosted services are provided below. 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.

Referral Support Service and Referral Management Service

NHS Vale of York CCG host the Referral Support Service on behalf of NHS Vale of York CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG. All payments relating to this service are transacted through NHS Vale of York CCG's ledger and expenditure is apportioned between the Clinical Commissioning Groups based upon proportion of use as follows:

NHS Hambleton, Richmondshire and Whitby CCG 8% £43,881 (2017-18 8% £41,750)
NHS Harrogate and Rural District CCG 8% £43,881 (2017-18 8% £41,750)
NHS Vale of York CCG 50% £272,844 (2017-18 49% £241,507)
NHS Scarborough and Ryedale CCG 34% £182,729 (2017-18 35% £173,192)

Serious Incidents

NHS Vale of York Clinical Commissioning Group host the serious incidents service on behalf of the NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and NHS Harrogate and Rural District CCG. All payments relating to this service are transacted through NHS Vale of York CCG's ledger and expenditure is apportioned between the Clinical Commissioning Groups on a weighted basis as follows:

NHS Harrogate and Rural District CCG 33% £29,326 (2017-18 25% £23,753)
NHS Vale of York CCG 33% £29,326 (2017-18 50% £47,506)
NHS Scarborough and Ryedale CCG 33% £29,326 (2017-18 25% £23,753)

Medicines Management

NHS Harrogate and Rural District Clinical Commissioning Group host the regional medicines management team on behalf of NHS Harrogate and Rural District CCG, NHS Airedale, Wharfedale and Craven CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG. All payments relating to these services are transacted through NHS Harrogate and Rural District CCG's ledger and expenditure is recharged based upon proportion of use as follows:

NHS Hambleton, Richmondshire and Whitby CCG 16% £123,547 (2017-18 15% £112,152)
NHS Harrogate and Rural District CCG 23% £181,848 (2017-18 18% £140,831)
NHS Vale of York CCG 6% £45,969 (2017-18 10% £78,053)
NHS Scarborough and Ryedale CCG 28% £225,423 (2017-18 28% £216,205)
NHS Airedale, Wharfedale and Craven CCG 27% £214,913 (2017-18 29% £218,849)

Notes to the Financial Statements

Children's Safeguarding
NHS Scarborough and Ryedale CCG host the children's safeguarding service 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 this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 19% £73,332 (2017-18 20% £74,373)
NHS Harrogate and Rural District CCG 23% £88,020 (2017-18 24% £88,491)
NHS Vale of York CCG 42% £158,384 (2017-18 37% £140,084)
NHS Scarborough and Ryedale CCG 16% £62,705 (2017-18 19% £69,568)

Primary Care Safeguarding
NHS Scarborough and Ryedale CCG host 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. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 18% £16,011 (2017-18 19% £14,522)
NHS Harrogate and Rural District CCG 21% £18,123 (2017-18 20% £15,609)
NHS Vale of York CCG 46% £39,727 (2017-18 46% £34,794)
NHS Scarborough and Ryedale CCG 15% £13,394 (2017-18 15% £11,629)

Adult Safeguarding
NHS Scarborough and Ryedale CCG host adult 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. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 18% £47,296
NHS Harrogate and Rural District CCG 21% £53,292
NHS Vale of York CCG 46% £117,237
NHS Scarborough and Ryedale CCG 15% £39,499

In 2017-18, this expenditure was included within the charges in relation to the Partnership Commissioning Unit.

Strategic Clinical Networks
Strategic Clinical Networks are hosted by NHS Scarborough and Ryedale CCG 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. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on an a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 11% £24,980 (2017-18 11% £23,806)
NHS Harrogate and Rural District CCG 13% £28,182 (2017-18 13% £26,857)
NHS Vale of York CCG 28% £61,255 (2017-18 28% £58,375)
NHS Scarborough and Ryedale CCG 10% £20,782 (2017-18 10% £19,805)
NHS East Riding of Yorkshire CCG 24% £52,505 (2017-18 24% £50,037)
NHS North Lincolnshire CCG 14% £30,084 (2017-18 14% £28,669)

Specialist Neurological Rehabilitation Payments
Since 1 April 2018, NHS Vale of York CCG has hosted the specialist neurological rehabilitation service on behalf of NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Vale of York CCG and NHS Harrogate and Rural District CCG. All payments relating to this service are transacted through NHS Vale of York CCG's ledger. NHS Hambleton, Richmondshire and Whitby CCG are charged 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 £326,369 (2017-18 actual basis £350,850)
NHS Harrogate and Rural District CCG risk share 25% £542,350 (2017-18 risk share 26% £762,803)
NHS Vale of York CCG risk share 56% £1,189,220 (2017-18 risk share 54% £1,594,140)
NHS Scarborough and Ryedale CCG risk share 19% £400,908 (2017-18 risk share 21% £622,757)

During 2017-18 the service was hosted by NHS Scarborough and Ryedale CCG.

Notes to the Financial Statements

Specialist Neurological Rehabilitation Commissioning
NHS Vale of York CCG host the specialist neurological rehabiliation commissioning service on behalf of NHS Vale of York CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG and NHS Harrogate and Rural District CCG. All payments relating to these services are transacted through the NHS Vale of York CCG's ledger. Expenditure is recharged on a weighted capitation basis.

NHS Hambleton, Richmondshire and Whitby CCG 19% £5,488 (2017-18 19% £5,383)
NHS Harrogate and Rural District CCG 21% £6,192 (2017-18 21% £6,074)
NHS Vale of York CCG 45% £13,457 (2017-18 45% £13,201)
NHS Scarborough and Ryedale CCG 15% £4,565 (2017-18 15% £4,479)

Estates
Estates services are hosted by NHS Hambleton, Richmondshire and Whitby CCG on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural Districts CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Hambleton, Richmondshire and Whitby CCG's ledger and expenditure is recharged based upon an actual basis.

NHS Hambleton, Richmondshire and Whitby CCG 43% £39,248 (2017-18 42% £38,263)
NHS Harrogate and Rural District CCG 8% £7,830 (2017-18 11% £9,666)
NHS Vale of York CCG 45% £41,758 (2017-18 45% £41,114)
NHS Scarborough and Ryedale CCG 2% £1,418 (2017-18 2% £2,000)
NHS Wakefield CCG 2% £2,105 (2017-18 0% £0)

Children's Continuing Healthcare Team
The children's continuing healthcare team is hosted by NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Hambleton, Richmondshire and Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 18% £19,973 (2017-18 19% £22,707)
NHS Harrogate and Rural District CCG 21% £22,607 (21% £25,621)
NHS Vale of York CCG 46% £49,557 (2017-18 45% £55,682)
NHS Scarborough and Ryedale CCG 15% £16,708 (2017-18 15% £18,891)

Children and Young People's Commissioning
NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group host the children and young people's commissioning team on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG. The NHS Vale of York CCG recharge is for the North Yorkshire population only as children and young people's commissioning for the City of York has been in-housed. All payments relating to this service are transacted through NHS Hambleton, Richmondshire and Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Hambleton, Richmondshire and Whitby CCG 27% £27,697 (2017-18 26% £31,782)
NHS Harrogate and Rural District CCG 30% £31,344 (2017-18 30% £35,861)
NHS Vale of York CCG 21% £22,474 (2017-18 22% £26,537)
NHS Scarborough and Ryedale CCG 22% £23,169 (2017-18 22% £26,442)

Mental Health and Learning Disabilities Commissioning
NHS Harrogate and Rural District Clinical Commissioning Group host the regional mental health (adults) commissioning team on behalf of NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG. All payments relating to these services are transacted through NHS Harrogate and Rural District CCG's ledger and expenditure is recharged on a risk share basis as follows:

NHS Harrogate and Rural District CCG 31% £ 73,553 (2017-18 33% £56,076)
NHS Hambleton, Richmondshire and Whitby CCG 30% £72,867 (2017-18 31% £53,268)
NHS Scarborough and Ryedale CCG 30% £71,951 (2017-18 29% £49,546)
NHS Vale of York CCG 9% £20,971 (2017-18 7% £12,465)

Continuing Healthcare, Funded Nursing Care and Other Mental Health
The commissioning of Continuing Healthcare, Funded Nursing Care and Other Mental Health services for NHS Vale of York CCG were in-housed by NHS Vale of York CCG from 1 February 2018. Payments relating to these services from 1 February onwards have been transacted through the NHS Vale of York CCG's ledger. Services prior to this date were commissioned and paid for by NHS Scarborough and Ryedale CCG who hosted the service on behalf of NHS Vale of York CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG.

Notes to the Financial Statements

Research and Development
NHS East Riding of Yorkshire CCG host research and development services on behalf of 8 Clinical Commissioning Groups. NHS Vale of York CCG withdrew from the service from July 2018. NHS Vale of York CCG expenditure in 2018-19 was £5,061 (2017-18: £22,094).

Infection Prevention and Control
NHS East Riding of Yorkshire CCG host infection prevention and control services on behalf of 5 Clinical Commissioning Groups. NHS Vale of York CCG expenditure in 2018-19 was £13,343 (2017-18: £11,156).

1.5.2 **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 2017-18. Payment for 2018-19 will be reconciled and paid to GP practices in June 2019.
The Clinical Commissioning Group has achieved the following level of accuracy in estimation during 2018-19:
Prescribing > 97%
Purchase of Healthcare >95%
· Provisions
A number of key assumptions have been included within the accounts concerning the future:
• Continuing Healthcare Provision - 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 information in the patient database, or from information provided by the clinical team where data is not available. Progress is being made to reduce the backlog.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken. The cost of leave earned but not taken by employees at the end of the period 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 two NHS Pensions Schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in the schemes is taken as equal to the contributions payable to the schemes for the accounting period. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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.

1.8 **Grants Payable**
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Clinical Commissioning Group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the Financial Statements

1.9 **Property, Plant and Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.9.2 **Measurement**

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

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

1.10 **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.

1.11 **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.

1.11.1 **The Clinical Commissioning Group as Lessee**

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.

1.12 **Cash**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

1.13 **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.

1.14 **Clinical Negligence Costs**

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

Notes to the Financial Statements

1.15 **Non-Clinical Risk Pooling**

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

1.16 **Contingent Liabilities and Contingent Assets**

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.

The Clinical Commissioning Group's financial assets are classified as financial assets at amortised cost.

1.17.1 **Financial Assets at Amortised Cost**

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

1.17.2 **Impairment**

For all financial assets measured at amortised cost the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables at an amount equal to lifetime expected credit losses.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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 and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the Financial Statements

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. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 **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.

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).

1.21 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care Group Accounting Manual does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

It is expected that the application of IFRS 16 will bring building leases held by the Clinical Commissioning Group on to the Statement of Financial Position in 2019-20. This would result in an increase to property, plant and equipment in the balance sheet offset by a corresponding liability to represent the financing. The amount is not yet quantifiable. The impact on voids charged by NHS Property Services is yet to be determined.

The application of the other standards as revised are not expected to have a material impact on the accounts for 2018-19, were they applied in year.

2. Other Operating Revenue

	2018-19 Admin	2018-19 Programme	2018-19 Total	2017-18 Total
	£'000	£'000	£'000	£'000
Revenue from services (contracts)				
Non-patient care services to other bodies	0	435	**435**	1,924
Prescription fees and charges	0	227	**227**	298
Other contract revenue	17	37	**54**	0
Total revenue from sale of services	**17**	**699**	**716**	**2,222**
Other operating revenue				
Charitable and other contributions to revenue expenditure: non-NHS	24	0	**24**	21
Non cash apprenticeship training grants revenue	4	0	**4**	3
Other non contract revenue	108	1,044	**1,152**	125
Total other operating revenue	**136**	**1,044**	**1,180**	**149**
Total operating revenue	**153**	**1,743**	**1,896**	**2,371**

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

IFRS 15 Revenue from Contracts with Customers has been introduced in 2018-19 and requires income from contracts to be recognised in line with the performance obligation. Revenue recognised in 2017-18 has been reviewed and determined to have been recognised in the correct period however no adjustment has been made to recategorise into contract and non-contract.

Prescription fees have been recategorised from other operating income in 2017-18 to revenue from services in 2018-19.

3. Disaggregation of Revenue - Revenue from Services

	Non-patient care services to other bodies	Prescription fees and charges	Other contract revenue	Total contract revenue
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	0	0	0	0
Non NHS	435	227	54	716
Total	**435**	**227**	**54**	**716**

	Non-patient care services to other bodies	Prescription fees and charges	Other contract revenue	Total contract revenue
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	0	0	37	37
Over time	435	227	17	679
Total	**435**	**227**	**54**	**716**

4. Employee Benefits and Staff Numbers

4.1 Employee Benefits

	2018-19		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Salaries and wages	4,732	434	5,166
Social security costs	477	0	477
Employer contributions to NHS Pension scheme	597	0	597
Apprenticeship Levy	6	0	6
Termination benefits	87	0	87
Total employee benefits expenditure	**5,899**	**434**	**6,333**

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

	2017-18		
	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	4,479	528	5,007
Social security costs	441	0	441
Employer Contributions to NHS Pension scheme	564	0	564
Apprenticeship Levy	4	0	4
Termination benefits	72	0	72
Gross employee benefits expenditure	5,560	528	6,088

4.2 Average Number of People Employed

		2018-19		2017-18
	Permanently employed Number	**Other Number**	**Total Number**	Total Number
Total	**115**	**6**	**121**	**116**

4.3 Exit Packages Agreed in the Financial Year

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	1	2,492	0	0	1	2,492
£10,001 to £25,000	2	36,464	0	0	2	36,464
£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	1	129,155	0	0	1	129,155
Total	**4**	**168,111**	0	0	**4**	**168,111**

	2017-18 Compulsory		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	2,085	1	1,027	2	3,112
£10,001 to £25,000	1	23,246	0	0	1	23,246
£25,001 to £50,000	1	46,841	0	0	1	46,841
Total	**3**	**72,172**	**1**	**1,027**	**4**	**73,199**

There were no payments for other agreed departures made in 2018-19 (2017-18: 1 exit payment following Employment Tribunal cost of £1,027).

These tables report the number and value of exit packages agreed in the financial year. The expense associated with the departures above was partly provided for in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the 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.

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

4.4 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

For 2018-19, the Clinical Commissioning Group paid £547,548 of employers' contributions directly to the NHS Pensions Scheme (2017-18: £503,811) at the rate of 14.38% of pensionable pay. The Clinical Commissioning Group paid £597,131 in total for employers' contributions which includes contributions made by other organisations and recharged to the Clinical Commissioning Group (2017-18: £563,757). 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 2016. These costs are included in the NHS pension line of note 4.1.

5. Operating Expenses

	2018-19 Admin £'000	2018-19 Programme £'000	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	284	184	468	681
Services from foundation trusts	0	279,949	279,949	270,882
Services from other NHS trusts	0	28,879	28,879	31,291
Purchase of healthcare from non-NHS bodies	0	63,422	63,422	60,092
Rentals under operating leases	423	942	1,365	2,058
Prescribing costs	0	48,596	48,596	49,508
General ophthalmic services	0	127	127	145
GMS and PMS	0	45,913	45,913	43,950
Supplies and services – clinical	0	335	335	85
Supplies and services – general	638	10,075	10,713	11,190
Consultancy services	126	2	128	393
Establishment	254	587	841	491
Transport	3	2,246	2,249	8
Premises	3	106	109	147
Audit fees*	52	0	52	52
Other non statutory audit expenditure				
· Internal audit services	37	0	37	41
· Other services	0	10	10	0
Other professional fees	23	30	53	0
Legal fees	0	10	10	22
Education, training and conferences	36	7	43	29
Total purchase of goods and services	**1,879**	**481,420**	**483,299**	**471,064**
Depreciation charges				
Depreciation	76	0	76	76
Total depreciation charges	**76**	0	**76**	**76**
Provision expense				
Provisions	0	22	22	124
Total provision expense	0	**22**	**22**	**124**
Other operating expenditure				
Chair and Non-Executive Members	106	0	106	44
Expected credit loss on receivables	14	0	14	0
Non cash apprenticeship training grants	4	0	4	3
Other expenditure	10	1	11	43
Total other operating expenditure	**134**	**1**	**135**	**90**
Total operating expenditure	**2,089**	**481,443**	**483,532**	**471,355**

*There is no limitation of the auditor's liability in the Clinical Commissioning Group's contract with its external auditors.

Please note that patient transport totalled £2,390k in 2017-18. This was included within services from other NHS trusts, services from foundation trusts and purchase of healthcare from non-NHS bodies. Expenditure on patient transport has been included within transport in 2018-19.

6. Better Payment Practice Code

6.1 Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	10,398	120,381	4,629	81,753
Total non-NHS trade invoices paid within target	9,975	118,503	4,481	80,951
Percentage of non-NHS trade invoices paid within target	**95.93%**	**98.44%**	96.80%	99.02%
NHS payables				
Total NHS trade invoices paid in the year	3,625	320,185	3,263	339,588
Total NHS trade invoices paid within target	3,546	319,663	3,215	338,343
Percentage of NHS trade invoices paid within target	**97.82%**	**99.84%**	98.53%	99.63%

The Clinical Commissioning Group transferred commissioning functions for Continuing Healthcare from 1 February 2018 from the Partnership Commissioning Unit and the volume and value of non-NHS invoices has therefore increased in 2018-19.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made in relation to the late payment of commercial debts (2017-18: nil).

7. Operating Leases

7.1 As Lessee

In 2018-19, the Clinical Commissioning Group leased its corporate offices (West Offices) from the City of York Council. The tenancy agreement for this space has not been signed.

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 2018-19, the Clinical Commissioning Group paid £1,303,149 (2017-18: £1,953,292) directly for rent, subsidy and void costs. The Clinical Commissioning Group was charged £61,348 by other organisations in respect of rent for hosted services (2017-18: £104,927). The subsidy and void charges will continue in 2019-20 subject to the 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.

7.1.1 Payments Recognised as an Expense

	2018-19			2017-18		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	1,363	1	**1,364**	2,059	(1)	2,058
Total	**1,363**	**1**	**1,364**	**2,059**	**(1)**	**2,058**

Whilst our arrangements with City of York Council and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements.

8. Property, Plant and Equipment

	2018-19			2017-18		
	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
Disposals other than by sale	0	(5)	(5)	0	0	0
Cost/Valuation at 31 March	**756**	**0**	**756**	**756**	**5**	**761**
Depreciation 1 April	378	5	383	302	5	307
Disposals other than by sale	0	(5)	(5)	0	0	0
Charged during the year	76	0	76	76	0	76
Depreciation at 31 March	**454**	**0**	**454**	**378**	**5**	**383**
Net Book Value at 31 March	**302**	**0**	**302**	**378**	**0**	**378**
Purchased	302	0	302	378	0	378
Total at 31 March	**302**	**0**	**302**	**378**	**0**	**378**
Asset financing:						
Owned	302	0	302	378	0	378
Total at 31 March	**302**	**0**	**302**	**378**	**0**	**378**

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 2018-19 £'000	Current 2017-18 £'000
NHS receivables: revenue	3,013	700
NHS prepayments	922	866
NHS accrued income	646	85
Non-NHS and other WGA* receivables: revenue	115	374
Non-NHS and other WGA prepayments	130	111
Non-NHS and other WGA accrued income	363	154
Non-NHS and other WGA contract receivable not yet invoiced/non-invoice	39	0
Expected credit loss allowance - receivables	(3)	0
VAT	70	79
Other receivables and accruals	1	2
Total trade and other receivables	**5,296**	**2,371**

*Whole of Government Accounts

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

The vast majority of trade is with other NHS organisations which are funded by Government and therefore no credit scoring of them is considered necessary.

9.1 Receivables Past their Due Date but Not Impaired

	2018-19 DHSC Group Bodies £'000	**2018-19 Non DHSC Group Bodies £'000**	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	47	33	153	31
By three to six months	48	3	0	2
By more than six months	18	6	28	32
Total	**113**	**42**	**181**	**65**

9.2 Impact of Application of IFRS 9 on Financial Assets at 1 April 2018

	Cash and cash equivalents	**Trade and other receivables - NHSE bodies**	**Trade and other receivables - other DHSC group bodies**	**Trade and other receivables - external**	**Other financial assets**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Classification under IAS 39 as at 31st March 2018						
Financial assets held at amortised cost (previously loans and receivables)	95	698	86	529	2	**1,410**
Total at 31st March 2018	**95**	**698**	**86**	**529**	**2**	**1,410**
Classification under IFRS 9 as at 1st April 2018						
Financial assets measured at amortised cost	95	698	86	529	2	**1,410**
Total at 1st April 2018	95	698	86	529	2	**1,410**

10. Cash

	2018-19 £'000	2017-18 £'000
Balance at 1 April	95	163
Net change in year	35	(68)
Balance at 31 March	**130**	**95**
Made up of:		
Cash with the Government Banking Service	130	95
Cash in statement of financial position	**130**	**95**
Balance at 31 March	**130**	**95**

11. Trade and Other Payables

	Current 2018-19 £'000	Current 2017-18 £'000
NHS payables: Revenue	2,848	1,808
NHS accruals	2,414	2,407
Non-NHS and Other WGA payables: Revenue	9,801	5,891
Non-NHS and Other WGA accruals	12,272	12,822
Non-NHS and Other WGA deferred income	24	0
Social security costs	64	58
Tax	51	51
Other payables and accruals	920	750
Total trade and other payables	**28,394**	**23,787**

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

Other payables include £78,739 of outstanding pension contributions at 31 March 2019 (31 March 2018: £76,685).

11.1 Impact of Application of IFRS 9 on Financial Liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other financial liabilities	Total
	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018					
Financial liabilities held at amortised cost (previously other)	644	4,976	17,309	749	**23,678**
Total at 31st March 2018	**644**	**4,976**	**17,309**	**749**	**23,678**
Classification under IFRS 9 as at 1st April 2018					
Financial liabilities measured at amortised cost	644	4,976	17,309	749	**23,678**
Total at 1st April 2018	644	4,976	17,309	749	**23,678**

12. Provisions

	Current 2018-19 £'000	Current 2017-18 £'000
Redundancy	0	82
Continuing care	22	42
Total	**22**	**124**

The Clinical Commissioning Group has no non-current provisions.

	Redundancy £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2018	**82**	**42**	**124**
Arising during the year	0	22	**22**
Utilised during the year	(82)	(42)	**(124)**
Balance at 31 March 2019	**0**	**22**	**22**
Expected timing of cash flows:			
Within one year	0	22	**22**
Balance at 31 March 2019	**0**	**22**	**22**

The provision for continuing care relates to the potential cost for continuing care reviews. There is uncertainty regarding the outcomes and timings of individual case reviews.

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.

The provision for redundancy in 2017-18 was as a result of restructuring changes to the Clinical Commissioning Group's Governing Body.

13. Contingencies

13.1 Contingent Liabilities	2018-19 £'000	2017-18 £'000
NHS Resolution Legal Claims	0	38
Net value of contingent liabilities	**0**	**38**

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

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 and so it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Clinical Commissioning Group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Clinical Commissioning Group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Clinical Commissioning Group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

14.1.1 Market Risk

The Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Clinical Commissioning Group has no overseas operations and therefore has low exposure to currency rate fluctuations. The Clinical Commissioning Group does not borrow and therefore has low exposure to interest rate fluctuations.

14.1.2 Credit Risk

The majority of the Clinical Commissioning Group's revenue comes 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.

14.1.3 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.

14.1.4 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14. Financial Instruments continued

14.2 Financial Assets

	Financial Assets measured at amortised 2018-19 £'000	Total 2018-19 £'000	Total 2017-18 £'000
Trade and other receivables with NHSE bodies	1,457	**1,457**	698
Trade and other receivables with other DHSC group bodies	2,202	**2,202**	86
Trade and other receivables with external bodies	516	**516**	529
Other financial assets	1	**1**	2
Cash and cash equivalents	130	**130**	95
Total at 31 March 2019	**4,306**	**4,306**	**1,410**

14.3 Financial Liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Total 2018-19 £'000	Total 2017-18 £'000
Trade and other payables with NHSE bodies	851	**851**	644
Trade and other payables with other DHSC group bodies	8,088	**8,088**	4,976
Trade and other payables with external bodies	18,396	**18,396**	17,309
Other financial liabilities	920	**920**	749
Total at 31 March 2019	**28,255**	**28,255**	**23,678**

15. Operating Segments

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

16. Joint Arrangements - Interests in Joint Operations

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.

16.1 Interests in Joint Operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in CCG accounts 2018-19		Amounts recognised in CCG accounts 2017-18	
			Income	Expenditure	Income	Expenditure
			£'000	£'000	£'000	£'000
Better Care Fund - City of York Health and Wellbeing Board	NHS Vale of York CCG City of York Council	Health and Social Care pooled commissioning budget	286	11,903	0	11,400
Better Care Fund - North Yorkshire Health and Wellbeing Board	NHS Vale of York CCG NHS Airedale, Wharfedale and Craven CCG NHS Scarborough and Ryedale CCG NHS Hambleton, Richmondshire and Whitby CCG NHS Harrogate and Rural District CCG NHS Cumbria CCG North Yorkshire County Council	Health and Social Care pooled commissioning budget	0	7,442	0	7,303
Better Care Fund - East Riding Health and Wellbeing Board	NHS Vale of York CCG NHS East Riding of Yorkshire CCG East Riding of Yorkshire County Council	Health and Social Care pooled commissioning budget	0	1,289	0	1,265

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 Aaron Brown - Governing Body - Local Medical Liaison Officer, Selby and York - GP York Medical Group	5,189	(9)	0	0
Dr Aaron Brown - Governing Body - Local Medical Liaison Officer, Selby and York - RSS Reviewer NHS Scarborough and Ryedale CCG	2,099	(776)	651	(319)
Dr Arasu Kuppuswamy - Audit Committee and Governing Body - Secondary Care Doctor - Consultant at South West Yorkshire Partnership NHS Foundation Trust	39	0	3	0
Denise Nightingale - Executive Committee - Executive Director of Transformation and Delivery - seconded from Bassetlaw CCG	93	0	8	0
Keith Ramsay - Lay Member of the Governing Body - Member of Tees, Esk and Wear Valleys NHS Foundation Trust	42,914	0	0	(2,000)
Keith Ramsay - Lay Member of the Governing Body - Member of Harrogate and District NHS Foundation Trust	5,475	0	263	(18)
Dr Kevin Smith - Finance and Performance Committee and Executive Committee - Director of Primary Care and Population Health - substantive post as Deputy Director Public Health England, Yorkshire and the Humber	101	0	105	0
Sharon Stolz - Governing Body attendance - Interim Director of Public Health, City of York Council	15,568	(582)	389	(363)
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Surgery	2,454	(19)	0	0
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Eyecare	2	0	0	0
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - Founder Yorkshire Health Solutions	744	0	0	0
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - Shield GP Limited	47	0	4	0
Simon Bell - Chief Finance Officer - Partner works as a Business Intelligence Manager at Embed Health Consortium (Kier Business Sevices Limited)	1,112	0	36	0
Michael Ash-McMahon - Acting Chief Finance Officer (30 April 2018 to 31 July 2018) - wife is an employee of Priory Medical Group	6,740	(5)	16	0
David Booker - Lay Chair - volunteer First Responder for Yorkshire Ambulance Services Trust	16,820	0	0	(68)
Dr Helena Ebbs - Governing Body GP - GP Partner Pickering Medical Practice	1,856	0	4	0
Dr Helena Ebbs - Governing Body GP - Director of City and Vale GP Alliance	236	0	16	0
Dr Ruth Walker - Governing Body GP - GP Partner Scott Road Medical Practice	1,270	(8)	0	0

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Andrew Field - Governing Body GP (1 April 2018 to 6 September 2018) - GP Partner York Medical Group	5,189	(9)	0	0
Dr Andrew Field - Governing Body GP (1 April 2018 to 6 September 2018) - Director of City and Vale GP Alliance	236	0	16	0
Sheenagh Powell - Chair of Audit Committee (1 April 2018 to 31 May 2018) - Paid member of Harrogate and Rural District CCG Audit Committee	102	(554)	52	(362)
Michelle Carrington - Executive Director of Quality and Nursing - Friend and former colleague is a Director of In-Form Solutions Limited	0	0	4	0

The roles detailed in the table above are those held during the year.

The Department of Health and Social Care 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 Resolution
- 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 Hospitals 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 that will have a material effect on the financial statements of the Clinical Commissioning Group.

19. Financial Performance Targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended). NHS Vale of York CCG's performance against those duties was as follows:

	2018-19 Target	**2018-19 Performance**	2017-18 Target	2017-18 Performance
Expenditure not to exceed income	471,225	489,865	457,370	477,442
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	469,329	487,969	454,999	475,071
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	7,603	6,992	7,618	6,309

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2018-19 expenditure performance is £18.6m 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 Clinical Commissioning Groups 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 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 on 24 January 2019.

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 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	22	11	37	41
Cash losses	1	10	0	0
Total	**23**	**21**	**37**	**41**

The administrative write-off relates to the write-off of overseas visitors debts. In line with national guidance, the Clinical Commissioning Group is party to a risk share agreement with York Teaching Hospital NHS Foundation Trust whereby the Clinical Commissioning Group recognises 50% of any unrecoverable overseas visitors charges.

The cash loss relates to a historic overpayment of a Personal Health Budget for Continuing Healthcare for which reimbursement was not pursued.

20.2 Special payments

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Compensation payments	0	0	1	1
Total	**0**	**0**	**1**	**1**