NHS
Vale of York
Clinical Commissioning Group

# Annual Report

## 2019-20

# Annual Report and Accounts 2019-20

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# Annual Report and Accounts 2019-20

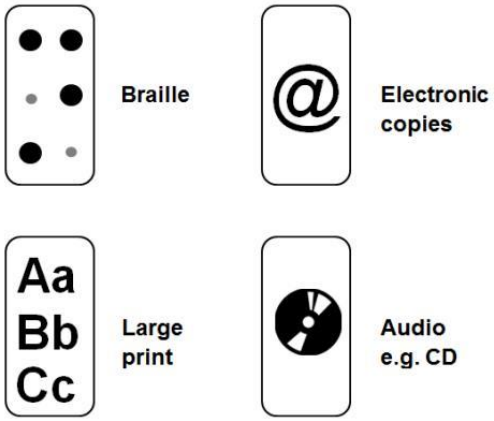
NHS organisations are required to publish an annual report and financial accounts at the end of each financial year. This report provides an overview of the CCG's work between 1 April 2019 and 31 March 2020.

The report is made up of three parts. The first section contains details of the organisation's performance for 2019-20, with the second section covering details of governance and risk. The third is the financial accounts for the year 2019-20. 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 2019-20 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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# Foreword

## By Dr Nigel Wells, Clinical Chair

In reflection of my second year in tenure as the CCG's Clinical Chair I am pleased to report on many areas of continued improvement through transformative work that is improving outcomes for our patients and providers.

Our Primary Care Networks are working hard to integrate primary care services with the wider health and care system and the clinical workforce, through shared learning, development opportunities and the rebuilding of relationships is beginning to bridge gaps to develop the right services that the populations across the city and vale tell us they want to have.

The Governing Body has continued with refocusing the CCG's work away from the long standing local money issues, to putting clinical improvement at the centre. Whilst this work has continued it has still been possible to stabilise and balance the local health and care system's finances. This positive financial position has been long coming and made possible through hard work and stronger relationships with our providers.

Then came COVID-19 – and it hit our local area hard. During the pandemic, services across the country have been under intense pressure as the coronavirus spread but our local health and care system and CCG staff have responded swiftly and positively through some extremely challenging times. This resilience and hard work, in the most difficult of situations, is what makes the NHS great and I am proud of every single staff member in our local health and care system.

Bringing about transformative change requires the NHS and local councils, patients and the public to work together to deliver shared goals. To enable this and bring the voices of the health and care community to the development of collaborative, transformative work I accepted the role of Humber, Coast and Vale Health and Care Partnership's Clinical Lead.

The NHS – locally and nationally – will have to deliver care in new ways to deal with the pandemic. We are fortunate to have an extremely dedicated and hard-working NHS workforce that is doing everything it can to help in this extremely challenging situation. My role as the CCG's Clinical Chair and the Partnership's Clinical Lead are enablers to put forward the voice of the Vale of York population into work that aims to achieve sustainable health equity, improve health, wellbeing, care and the quality of services in what will be 'new', normal times to come.

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

# Performance Report

**Phil Mettam**
Accountable Officer
23rd June 2020

# The year in review

## A note from Phil Mettam, our Accountable Officer

This year the CCG's work has played a central role in the transformation and improvement of services on commissioner / provider, financial and organisational levels. The most important part of this work has been the improvement of services for patients and service users and this work, delivered in conjunction with our providers, has seen the delivery of transformative plans that are now delivering better access and services for patients that rely on our local primary care, outpatient and acute care services.

Transformation has been a watchword for the CCG in 2019-20 and it continues to be so. It has been embedded throughout our all of work. Our staff have continued to focus their efforts on achieving better outcomes for our population especially around the CCG's work to transform local musculoskeletal, mental health and learning disability services improvements, to name a few, along with the introduction of the Rapid Access to an Expert Opinion service which is improving outcomes for patients, primary care and our providers.

This transformation is also evident in the development of our local Primary Care Networks. The main aim of these networks is to easily integrate the wider health and care system with primary care. They play a key part in our local work to deliver the NHS Long Term Plan and bring general practices, our partners and providers even closer together to work at scale, focus on delivery and provide a wider range of services to patients in a coordinated way.

2019-20 saw further stabilisation and balance of the system's finances thanks continued efforts to commission services that offered greater value and efficiency, such as those described above. Some of the work on the financial front saw the CCG look inwards at its running costs and identify ways to do things more efficiently. This inward reflection resulted in a reorganisation of the CCG's staffing structure.

This year we have had some great successes including award winning work for our Health Navigator and React to Red projects that have delivered some fantastic results for local patients. But it is impossible not to mention the effect of COVID-19. The pandemic, as in every other part of the country, has hit the Vale of York hard. That said, I am so very proud of our local health and care services and our own CCG staff at their response to what are extremely challenging times. The NHS is truly amazing and resilient even when it faces the most difficult situations. I thank each and every one in the local health and care system for their hard work and commitment to help make a difference.

**Phil Mettam**
Accountable Officer

# Performance analysis

## 1.1 Performance summary 2019-20

### 1.1.1 Context

The CCG commissions healthcare for the Vale of York area 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.

It has 25 member practices which now form part of 6 primary care networks with list sizes of between 30,000 and 150,000 patients. Further details of the organisational structure is given in the members' report on p. 61.

### 1.1.2 Improvement and Assurance Framework (IAF)

The CCG continued to discharge its duties providing quarterly assurance checkpoints with NHS England throughout 2019-20. This work was supported by comprehensive performance reporting to Finance and Performance Committee.

In August 2019 NHS England and NHS Improvement notified CCGs and its providers that a single NHS Oversight Framework would replace the provider Single Oversight Framework and the CCG Improvement and Assessment Framework. This was to capture the joint approach NHS England and NHS Improvement will take to oversee organisational performance and identify where commissioners and providers may need support. The single NHS Oversight Framework will provide a local point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and Health and Care Partnerships (HCPs) that were previously known as Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). The roll out of the new oversight framework will now be delayed until after the current COVID-19 pandemic.

NHS England and NHS Improvement have described that changes to oversight will be characterised by several key principles:

- NHS England and NHS Improvement teams speaking with a **single voice**, setting consistent expectations of systems and their constituent organisations.
- A greater emphasis on **system performance**, alongside the contribution of individual healthcare providers and commissioners to system goals.
- Working with and through **system leaders**, wherever possible, to tackle problems.
- Matching accountability for results with **improvement support**, as appropriate.

- **Greater autonomy for systems** with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The internal audit of performance assurance in January 2018 reported 'significant assurance' around the governance of performance assurance in the CCG, and there has been no further audit undertaken during 2019-20 due to the high level of assurance achieved.

## 1.2 Performance Overview

Performance during 2019-20 has been defined by the increasingly aligned work across commissioners and providers as joint system partners to improve service access, performance and quality within the system financial envelope and outside of a Payment by Results (PbR) contracting framework.

The focus has been on jointly understanding and addressing the most significant pressures and challenges in workforce, estate and equipment capacity, opportunities for improved integration across providers and developing interventions for local people where they need more signposting, support and empowerment to get to the right service they need.
2019-20 is the third year the CCG has worked in this way with mental health providers and partners to drive the improvement plans funded through the Mental Health Investment Standard. This has been supported by joint posts across the system and the impact of this work can be seen in the month on month performance improvements in the majority of mental health, learning disability and autism targets.

Similarly, the development of a single system work plan of priority improvements for local partners to drive resilience in our urgent and emergency care services has been fundamental to improving Delayed Transfers of Care (DTOCs) in 2019-20, as well as improving Emergency Care Services (ECS) performance despite attendances increasing for another consecutive year.

The CCG and York Teaching Hospital NHS Foundation Trust (YTHFT) agreed a fixed upper value contract in May 2019 and have worked to develop a financial recovery plan based on joint programmes of transformation work which avoid costs associated with additional waiting list initiatives and outsourcing of activity, reduced unwarranted demand and explored where productivity could be improved.

The impact of delivering care based on current pathways within fixed financial resources has influenced in-year acute performance with deterioration in some areas where previously additional funding would have been used to purchase external capacity. However, as joint work and collective decision-making about priorities for investment develops further, system partners can develop more transformational ways of accessing and delivering care and our local performance will start to improve alongside financial sustainability.

## A summary of the CCG performance in 2019-20 across key NHS Constitution targets

| | | Target | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E | % of attendances where patient was discharged, admitted or transferred within 4 hours of arrival | ≥95% | 80.5% | 81.9% | 83.2% | 81.1% | 81.3% | 78.1% | 80.4% | 75.7% | 75.1% | 75.2% | 81.7% | 83.7% |
| Diagnostics | % of patients waiting over 6 weeks for a Diagnostic test | ≤1% | 12.7% | 13.7% | 11.7% | 12.2% | 18.6% | 17.4% | 17.9% | 15.4% | 18.3% | 19.7% | 16.5% | - |
| RTT | % of patients on incomplete pathways waiting no more than 18 weeks from referral | ≥92% | 81.6% | 81.9% | 80.5% | 79.7% | 79.1% | 78.4% | 77.7% | 77.0% | 76.7% | 75.6% | 75.4% | - |
| | Total number of patients on incomplete pathways | - | 17,344 | 18,021 | 17,849 | 17,996 | 18,300 | 18,792 | 18,738 | 18,328 | 18,762 | 18,341 | 18,146 | - |
| Cancer | % seen within 14 days of urgent referral - all cancer types | ≥93% | 88.9% | 84.9% | 81.7% | 88.8% | 94.3% | 93.6% | 96.5% | 95.7% | 95.8% | 93.9% | 96.0% | - |
| | % seen within 14 days of urgent referral - breast symptoms | ≥93% | 81.3% | 86.1% | 92.8% | 95.0% | 97.3% | 97.4% | 98.0% | 98.5% | 97.6% | 98.6% | 98.6% | - |
| | % of patients receiving first definitive treatment within 31 days of diagnosis | ≥96% | 95.4% | 96.3% | 97.9% | 96.1% | 97.8% | 95.5% | 95.3% | 94.9% | 97.1% | 96.5% | 96.6% | - |
| | % of patients receiving second or subsequent treatment within 31 days - Surgery | ≥94% | 92.1% | 88.6% | 90.6% | 89.7% | 88.9% | 96.9% | 88.9% | 95.0% | 94.9% | 76.1% | 97.3% | - |
| | % of patients receiving second or subsequent treatment within 31 days - Drug | ≥98% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.8% | 98.8% | 100.0% | 100.0% | 98.6% | - |
| | % of patients receiving second or subsequent treatment within 31 days - Radiotherapy | ≥94% | 100.0% | 98.1% | 98.0% | 100.0% | 100.0% | 92.3% | 90.7% | 100.0% | 100.0% | 100.0% | 96.4% | - |
| | % of patients receiving first definitive treatment within 62 days of urgent GP referral | ≥85% | 80.2% | 77.9% | 84.2% | 82.1% | 82.4% | 76.0% | 75.9% | 72.3% | 77.6% | 74.8% | 75.3% | - |
| | % of patients receiving first definitive treatment within 62 days of referral from an NHS cancer screening service | ≥90% | 100.0% | 88.9% | 88.9% | 100.0% | 90.9% | 94.1% | 84.6% | 100.0% | 70.0% | 64.7% | 68.4% | - |
| IAPT | Improving Access to Psychological Therapies - Access Rate (3 month rolling basis) | 5.5% at March 2020 | 3.52% | 3.55% | 3.47% | 3.3% | 3.6% | 3.9% | 4.4% | 4.5% | 4.3% | 4.6% | - | - |
| | Improving Access to Psychological Therapies - Recovery Rate (3 month rolling basis) | 50% | 50.0% | 48.6% | 48.5% | 51.4% | 50.9% | 52.7% | 51.4% | 53.8% | 50.8% | 50.8% | - | - |
| EIP | Early Intervention in Psychosis - % seen within 2 weeks (3 month rolling basis) | 56% | 45.0% | 44.0% | 51.0% | 67.0% | 70.0% | 80.0% | 91.0% | 91.0% | - | - | - | - |

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

## 1.3 Performance Improvement Framework

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 jointly 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. These actions and the funding to support transformation has in 2019-20 been supported in some areas by continued NHS England and NHS Improvement non-recurrent funding and allocations from the Humber, Coast and Vale (HCV) Care Partnership as part of collaborative programmes of improvement (e.g. respiratory, diabetes).

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. It is then linked to the CCG risk register and framework and an integrated performance and risk assessment undertaken to support any escalations to Governing Body.

The 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, understanding the potential impact of performance deterioration or improvement on our patient safety and experience of care.

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

Contractually performance is formally monitored with providers through formal contract management boards and subgroups with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and Nuffield Health York Hospital and Ramsay Healthcare UK.

During 2019-20 the CCG monitored finance, quality and performance for acute services with YTHFT through an aligned fixed upper value contract and associated subsystem governance framework across York and North Yorkshire (Scarborough & Ryedale population) which incorporates joint working groups for performance, quality improvement and financial and contracting.

Additionally, there are now joint provider commissioner subsystem boards which have collective and single oversight of all improvement and transformation work being undertaken across health and care partners in the system to support financial, performance or quality recovery. These include the Planned Care Board, the Cancer Strategic Board, the Quality Improvement Board, the Health and Care Resilience Board (the local A&E Delivery Board) and System Delivery Board (financial recovery).

## 1.4 Insight and intelligence

The CCG proactively works with all partners and across localities to understand the challenges and pressures services and teams face in providing access to and delivering care to our patients.

The Governing Body GP Leads provide a direct link to their localities and practices, steering where the CCG teams need to focus on performance queries and in-depth analysis.

During 2019-20 the CCG clinical leads and lead officers have worked with providers and partners to explore the demand, capacity and sustainability pressures experienced in delivering services, including ophthalmology, radiology, pathology, gastroenterology, dermatology and MSK orthopaedics services. This has led to joint work led by local clinicians to scope new models of prime provider delivery across all partners.

In February 2020 the CCG along with North Yorkshire CCG (NYCCG) started a systematic desk top review of all clinical services with YTHFT to highlight sustainability issues in services which are working to deliver care across their footprint and sites. This review will be revisited in the recovery period after COVID and in light of changes to pathways and care delivery during COVID-19 pandemic.

The Council of Representatives have supported service deep dives with dedicated time on their bi-monthly meeting agendas, and members have provided primary care clinical input to some of the work streams prioritised from deep dive discussions (e.g. pathology).

The Governing Body and CCG Committees have dedicated time throughout 2019-20 to focus on the following priorities:

- End of life care
- Enhanced care in care homes and domiciliary care
- Physical health checks for people with severe mental illness
- Rapid expert input from secondary care prior to referral
- Urgent care in primary care and out of hospital settings including Urgent Treatment Centres
- Community services
- Improving access to general practice at weekends and evenings
- Primary care estates

The shared local system Commissioner and Provider Boards have responsibility for delivery and oversight of the impact of the priority work streams collectively identified by providers and commissioners to improve service performance, quality and efficiency. These link to the Humber, Coast and Vale Health and Care Partnership, NHS England and NHS Improvement collaborative programmes of work supported by local CCG and provider Senior Responsible Officers, and share the learning from other parts of the Humber, Coast and Vale region with local services and clinicians.

## 1.5 Drivers for performance improvement

### 1.5.1 Collaborative work as a system

In 2019-20 the focus of the CCG, local clinicians and partners to improve performance has been focused on **working collectively and collaboratively** to:

- better understand local population health needs and behaviours in accessing services particularly in community settings (**need**);
- better understand where care pathways are not always meeting needs and the root causes why; this has included workforce, estates and equipment (**capacity**) pressures which services are managing which have made some care pathways unsustainable to support the levels of need in our local population;
- **identify joint priorities** for working together to improve and integrate services and change the way care is delivered;
- agree **target investments and transformational funding** to help drive these improvement priorities and in turn have the greatest impact for local people's health outcomes and our workforce.

This increasingly **aligned approach to services, performance and quality improvement** has been supported through:

- moving from contracting acute services under a Payment by Results framework and instead working within an agreed **fixed value contract that focuses on transformation** rather than performance improvement through additional expenditure on extra capacity;
- funding to support clinical backfill to **enable clinicians to lead improvement** work including testing new provider models;
- the establishment of our Primary Care Networks with a stronger focus, influence and **clinical leadership at place and locality** to drive opportunities for improvement and build resilience at a time when the GP workforce is most fragile;
- joint intelligence from **population health needs** (investment in new RAIDR tools) and **multi-morbidity needs assessment** which support all partners in prioritising the people with the greatest health inequalities in our communities to support and target;
- further strengthening of the third year of **partnership working with our mental health provider** TEWV, building on two years of increased investment in mental health services;
- the further development of **joint commissioning with our local authority partners** and the establishment of place-based Partnership Boards;
- intensive **external support provided by NHS England and NHS Improvement** and our regulatory bodies transitioning into one joint provider and commissioning regulator and the associated development of **single system oversight** of finance, performance and quality;
- the development of **joint modelling tools** across health and care which allow partners to collectively understand the impact of agreed changes;
- **transformational funding** from our Humber, Coast and Vale Health and Care Partnership (ICS) to support all partners in collectively developing and delivering improvement programmes and focusing on the most complex and challenged services and pathways (e.g. Cancer Alliance timed pathways for colorectal, breast and prostate and emerging lung health, eye care, diabetes, respiratory, cardiovascular disease (CVD), outpatients transformation);
- early **provider collaboration**, stronger **provider networks** and emerging ideas around what a future integrated care partnership would look like across North Yorkshire and York.

### 1.5.2 CCG leadership in the local system

The **CCG's commissioning intentions for 2019-20** laid out a clear ambition to jointly transform physical and mental health care which would focus on addressing some of the key drivers underpinning performance improvement, including:

- Avoiding patients going into **crisis** and presenting in crisis at the wrong place and service (urgent care and crisis response in community; 24/7 mental health crisis).
- **Early intervention** and improved management of long term and chronic conditions to avoid deterioration (Anticipatory care; access to IAPT; frailty and ageing well; CAMHS

therapy and online tools; improving the autism pathway and assessments; schools-based mental health teams).

- **Early detection and preventative** thinking and practice across all care providers (weight management and very low calorie diet pilot; alcohol support; improved diagnosis and management of COPD and pneumonia; pharmacy support for identifying patients with CVD; heart failure care pathway; stroke; dementia diagnosis; early intervention in psychosis).
- Screening and **early/ rapid diagnosis** to improve health outcomes, survival and quality of life such as rapid diagnosis centre for vague symptoms and straight to test and FIT testing (cancer).
- **Early specialist input and outreach** including the diabetes specialist outreach and footcare teams, health navigators and IAPT & first contact practitioners co-located in primary care.
- **Rapid expert input** before patients are referred for outpatient care and avoid waiting on waiting lists; using video consultations technology to support patients virtually; optimising the back pain pathway supported by escape pain support tools for local people with hip, knee and back pain.
- **Personalised and Co-ordinated Care** including social prescribing, shared decision making, support for high intensity users of local services, care co-ordinators in primary care, self-care and empowerment, personal health budgets and personalised stratified follow-up care.
- **Supporting everyone to be digitally capable** so that all technological enablers can be used to improve access, support and care.
- **Shared care records and networked imaging / pathology** so that core patient information and diagnostics are always available for our teams.
- **Shared care plans** so that teams across our services can work together to produce a single care plan.
- **Improving early access to psychological therapies** for local people to support their mental health and wellbeing alongside their physical health, and supporting our population managing functional illness and enduring conditions.
- **Sign-posting** for local people and all first contact services and practitioners so they can understand which services are available to local people and how to access them (‘right care first time’).

The CCG has actively supported and enabled the development of stronger and more resilient partners and partnerships locally during 2019-20 to allow these commissioning intentions to evolve into collective integrated care intentions. This was a key strategic objective in 2019-20 to establish a foundation for a local integrated care system that is able to deliver the ambitions of the NHS Long Term Plan.

This has involved the CCG providing senior leadership and programme capacity to work directly with and in partner organisations, to lead and support all local shared Boards and deliver joint work programmes.

CCG lead officers are now working predominantly in Primary Care Networks (PCNs), in joint commissioning and partnership roles with providers and local authorities, and as Senior Responsible Officers (SROs) for HCV collaborative networks and programmes (e.g. outpatient transformation, respiratory, diabetes, personalised care).

### 1.5.3 Primary Care Networks and clinical leadership in primary care

Primary Care Networks have created a strong foundation of place-based priorities and worked to establish stronger community partnerships which have started to develop the vision for proactive out of hospital care delivery integrated across health, care and voluntary services. The CCG have supported this with the commencement of their work with Primary Care Networks and partners to co-design the future delivery of same day urgent care across each place. This Urgent Care in Primary Care Transformation Programme will further develop in 2020-21alongside the CCG's work with primary care partners to improve resilience through improvements to workforce, estates and digital capability.

Additionally, the CCG has continued to work with primary care to manage the growing Care Home and Nursing Home population more effectively and collaboratively.

### 1.5.4 Partnership working across mental health, learning disabilities and autism

The CCG and TEWV jointly recruited a **Head of mental health partnerships role** to work across system and strengthen partnerships which cut across health and social care. The CCG worked with Dementia Forward to commission a **specialist dementia nurse** with the aim of preventing avoidable unplanned hospital admissions. The specialist dementia nurse is providing wrap-around care across the health system to identify patients and risk factors for avoidable hospital admissions.

The CCG has supported further **crisis resolution** through allocating crisis transformation funds to improve crisis pathways and access to 24/7 urgent and emergency crisis resolution and intensive home treatment functions by 2020 across the sub systems. The crisis telephone response will operate as a virtual single point of access with North Yorkshire to support demands 24/7 and in particular out of hours. This has allowed open access to the urgent mental health pathway and achieves high fidelity across the local population which is tailored to locally identified priority demographics.

A therapeutic intensive short breaks facility children and young people with high level mental health needs is now in place in York as an alternative to inpatient or residential placements. This is part of the cross partner work to integrate services and care across the whole children's pathway along with the development of plans for bespoke supported living accommodation for those with behaviours that challenge and/or autism in York which will open in 2020.

The **Learning Disability education facilitator** for health interventions with care providers has been established during 2019-20.

### 1.5.5 Focus on personalised care and complex care

The CCG's Programme Manager for Complex Care now provides a **personal health budget mentoring role** to other CCGs to support them to offer personal health budgets as the default delivery model for continuing health care domiciliary packages of care and help build expertise in implementing personal wheelchair budgets.

**Personal wheelchair budgets have been implemented** across the York and North Yorkshire sub-system to improve choice and control for wheelchair users and drive the integration of budgets across health and social care.

A **Humber, Coast and Vale Continuing Health Care Network** has been established and led by the CCG to collaborate, share resource and explore how we can work at scale and standardise our complex healthcare offers to patients including settings of care.

The CCG has engaged in transformation work across Humber Coast and Vale regarding pathways and outcomes for neuro-rehabilitation.

## 1.6 Cancer

The key ambitions in the NHS Long Term Plan for cancer, to be delivered by 2028 are:

- 55,000 more people each year will survive their cancer for five years or more;
- 75% of people with cancer will be diagnosed at an early stage (1 or 2).

In support of delivery of the CCG's contribution to the national ambitions the organisation has continued to develop an integrated approach to planning and operational delivery with its partners, via the local joint partner Cancer Delivery Board and Cancer Strategy Group (York Teaching Hospital NHS Foundation Trust and North Yorkshire CCG) and all key stakeholder organisations allied to the Humber Coast and Vale Cancer Alliance.

Each year in the Vale of York, circa 2000 individuals are diagnosed with cancer and there are circa 890 cancer deaths.

### 1.6.1 Improved survival

Advances in diagnostics, treatment and care (including genomics testing and individualised treatments) are significant contributing factors to improve survival rates.

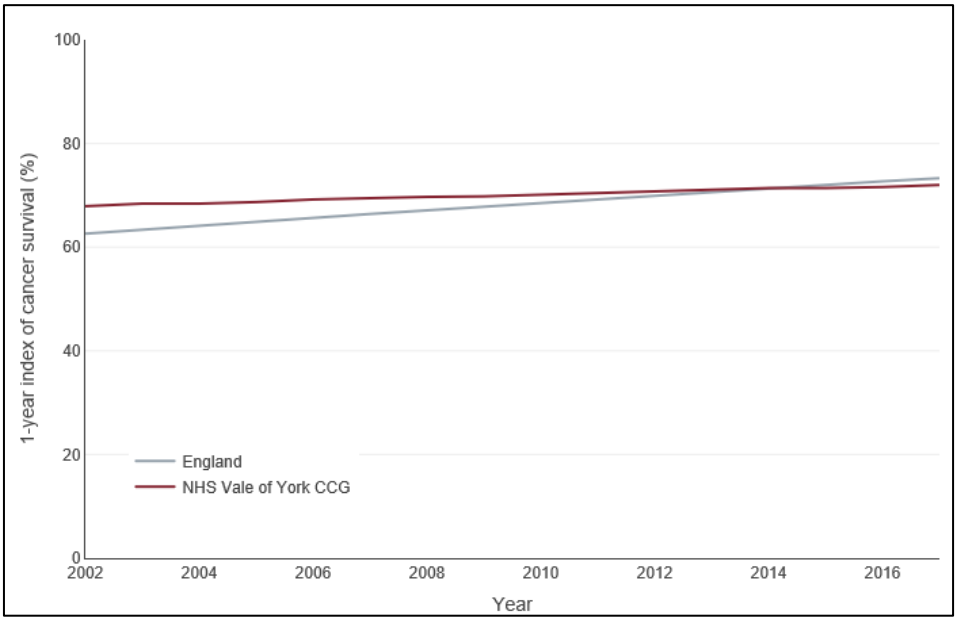


**Figure 1** – One year index of cancer survival 2002-16 in the Vale of York compared to national data

Whilst one-year survival rates for cancer patients in the Vale of York are not dissimilar to that of England, the rate of increase in survival rates is less that the national rate. Further analysis will be undertaken in 2020-21 to understand this difference and action plans will be reviewed accordingly. The CCG and the Humber, Coast and Vale Cancer Alliance has worked with partners across primary and secondary care to deliver earlier diagnosis, rapid diagnosis for patients with vague symptoms whilst ensuring the timed pathways for patients with prostate, breast and colorectal cancers are all in line with national best practice. The CCG has also been able to reflect and understand the potential impact of early work in Hull and nationally for lung health checks and oesophageal cancer.

### 1.6.2 Cancer Champions

Improved survival rates also require individuals to engage in 'healthy' behaviours and to respond appropriately to the signs and symptoms of suspected cancer. In partnership with the Humber, Coast and Vale Cancer Alliance, there are 520 Cancer Champions in the Vale of York (as of April 2020). Cancer Champions help to spread messages in their neighbourhoods and workplace about cancer prevention, making people more aware of signs and symptoms of cancer and encouraging people to take up screening opportunities.

### 1.6.3 Screening

Regular screening for breast, bowel and cervical cancer provides an opportunity to identify and treat cancers at an early stage of development, detect and treat pre-cancer disease (e.g. management of lower GI polyps). These appointments also provide an opportunity to identify and address if possible, behaviours which are not conducive to good health (e.g. smoking). In general the population of the CCG responds positively to the opportunities offered by the screening programme.

| | | NHS Vale of York CCG | England |
|---|---|---|---|
| **Breast** | Females aged 50-70 screened within the last 36 Months | 77.8% | 71.6% |
| **Cervical** | Females aged 25-64 attending within target period | 75% | 72.6% |
| **Bowel** | Adults aged 60-74 participating in the programme following invitation | 66.7 | 60.4 |

**Table 2** – Screening rates for breast, cervical and bowel cancer in 2018-19

In 2019-20 there have been two changes which are, and will continue to have, an impact on the cancer screening programmes. These are:

- The introduction of an updated screening test in the bowel screening programme has resulted in an increase in uptake following invite in addition to increasing the detection rate for bowel cancer following screening.

- The introduction of the Human papillomavirus (HPV) test as the primary test in the cervical screening programme will, as a result of increased sensitivity provide a longer protection of negative results and increased detection rates.

In addition, the introduction of the HPV vaccination in boys aged 12 -13 years will reduce the numbers of HPV related cancers in the future.

Further work in 2020-21 will be undertaken to determine the factors underlying the apparent reduction in proportion of stage 1 and stage 2 cancers diagnosed from 55.1% in 2017 to 51.9% in 2018.

### 1.6.4 Early diagnosis

In response to national guidance, a Rapid Diagnostic Centre has been developed at York Hospital for patients with ‘serious, non-specific symptoms’. The pathway went live in South Hambleton in January 2020 and early data suggests an average time from referral to diagnosis of 7-10 days. This pathway also supports the efficient use of resources in addition to reducing patient anxiety. Plans are in place to include upper gastrointestinal referrals as part of the five year plan.

### 1.6.5 Imaging

Throughout the year, work has continued with the radiology team at York Hospital to complete the technical roll out of the radiology workflow solution. This system will enable shared

reporting capabilities across the Humber, Coast and Vale area, supporting more rapid turnaround of radiology reporting and access to specialist and second opinions. The majority of work has been completed and the system will go live in early 2020-21.

Workstations have been tested and approved by the radiologists and IT teams. The team at York Hospital has also benefitted from c£50k investment from Humber Coast and Vale Cancer Alliance to support investment in additional training in areas including: ultrasonography, nuclear medicine, MRI, CT and fluoroscopy which will help to build diagnostic capabilities for the future.

### 1.6.6 Pathology

The York and Hull Pathology Partnership have carried out significant pieces of work towards developing a future service model for the region. Funding from the Cancer Alliance has enabled work to commence on the digitalisation of services which should support more rapid diagnosis and easier access to specialist and second opinions.

### 1.6.7 Cancer two week waits

The CCG met and exceeded the **Cancer** two week wait (fast track referrals) performance target of 93% in August 2019. Performance at end February 2020 was 96% and this was achieved while managing an increase in fast track two week referrals of 6% compared to referral levels in 2018-19. The improvement work in dermatology to delivery tele-dermatology and also the one stop model of care has been a significant driver in delivering this fast track performance above target.

### 1.6.8 Cancer 62 day referral to treatment

The CCG 62 day cancer target from GP referral to first treatment in 2019-20 remains below national target and this has deteriorated during 2019-20 despite the joint work across the local and Humber, Coast and Vale Health and Care Partnership and Cancer Alliance to improve performance. There have been significant pressures on:

- Workforce capacity – affecting dermatology, urology and oncology.
- Diagnostics capacity - impacted by increasing fast track referrals and screening programmes.

However, York Teaching Hospital NHS Foundation Trust has prioritised diagnostics capacity to support faster diagnosis to support delivery of a 7-day turnaround for all fast track referrals requiring diagnostics, and this has contributed to improving the 28 day faster diagnosis standard performance during 2019-20 and being close to target for 2020-21.

Additionally, the Rapid Diagnostics Centre pilot has been established and early impact assessment has seen patients that enter the rapid pathway receiving their results within 3 to 5 days.

### 1.6.9 28 days Faster Diagnosis Standard

The new 28 day Faster Diagnosis Standard ensures that patients who are referred for investigation of suspected cancer can find out, within 28 days of referral, if they do or do not have a cancer diagnosis. The standard was introduced in April 2020 with a national operating standard of 75%, as published in the 2020-21 NHS Standard Contract. The CCG's main provider, York Teaching Hospital NHS Foundation Trust, achieved 71% in January 2020 against a benchmark of 63% in July 2019. The Faster Diagnosis Standard is particularly challenging for prostate, colorectal and skin pathways.

### 1.6.10 62 Days (from referral to first treatment)

Whilst the population served by the CCG and York Teaching Hospital NHS Foundation Trust, in general, achieve the shortest 62 day waits across the Humber, Coast and Vale Cancer Alliance area, both organisations failed to achieve the 85% standard for the majority of the year. Performance at end February 2020 was 75.3% but performance earlier in the year had reached 84.2%.

Diagnostic capacity and the management of patients on complex diagnostic and treatment pathways were attributable to the majority of breaches. Colorectal, urology (prostate) and head and neck cancers were the pathways most challenged by the 62 day standard.

There has been a concerted focus on supporting the skin cancer pathway and encouraging the use of tele-dermatology in primary care. This work is led by the CCG's Macmillan Cancer GP Lead. This has contributed to the delivery of the fast track performance at target and in turn to 62 day performance.

In summary, 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 drive further improvement in the one year survival rates for our local population diagnosed with cancer.

## 1.7 Diagnostics

There has been a continued deterioration in performance against the diagnostic target of 99% throughout 2019-20. Eight out of the 11 diagnostics modalities have regularly experienced breaches which have reduced their performance below the target of 99%. The areas most challenged in 2019-20 have included radiology, echocardiography, endoscopy (colonoscopy in particular) and non-obstetric ultrasound.

These areas have been driven by pressures from increases in diagnostics referrals, including particularly direct access referrals and a 6% increase in all fast track referrals, as well as capacity constraints in workforce, estate and equipment. There was a five month delay in the new endoscopy unit opening which had a significant impact on the overall diagnostics performance, but capacity for endoscopy is now significantly increased and supported by

additional specialist nurse roles in the new unit. There has been work undertaken to optimise the demand and direct access for some diagnostics, including MRI and for lower back scans, knees and shoulders in line with evidence-based guidance and the national back pain pathway; groin ultrasounds and changes to the criteria for prostate diagnosis to reduce MRI demand. These have helped reduce pressures on existing capacity and reduce backlogs; as well as improve routine reporting, and allowing YTHFT to protect diagnostic capacity for supporting seven-day turnaround of fast track referrals and rapid diagnostic testing.

Returning performance for diagnostics delivery to target remains a priority for the local system in 2020-21 with a focus on the Humber, Coast and Vale Health and Care Partnership diagnostics programme of investment in MRI, CT and networked pathology. The YTHFT diagnostics recovery programme will be revisited in the light of the COVID-19 pandemic.

### 1.7.1 Referral to treatment

Performance in 2019-20 for Referral to treatment in 18 weeks has reduced from 81.6% in April 2019 to 75.4% in February 2020 across all specialties and a significant proportion of this reduction has been due to workforce capacity shortages in key specialties, reducing the number of waiting lists in orthopaedics in order to manage the joint financial recovery plan and a delay in opening the additional outpatient clinics scheduled in the Community Stadium in York for sleep medicine and ophthalmology.

The specialties that remain the most challenged with workforce shortages include general surgery, gastroenterology, cardiology, ENT, ophthalmology and trauma and orthopaedics.

Referral to treatment in 2019-20 has also focused on reducing the size of the Total Waiting List (TWL) and improvement back towards the March 2019 position of 17,143 for the CCG and 27,536 for York Teaching Hospital NHS Foundation Trust.

Routine referrals to the main acute provider York Teaching Hospital NHS Foundation Trust have reduced by 3.7% overall during 2019-20 compared to 2018-19, with the local system benefitting from the Referral Support Service and joint work across commissioner and provider clinicians under an aligned contract to address unwarranted variation in demand for elective care and ensure value based commissioning across key pathways who are experiencing capacity pressures (ophthalmology, dermatology, MSK and orthopaedics).

The CCG and York Teaching Hospital NHS Foundation Trust have mobilised the programme of work around Rapid Expert Input Outpatients pathway building on the demand management platform supported by the local Referral Support Service 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.

York Teaching Hospital NHS Foundation Trust has one of the greatest levels of advice and guidance provision nationally and this continues to grow, providing a strong platform for the Rapid Expert Input Opinion transformation.

The provision of the new Patient Initiated Follow Up (PIFU) pathways for supporting patients have now been piloted in rheumatology and will be expanded across more specialties throughout 2020-21.

Additionally, the work to develop digital tools to support remote delivery of outpatient care, for example video consultations and telephone clinics, alongside shared care records and plans facilitated by the development of the Yorkshire and Humber Shared Healthcare Record exemplar have fundamentally changed the way our clinicians will jointly manage outpatient care and share patient information.

The Planned Care Board has refreshed a number of diagnostics pathways and implemented the national back pain pathway to ensure the diagnostics capacity and MSK support available is targeted to where it will have the greatest impact and outcomes.

### 1.7.2 52 week breaches

The number of 52 week breaches has reduced significantly from 87 in 2018-19 to 38 in 2019-20.

## 1.8 ECS performance

### 1.8.1 4 hour A&E waiting time

Performance against the 4 hour standard has improved during 2019-20, increasing from 80.5% in April 2019 to 83.7% in March 2020 with a more resilient winter period for all partners supported by targeted winter schemes and funding. 12 hour breaches have increased, however, and the quality impact of delivering emergency care with insufficient Emergency Department capacity and workforce has also resulted in some corridor care and long ambulance handovers on certain days. A dedicated patient safety group is focusing on these recovery areas under the Quality Improvement Board.

A significant amount of cross-partnership work was undertaken in 2019-20 to develop a single work programme across all partners with single oversight by the Health and Care Resilience Board. External support from the NHS England and NHS Improvement Emergency Care Intensive Support Team has facilitated all partners to collectively develop three core work streams targeting:

- transforming the delivery of urgent primary care to avoid patients needing to attend A&E or being conveyed there when there are other first contact services they can access to meet their needs out of hospital;

- in-hospital processes including ambulance handover and surge management in A&E; SAFER and same day for all emergency care and frailty models for inpatient areas to reduce admissions and length of stay to zero or one day;
- the delivery of improved multi-agency discharge pathways into the community for hospital inpatients to prevent prolonged hospital stays. This has included developing of an integrated discharge hub to support the implementing the new '*Why not home, why not today?*' discharge policy, known locally as Home First.

The CCG has continued to support funding for reducing the pressures on the local Emergency Department from:

- **Urgent Care Practitioners** in local Care Homes and supporting inner-city GP home visits to avoid unnecessary Emergency Department attendances and admissions;
- **enhanced care in care homes** programme,
- the provision of **additional staff in the Out of Hours** team to work alongside staff in the ED as well as additional capacity in out of hospital locations;
- developing the **Urgent Treatment Centre** based in York ED has been reviewed to understand that the patients it sees are appropriate;
- **UEC RAIDR App** to support live tracking of system pressures and proactive partnership response to de-escalation;
- **Improved access to primary care** with additional appointments now available every week;
- **Health Navigators** to proactively identify and support those patients in out of hospital settings;
- **high intensity users** pilot to support patients who frequently attend ED and who could have better support from services and interventions outside of hospital.

### 1.8.2 Delayed Transfers of Care

Local performance has improved during 2019-20. The total beds days lost to delays in transfers have reduced in both acute and non-acute providers. This improvement has been driven by work to:

- increase hours of home care
- develop a new neighbourhood care model for home care
- deliver improved multi-agency discharge pathways into the community for hospital inpatients to prevent prolonged hospital stays. This has included developing of an integrated discharge hub to support the implementing the new '*Why not home, why not today?*' discharge policy, known locally as Home First.

- refresh the assessment of care needs for patients needing nursing care in care homes to ensure this is optimised across clinical and care needs.

Local partners have also invested in a joint demand and capacity modelling tool which supports the collective assessment of the impact of joint actions and work around discharge. This has indicated that if discharge pathways can be improved alongside improvements in delivery of urgent care out of hospital and better flow in hospital, then the current care capacity available in the local system could better meet current needs.

### 1.8.3 Mental health overview

The work with partners to target additional investment and deliver jointly agreed improvement plans over the past two years has resulted in a significant improvement in performance across almost every mental health indicator.

### 1.8.4 Improved access to psychological therapies and recovery

Improved access to psychological therapies (IAPT) has improved from 3.52% in April 2019 to 4.6% in January 2020 (against the national 5.5% target by end Quarter 4) during 2019-20. Improved access to psychological therapies recovery has remained stable and at target at ~50%.

While recruitment of suitable qualified staff has proved a challenge in 2019-20 local action plans have been delivered using targeted investment. The assessment and treatment pathway has been refreshed and the backlog cleared working with Mental Health Matters to access additional capacity.

Alongside this there has been increased efficiency through the use of group therapy and the on-line referrals have improved productivity in order to target access rates. The service is now able to anticipate changes in demand and is able to plan appointment capacity and stress courses accordingly alongside workforce capacity.

Improved access to psychological therapy workers have been co-located in general practice and there has been significant engagement with practices to educate and improve awareness of the improved access to psychological therapies offer and champion the service with the wider system. Employment advisers are also now working within the improved access to psychological therapies programme and two additional advisers will be in post in 2020-21.

### 1.8.5 Early intervention in psychosis

Despite referrals remaining high in the local area early intervention psychosis performance has improved significantly from 45% in April 2019 to 91% in November 2019 against the national target of 56%. This has been driven by increased investment of £200K to support additional posts and provision of increased slots every week to support the work of this dedicated clinical team.

### 1.8.6 Dementia diagnosis

Dementia coding and identification on GP registers has remained a priority for the CCG and practices, with a dedicated piece of improvement work undertaken with the practices in Ryedale to explore what the services could deliver to ensure all those with dementia are properly captured on a primary care register and supported appropriately. This has been supported by a dementia care co-ordinator recruited to the local Primary Care Network. There has been on-going implementation of an Intensive Support Team action plan including:

- raising awareness with GPs, highlighting the pathway in terms of memory assessment and the range of post diagnostic support available;
- targeted case finding now in most of Vale of York care homes and use of Diadem tool;
- training to central locality Integrated Care Team on use of Diadem and dementia quality toolkit to undertake case finding in the largest care homes in York, initially covered by 3 practices;
- Tees, Esk and Wear Valleys NHS Foundation Trust has now cleansed data from memory service and ready to reconcile with primary care dementia registers. Testing and then roll out;
- Tees, Esk and Wear Valleys NHS Foundation Trust recruited a research assistant post to undertake case finding in care homes;
- a Specialist Dementia Nurse has been in post from 1 February 2020 to support work aimed at reducing avoidable hospital admissions which will include liaison with GPs on strategies for case finding, screening for dementia and referrals for diagnostic assessment.

Two dementia coordination roles in primary care are supporting General Practice, clients and families to plan and access support they need. Dementia Forward is a key partner agency in offering this support. However, diagnosis rates remain challenged due to the on-going issues with 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, numbers of deaths and moves out of area.

## 1.9 Children and Young People's Mental Health

### 1.9.1 Access rates

Following investment in Children and Young People's Mental Health services this year, the additional funds have improved initial access rates and there are signs that the long waiting lists are beginning to reduce.

Internal waiting times however remain long and there continues to be increasing growth in referrals and caseloads.

The CCG and providers are working to establish appropriate local referral to treatment targets and to consider what level of additional investment will be required moving forward. Bids for central funding via the national New Models of Care programme have been submitted. Medical staff continue to prioritise crisis, the Single Point of Access service and eating disorders and are exploring the scope for telephone / Skype therapy for less complex cases.

Eating disorders waiting times for routine cases within 4 weeks have improved significantly and are now above the in-year national target of >60% .The urgent 1 week waiting time remains more challenged but performance has improved during 2019-20 with the rolling 12 month position at the end of quarter 3 performance up by almost 10% compared to the same period in the previous year.

### 1.9.2 Autism assessments

There has been sustained work throughout 2019-20 to address the long waiting lists for assessments through increased investment in staff of £180,000. The backlog has now been cleared and the long waits are reducing, whilst the overall waiting list remains stable despite on-going high referral levels. The team are working to deliver a 13 week waiting time target by June 2020.

### 1.9.3 Annual severe mental illness health checks

The update of the Local Enhanced Scheme to implement annual health checks for people with severe mental illness has proved challenging in 2019-20 with rolling 12 month performance at the end of quarter 3 at 27.3% against a national target of 60%. 16 practices have signed up to implement a Local Enhanced Service and a commitment to make improvements. Further uptake remains a key priority for the CCG and Primary Care Networks to drive this work forward in 2020-21.

## 1.10 Complex Health Care

### 1.10.1 Continuing Health Care Decision Support Tool in acute settings and Continuing Health Care decisions in 28 days

The CCG has undertaken sustained and significant improvement work across all aspects of the Continuing Health Care pathway to target long waiters and the discharge to assess process in acute settings. Additional staff have been appointed and a new IQA system was put in place to support decision making and streamline processes. The result of this work is that Continuing Health Care performance is above national targets and has been since May 2019. The local pathway and processes are now being used across the Humber, Coast and Vale area as an example of good practice.

### 1.10.2 Personal health budgets

Personal health budgets are the delivery model for all new and existing fully funded Continuing Health Care clients, including expanding this offer to all people eligible for Section 117 aftercare. Personal wheelchair budgets have also been implemented during 2019-20 for local wheelchair users to improve their choice and control. The CCG has driven the integration of budgets across health and social care to support personal health budgets and the result has been an increase in personal health budgets from 38 in 2018-19 to 174 in 2019-20. Children's wheelchair waiting times are also close to target performance.

### 1.10.3 Learning Disability Annual Health Checks

The CCG aims to promote health equality and better health outcomes for people with learning disabilities. Adults and young people aged 14 or over with a learning disability on the GP practice learning di register should be invited to attend an annual health check with the aim of improving health outcomes**.** 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.

A learning disabilities clinician training event for all practices and subsequent carer event were delivered during 2019-20 and there is a now a newly commissioned Learning Disabilities Support Team in York led by a GP Partner from Haxby Group Practice. Together these partners are developing a healthcare service that is accessible and appropriate to meet the specific needs of the learning disabilities community.

## 1.11 Financial performance

### 1.11.1 An overview of 2019-20

In May 2019 the CCG submitted a financial plan which described a financial deficit of £18.8m. This plan was accepted by NHSE/I although it was not compliant with the published control total deficit of £14.0m. However, the Governing Body considered the plan to be achievable in the wider context of NHS service delivery, access and performance standards, and safety.

As part of the plan a fixed value contract was agreed with the CCG's main provider of acute and community services for the first time. This provided important financial stability which had previously been absent in the CCG. As part of that contract agreement, the hospital and CCG committed to a joint programme management approach to significant additional system savings plan, valued at £11.2m, and in excess of savings plans submitted as part of draft plans

in January. Commitment was also made to take an equal share of any over or under achievement of plan.

In this context the CCG has continued to forecast delivery of this plan throughout the financial year and this has been reported to the Finance & Performance Committee, Audit Committee, and at the public meeting of the Governing Body as well as to NHSE/I in its role as the CCG's regulatory body. The CCG continues to operate under legal directions from NHSE/I in regard to its deficit financial position.

Although the CCG has not delivered planned savings in prescribing spend, in part due to national changes in medicines pricing around category M drugs, and other supply issues (no cheaper stock obtainable), appropriate recovery actions were identified and agreed by the Executive Team in September, implemented, and offset the increased prescribing spend.

The system savings plan achieved a further £2.8m savings which otherwise would not have been delivered. This did mean a shortfall in the original plan of £8.3m of which £2.8m fell to the CCG to resolve. As part of its initial planning the CCG had set a contingency reserve of £2.4m which in the main has offset this issue.

As such, the CCG has been able to maintain its improvement trajectory in bottom line financial performance and prior to any additional sustainability funding from NHS England and Improvement (NHSE/I) delivered its agreed plan at £18.8m deficit in 2019-20, an improvement over 2018-19 where the deficit was £20.0m against a deficit plan of £14.0m. At the same time the CCG has been able to invest in improvements in mental health services, and in primary care capacity in line with Governing Body commitments and national planning expectations.

In achieving this improvement in bottom line financial performance the CCG has made several improvements in aspects of financial control. Operational aspects of the exceptions identified last year around QIPP delivery, budget control, and planning and forecasting which in part led to the failure to deliver the agreed financial plan have been addressed and improved.

Had the CCG agreed to the intended control total of £14.0m deficit for 2019-20, it would have had access to Commissioner Sustainability Funding of £14.0m and in effect been able to report a break-even position and importantly not add to its cumulative deficit. In not agreeing a plan compliant with control total the CCG lost access to that fund and that was the expected position throughout the year. At year-end however, NHSE/I reinstated access to the fund for the CCG which means a further £14.0m of revenue resource was made available to the CCG improving the bottom line deficit to £4.8m. In addition to that, NHSE/I allocated an additional £4.8m to the CCG which resulted in an overall break-even position. This will be the first time since the 14/15 financial year that the CCG has been able to report break-even.

However, the exit underlying position for 2018-19 was a deficit of £24.5m. The underlying position at the end of 2019-20 was the same deficit at £24.5m. While the CCG has successfully achieved an improved bottom line position overall, this was achieved non-recurrently. As such, maintaining financial control, and improving system delivery of clinically led change will continue to be a consistent feature of the medium term plan. This is recognised in the published financial recovery trajectory for the CCG which does not expect the CCG to

break even without additional financial recovery funding through the next four years to 2023-24.

The CCG's internal audit function has carried out annual audits covering budgetary control and forecasting and gave the highest level of assurance possible to the CCG's Audit Committee that a strong system of internal control is operating effectively. The draft Head of Internal Audit opinion for the year gives an overall rating of significant assurance that controls are effective and operating consistently across all aspects of the CCG's functions.

## 1.12 Sustainable development

The CCG's ambition is to commission safe, effective and clinically-led services for its local population and to do so in a way that secures better quality of life and health for its population in a sustainable way, meeting the needs of the present without prejudicing the needs of future generations. 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.

The realm of sustainable development covers a wide range of activities, from the reduction in the use of fossil fuels, to reducing waste for example in prescribing, increasing recycling and reducing the rate of use of single-use plastics. For 2019-20, the CCG has focused its efforts on the reduction of waste in prescribing, working to ensure that repeat prescriptions are reviewed on a regular basis, and a recycling for scheme for community equipment, asking members of the community to return old equipment such as crutches to a central point for re-use. This year has also seen the introduction of food recycling bins in West Offices as well as bamboo-based re-usable coffee cups made available for purchase to replace single-use coffee cups.
In order to fulfil its responsibilities for the role the CCG plays in the wider health economy, NHS Vale of York CCG seeks to achieve sustainable commissioning in line with definition cited in its Sustainable Development Management Plan (SDMP) 2016-20.

In 2017-18 the CCG was awarded recognition for excellence in sustainability reporting from the Sustainable Development Unit (SDU), NHS Improvement and the Healthcare Financial Management Association (HFMA). High quality reporting on sustainability is considered to be a fundamental route for organisations to demonstrate their commitment to embedding environmental, social and financial sustainability.

As part of the NHS, public health and social care system, it is the CCG's duty to contribute towards the level of ambition the NHS set in 2014 reducing CO2 emissions by 34% (from a 1990 baseline). The CCG's main office was constructed to high environmental standards, with heat exchanger systems, rainwater capture and re-use, bike storage and showers, multiple recycling points including for food waste, and is situated close to major public transport routes.

Given the existing energy-efficient properties of the building, the rate of energy usage has remained relatively constant.

The CCG aims to reduce carbon emissions from staff travel by enabling the use of teleconferencing and remote working, and encourages car-sharing and the use of public transport and cycling.

The CCG has assessed its environmental progress by means of the Sustainable Development Unit's Assessment Tool and has used this to develop further goals. The reduction of single-use plastics is a key NHS target for the forthcoming year and the CCG will be seeking to influence its partners to participate in such reduction. The CCG's sustainability plan, to be known in future as the 'Green Plan' (formerly the Sustainable Development Management Plan), is due for renewal in 2020-21 and the CCG will work with its partners to meet the challenging future goals of environmental sustainability as part of a Green NHS.

## 1.13 Improving quality

### 1.13.1 A summary of the CCG's quality and safety work

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 – Lay Member of the Governing Body (Chair) Clinical Chair of the Governing Body (Deputy Chair), the Executive Director of Primary Care and Population Health, and the Chief Nurse. 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

The committee increased the frequency of meetings in December 2019 to holding these monthly and introduced a new bi-monthly work plan for in depth analysis into individual service areas. This was introduced with a view to gaining a deeper understanding of quality, achievements and challenges and to determine additional ways the CCG can support its providers. The first in depth analysis in January 2020 focussed upon the rapidly changing landscape of primary care.

### 1.13.2 Monitoring quality

All services are reviewed in line with the NHS England and NHS Improvement's Quality Monitoring and Escalation Process and services are reviewed dependant on whether they are under enhanced or on 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.

The CCG acts on local intelligence and provides swift, effective support. Work during 2019-20 included a Risk Summit that took place in August 2019 and focused on York Teaching Hospital NHS Foundation Trust's quality and safety work to meet the essential Emergency Care Standards and to tackle outbreaks of C-Difficile. Following this a Quality Improvement Board was established with system partners to support wider understanding and the implementation of actions to make improvements and gain assurance on patient safety. A key example relates to how patients have their care needs met whilst being in the Emergency Department for lengthy periods and work to ensure that any later risks and potential harm are identified in subsequent days when the patient is transferred to a ward. Consistent approaches have been developed and implemented across YTHFT's sites at York and Scarborough.

System partners engaged within the Quality Improvement Board include both commissioners across the Vale of York and North Yorkshire, YTHFT, the Care Quality Commission, NHS England and NHS Improvement. A detailed work plan is in progress and being monitored through the Quality Improvement Board.

### 1.13.3 Quality intelligence

The CCG proactively works with partners to gather local intelligence. This comes from a number of sources that includes the robust monitoring of patient complaints and feedback as well as responding to soft intelligence gathered from through partnerships and the CCG's platform YorInsight.

The CCG also works closely with its safeguarding partners, 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 committee meeting the Head of Engagement provides an update about the CCG's patient and public involvement work and plans. Feedback from the CCG's engagement activity is highlighted and discussions around how this can help to shape the CCG's commissioning work and decisions have a pivotal role.

### 1.13.4 Palliative care and end of life care services

The End of Life Care Strategy and End of Life Citizens charter were developed and launched in 2019. These continue to shape the work being undertaken across the Vale of York to improve end of life care for individuals and their families.

Utilising our Protected Learning Time with our Macmillan GP Lead for Cancer and End of Life Care, we now have all GP practices signed up to our Electronic Palliative Care Coordination System. The system supports better conversations, advance care planning and coordination across the local health and care system.

A project to review the 'fast track' pathway for people requiring a package of care at the end of their life was undertaken in 2019. As a result processes have been streamlined and reduced to both ensure that more timely packages of care are in place by providers who regularly care for patients and their families at this stage in their lives. This will continue to be a focus of our work in 2020-21.

### 1.13.5 Research and development

The CCG continues to develop and expand its research, innovation and evaluation work. The Research and Development Manager supports research in primary care and takes the role as conduit between the Clinical Research Network and our member practices. The role also supports patient participation events in primary care.

General practice research has had another successful year recruiting 670 participants into National Institute for Health Research portfolio research. Collaboration with the Bradford Institute for Health Research has been established and through Research Capacity Funding work is underway for a research study entitled 'A small scale exploration and testing of the Shared Safety Net Action Plan intervention in primary care'. The Bradford Institute for Health Research will be working with our member practices to test this tool that supports the CCG's priority for early cancer diagnoses.

The Research, Innovation and Evaluation web information is regularly updated to include research events, new research opportunities and innovative work being undertaken within the

CCG. The CCG's Research Partnership Group continues to grow with new partners that respond to the current research agenda and landscape.

### 1.13.6 Patient insight and feedback

The Engagement Team and Patient Relations Team meet each month to analyse patient insight to identify key themes of feedback. A key area of patient feedback has related to changes the CCG implemented regarding ordering of repeat prescriptions. Changes were implemented in order to ensure patients ordered medicines which were required at the time to avoid any unnecessary home stockpiling. This had a significant impact upon ensuring patient safety and reducing costs associated with unnecessary prescriptions. Feedback from patients has been invaluable in terms of improving the explanation of the rationale behind this work and the procedures for reordering prescriptions.

### 1.13.7 Continence support for children and young people

In 2019, the CCG worked collaboratively with its partner and provider York Teaching Hospital NHS Foundation Trust to develop a new paediatric Level 2 bladder and bowel service as per guidelines set by the National Institute of Clinical Excellence. As a result two new nurse specialists have joined the service to enable early support for children and young people and in turn reduce the likelihood of longer term intervention.

### 1.13.8 Campaign to reduce opiate prescribing

In April 2019 the CCG's Medicines Management Service teamed up with West Yorkshire Research and Development to offer support to member practices to reduce opiate prescribing. Within eight months of this support being provided there was a 0.2% reduction in prescribing with the added benefits for patients of improved pain control and improved knowledge of prescribers. Resources were made available to healthcare professionals to inform of the risks of opioid prescribing and to provide the necessary support tools to optimise prescribing options.

The CCG enrolled all practices to PrescQIPP, an e-learning module designed to raise the awareness of opioid prescribing and embed opioid champions in GP practices. The CCG also worked closely with secondary care to ensure appropriate primary care prescribing advice was presented on all discharge letters where opioids were being initiated. The combined effect of each of these interventions was aimed at ensuring improved pain control and patient safety.

### 1.13.9 Quality improvement and supporting our Partners in Care

Our most vulnerable residents are those who have care needs where they either live in a care home or receive domiciliary care. The CCG, in partnership with its health, social care and third sector partners support care homes and domiciliary care agencies to provide high quality, good quality care. Work stream priorities were influenced primarily through locally identified needs and the national framework and guidance for enhanced health in care homes.

Engagement and communication with these key stakeholders took place through bi-monthly Partners in Care forums and weekly Partners in Care bulletins.

### 1.13.10 Smiles Matter project

Following publication of the CQC Smiles Matter report, a project focussing on improvement of oral health in care homes was commenced in 2019. A resident and staff experience survey was completed which highlighted some areas of good practice relating to mouth care for residents as well as some areas where care homes staff can be supported to better to help improve outcomes for their residents. A training package to support best practice will be initiated later in 2020.

### 1.13.11 Identification of deteriorating residents

Training and support has continued with care homes to recognise early signs of a deterioration in residents utilising a softer signs 'Recognition and Responding to Deterioration' tool. This enables earlier conversations to be held with the residents health care team and 'person centred' plans to be put in place to meet the needs of the resident. This helps to instigate earlier interventions to prevent further deterioration and transfers to hospital when they are not necessary.

Since the Recognition and Responding to Deterioration project began, 10 care homes and one care agency have engaged in training with circa. 600 clients and 400 staff benefiting. Training has also been shared virtually where face to face attendance has not been possible.

Feedback has been positive with managers commenting that it has given the staff more confidence to communicate with other health professionals and has led to a more structured and comprehensive approach to the observation and responsiveness to deterioration in residents. Work continues with a number of GPs to support the delivery of care to a cohort of care homes.

### 1.13.12 React to Red – the prevention of pressure ulcers

The prevention of pressure ulcers remains a high priority for the CCG and it has continued to support care homes and domiciliary care staff through the continued implementation of the React to Red programme. This work was recognised as Highly Commended by Health Service Journal in its Patient Safety awards as well as being a Finalist in the Nursing Times Care of Older People awards.

### 1.13.13 React to Falls prevention work

Falls continue to be a threat to an individual's independence and quality of life. The CCG's work to reduce the risk of falling continues utilising the React to Falls Prevention programme. The CCG has so far supported 32 care homes and trained 587 care workers. Feedback is positive with recognition given to the training approach adopted by the team. Early data

regarding reduction in falls is positive, suggesting an overall decrease in falls. One care home with 100% staff attendance at the training of falls risk achieved a significant drop in falls.

## 1.14 Engaging people and communities

### 1.14.1 Introduction

Our vision is to achieve the best health and wellbeing for everyone in our community, and this can only be achieved by putting them at the heart of our work. Over the last few years we have built strong foundations in public engagement and this section of the report illustrates the volume, and impact of meaningful engagement that took place with our Vale of York community.

### 1.14.2 Our responsibilities

We are answerable to the public, our communities and patients. We must always consider the benefits of involving the public in our work, and seek feedback about services we commission. We follow a set of guidance established by NHS England and outlined in the Health and Social Care Act (2012).

We formally report our community engagement activities through the Quality and Patient Experience Committee (QPEC), which occurs monthly, and is chaired by the lay representative for patient and public involvement. At the start of each committee we hear a patient story to ensure that the service user voice is at the heart of every meeting.

We have a dedicated communications and engagement team, but firmly believe that engagement is everyone's business. 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. 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.

### 1.14.3 Our engagement strategy and principles

During 2019 we went into our local communities to ask what was important to them about how we involve our population in improving health and wellbeing. This allowed us to develop a set

of principles that underpin the communications and engagement work we carry out within our communities. You can watch the video about what is important to our community about engagement at https://www.youtube.com/watch?v=NTOmyoMtELQ.

The CCG's new engagement strategy 'Shaping future care, together: 2019-23' sets out its intentions for ways in which it aims to involve stakeholders and the population in delivering the best health and wellbeing for our population.

### 1.14.4 Our new engagement principles

| Principle | Description |
|---|---|
| **Co-produce with our population** | Ensure engagement is core to our planning, prioritisation and commissioning activities. Involve people who use health and care services, carers and communities in equal partnership. Engage with our communities at the earliest stages of service design, development and evaluation. |
| **Listen** | Seek and listen to views of our partners, patients, carers and other local citizens. |
| **Honest and transparency** | Hold honest, open and collaborative conversations from the start, so that people know what to expect. |
| **Collaboration** | Develop and strengthen relationships within the local community and across organisations. |
| **Inclusivity and accessibility** | Ensure accessible language and format, which is diverse and easy to understand for all communities. Ensure that those who may not always have the chance to have their say, such as seldom heard communities are represented. |
| **Feeding back and informing** | Ensure that those who have given their contribution understand what difference it has made, and the feedback is provided in a timely manner. |

**Table 3 -** Our new engagement principles

### 1.14.5 How we involve our population

The CCG creates a range of engagement opportunities to gather views and enable people to get involved and have their say. The information received is always rich in personal experience and helps to shape commissioning decisions, service specifications and improvement programmes. We use a variety of mechanisms and networks to involve the local population and gather feedback, including:

- Focus groups

- Informal discussions
- Formal consultations
- Stalls and stands
- Public meetings
- Regular stakeholder newsletters
- Social media – such as Twitter, Facebook and Instagram
- Surveys
- Press and media
- Meetings with voluntary groups and stakeholders

In January 2020 the CCG launched its new website after patients and the public said they wanted a site that was more accessible and easier to use.

A dedicated 'Get involved' section was created to enable people to voice their views and contribute to decisions about healthcare services. Events, meetings, networks and forums have been made clearer in the hope that more patients and members of the public will work alongside health professionals, local government and voluntary organisations to provide an impact in the wider community.

Newsletters and social media channels are key communications channels. We have over 5,000 followers on Twitter and followers include key stakeholders such as providers, partners, local MPs, councils and voluntary sector partners as well as members of the public. In 2019, we recruited a dedicated digital communications, web and media officer who has helped to expand our social media channels. We re-launched our presence on Instagram and Facebook and have used these to connect with more of our population.

### 1.14.6 Partnership working

Working collaboratively with health colleagues, local authority partners, voluntary organisations and the wider community is vital for helping to achieve best outcomes for the local population. These relationships have further strengthened and the CCG would like to thank colleagues for their on-going support and feedback.

### 1.14.7 Primary Care Networks

Primary Care Networks are a key part of the NHS Long Term Plan, bringing member practices together to work at scale and focus on delivery, to provide a wider range of services to patients in a coordinated way across communities. Through the development of these Primary Care Networks the Governing Body's engagement with member practices has enabled health and other services to work together to provide better access for patients.

We have implemented dedicated communications and engagement leads within each Primary Care Network to help provide support to help develop services around the specific needs of patients within each of its three localities in the north, south and central areas of the Vale of York. For example, in the north area, among other priorities the focus has been dementia. In

the central area the focus, among other work has been on mental health support for students and in the south area work has focused on raising awareness of social prescribing.

### 1.14.8 Working with our diverse communities

Through our work we have looked at how we can try different approaches to reach diverse communities to ensure all voices are heard. It is critical that we understand our population as this will help us to deliver services that are focused on meeting their needs and make a real difference to their health and wellbeing.

We are committed to addressing health inequalities and understand that some groups of people, including people with protected characteristics experience different access to services and outcomes when they use NHS services. This last year we have made improvements in the way that we assess engagement in relation to the Equality Delivery System. We have been using this system to help us to review and improve our equality and engagement performance for people with characteristics protected by the Equality Act 2010. Examples of this work include:

- Our work to hear the voice of the young person – students, children with a disability and mental health condition.
- A review of maternity service user engagement through the Maternity Voices Partnership (MVP). We received over 500 responses to a survey about care needs, which has been shared with the maternity service to help make improvements in care for service users.
- Training and awareness around understanding the barriers to healthcare for LGBT+ people.
- Working with community midwives in some of the most deprived areas of the city, with the highest smoking while pregnant rates, to ask mums what would help them to quit smoking. This information will help inform the Public Health Team's approach to stop smoking services for women who are pregnant.
- The launch of the joint York Learning Disability Strategy.
- Partnership working with the North Yorkshire Public Health Team and Age UK to create ageing and dementia friendly communities.
- Improving experience for wheelchair service users through the reinstatement of the Wheelchair Service User Forum.

### 1.14.9 A year of patient and public involvement

During 2019-20 we held hundreds of conversations and events which have fed into our work. Here are some examples of the CCG's diverse engagement activities over the last year.

| Month | Activities |
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| **April 2019** | **Diabetes prevention with major York employers**<br>As part of the National Diabetes Prevention week we organised a road show. CCG members, along with the local authority's well-being team and primary |

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| | care staff, visited a number of large companies within York including Portakabin, Nestle and Tesco. We provided opportunities for their staff to discuss the risks of developing Type 2 diabetes and signpost to support that is available to help them reduce their risk.<br><br>**Local response to the long term plan**<br>Our engagement team attended the York Healthwatch Assembly at Priory Street, and helped run a table top session focusing on a conversation about the NHS long term plan. |

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| **May 2019** | **Young people and mental health**<br>Partners met with the university student mental health forum and Open Door service to monitor the quality of services and ensure capacity to support student mental health needs. This resulted in increasing Improving Access to Psychological Therapies (IAMT) services on campus.<br>**Speaking at patient groups**<br>Our Head of Community Strategy was a guest speaker at the Haxby Group patient speaker even to talk about improving health in the community and tackling health inequalities.<br>**Ageing friendly communities**<br>In partnership with the North Yorkshire Public Health Team and local community sector organisations the CCG helped to facilitate a Selby Ageing Friendly event on 23 May 2019. The informal session started the conversation with local residents and voluntary groups about what would help them to live a healthy life. The themes covered communication, health, transport and access, housing and social inclusion.<br>**Speaking to parents about maternity care**<br>We were at The Mount School for a parents and children's event to speak with people about the maternity care received during pregnancy, throughout birth and postnatal care. |
| **June 2019** | **Mental health experts by experience**<br>We were part of a session with the experts by experience steering group of York Safe Haven to identify an expansion to crisis pathways. As a result of a successful bid for NHSE transformation funds, the opening hours of the York safe haven at weekends will be expanded. |
| **July 2019** | **Young Minds Combined**<br>We attended a seminar which brought young people, commissioners and providers together to discuss key issues for children and young people including mental health champions, online access and equity of services across the whole area.<br><br>**Family and carer engagement event** |

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| | The event in Ricall gathered carers and patients/clients and to ask for people's feedback on a 'Stop and Watch' prompt tool to help recognise deterioration of clients they may visit. Not recognising that someone is becoming unwell can lead to delay in getting help.<br><br>**Age UK training session on Continuing Healthcare (CHC)**<br>The CCG engagement, patient experience and continuing healthcare team met with volunteers from Age UK York to deliver a training session on continuing healthcare (CHC). At this very informal session we discussed the CHC process and checklist, complexities of care and finding packages of care for service users. We also had a good discussion about signposting and the information provided to patients. |

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| **August 2019** | **Humber, Coast and Vale engagement event**<br>Over 90 people (patients, public and partners) joined our Accountable Officer and colleagues from across the York and North Yorkshire system to be part of an important conversation about the setting the future direction of local health and care and the ambitions of the NHS Long Term Plan.<br><br>**Survey of patients attending A&E**<br>We spoke to 103 people who attended A&E to understand why patients have chosen to attend the Emergency Department, and if they have accessed other healthcare options such as a GP or pharmacist before their visit. This was used to help inform pathways and health campaigns. |
| **September 2019** | **Speaking to local carers to understand their needs**<br>We visited East Riding and York carers groups to give an update on the changes to the way in which people can order repeat prescriptions and to listen to their views about health services.<br><br>**Maternity Voices Partnership – Service user launch**<br>Our Chair of the York and District Maternity Voices Partnership (MVP) held its first session in family friendly location, and service users were encouraged to come along with their children. The group is open to members of the public and aims to improve services for women and their families during pregnancy, birth and postnatal care. Watch a video about the event at https://www.youtube.com/watch?v=9hIZ_dco7Is. |
| **October 2019** | **LGBT+ awareness training**<br>We brought Yorkshire MESMAC to run a number of training sessions around LGBT+ awareness and how we can ensure that we are an inclusive |

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| | organisation when we commission services. We opened the session up to external partners, Healthwatch and voluntary organisations.<br><br>**Launch of our new communications and engagement strategy 2019-23**<br>Our updated strategy, which was co-produced with our population, was approved by the Quality and Patient Experience Committee. |
| **November 2019** | **Meeting with wheelchair users to help shape services**<br>Wheelchair providers, commissioners, clinicians and service users came together to share feedback and experience at our bi-annual forum. Topics included personal health budgets, user experience and eligibility criteria. |

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| **December 2019** | **Student health campaign**<br>We held a stall at York College as part of their winter health and wellbeing day to talk to students about what would make a health campaign attractive. We will be using this feedback to deliver some targeted campaigns.<br>**Mental health design event**<br>We supported our local mental health provider at an event about Early Intervention In Psychosis service model. The event involved mental health staff, commissioners and people with lived experience to inform and shape the design choices. Their feedback focussed on the need for continuity of care and a consistency from the local teams. This has formed the basis of the new model and service expansion, to ensure an equitable offer to service users and carers across the locality. |
| **January 2020** | **Access to services for deaf and hard of hearing people**<br>In partnership with the local authority, Healthwatch and voluntary sector advocacy groups we reviewed feedback around the barriers to accessing services for deaf and hard of hearing people. The group will be hosting an event in April 2020 to look at collaborative solutions with services users.<br>**Protected Learning Time for primary care**<br>This session focused on art and creativity to improvde health and wellbeing. There were over 270 healthcare professionals and 30 community facilitators who focused on a person-centred approach and non-medical interventions.<br>**Engaging with young people with a disability**<br>In partnership with the City of York Council, we spoke to a group of children aged between 11 and 18 about what health means to them. As part of the 'Access for all' session we took along some nurses from the hospital and talked about what it is like to access healthcare from the point of view of a young person with a disability. |
| **February 2020** | **Regular catch ups with our local Healthwatch**<br>Our relationship with our local Healthwatch is really important to us. We regularly meet with Healthwatch York and North Yorkshire to discuss our community engagement work and to look at working together on future engagement projects. |

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| | **Working in partnership on the northern quarter mental health project**<br>People attended an afternoon workshop and mapping exercise to help develop a community approach to mental health and wellbeing.<br>**Creating a dementia friendly community**<br>Stakeholders in the north primary care network were brought together to focus on the needs of patients with dementia, and how to support them better in the community. This workshop looked at improving diagnosis rates, support available to patients and gaps in knowledge. |
| **March 2020** | **Supporting suicide prevention**<br>We supported the suicide alliance training run by the Humber Coast and Vale Partnership at York Explore Library. |

**Table 4**
- A year of patient and public involvement

### 1.14.10 Working with our local Healthwatch partners 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.

A Healthwatch member sits on our Primary Care Commissioning Committee and our Quality and Patient Experience Committee to represent the patient voice. We also join Healthwatch York at their drop-in session in the foyer of the City of York Council on the second Monday of each month.

We regularly attend local Healthwatch Assembly meetings, and have catch ups with members of the team.

| Date | Activities with our Healthwatch partners |
|---|---|
| **July 2019** | The CCG helped to facilitate table top discussions about the local response to the Long Term Plan. |
| **September 2019** | Our senior pharmacist and patient experience team met with Healthwatch York to discuss the changes to repeat prescriptions, and hear feedback from concerned citizens. |
| **October 2019** | Head of Engagement gave an update at the October Healthwatch York Assembly on how the views of the Healthwatch Assembly had shaped the CCG's engagement principles and strategy.<br>Feedback was also provided about recommendations in a recent Healthwatch report into the experiences of the LGBT community in accessing healthcare. |

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| | Healthwatch York joined us at our LGBT+ awareness training run by Yorkshire MESMAC. |
| **January 2020** | We met with Healthwatch and voluntary sector advocacy groups to review feedback around the barriers to accessing services for deaf and hard of hearing people.<br><br>Healthwatch formed part of the new website user group, and gave us essential feedback about the navigation and accessibility of our website. |
| **February 2020** | We invited Healthwatch North Yorkshire to attend our Easy Read training session, provided by Louise from EasyRead UK.<br><br>We held meetings with all our local Healthwatch teams to discuss future engagement priorities. |

**Table 5** - Activities with our Healthwatch partner

### 1.14.11 Clinical engagement

The Governing Body's engagement with member practices has grown and strengthened, and this has led to more detailed discussions about services and the specific needs of our patients.

In 2019-20 the CCG, in partnership with Hull and York Medical School, introduced quarterly Protected Learning Time sessions to enhance our engagement with clinicians from our member practices. These quarterly peer-led sessions set aside dedicated time for primary care colleagues to learn and share best practice. Fundamentally the Protected Learning Time is about improving patient care by providing a dedicated learning time for healthcare professionals away from their busy day-to-day primary care work.


**Figure 2** – A summary of our clinical engagement

In January 2020, we held our first themed Protected Learning Time session that focused on understanding more about patients' needs and how community-based resources might help to meet them and improve their care outcomes. The event opened with a plenary session followed by three workshops about chronic illness, young adults and avoiding burnout of staff in primary care. Over 30 community facilitators representing organisations such as the local authority health and wellbeing teams, link workers and social prescribers, York Explore Library, local singing and dance groups and arts based community therapies helped to facilitate discussions around connecting patients with their local community and non-medical resources.

These events will be the key to forging relationships and building clinical networks over the coming years. This has been an 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. Some of the changes that GP practices have made as a result of the Protected Learning Time sessions include:

- Asking about Adverse childhood Experiences (ACEs)
- Looking at the bigger picture and asking ‘what matters to you’
- Back pain management
- Menopause
- Changed the management of abnormal Liver Function Tests
- Mental health pathways
- Compression bandaging and wound care
- No dip urinary tract infections
- De-prescribing, opioids and medication reviews
- Paediatric care and access to a Paediatric consultant by phone
- Discussions about pregnant patients regarding medication and risks of medication in females of child bearing age
- Safeguarding: Changing the way of asking questions to children and parents (for prevent and child protection)
- Directing patients to using social prescriber
- Sepsis identification and management
- End of life care – tools and pathways
- Sexual health
- Understanding more about what happens during IVF and fertility prescribing pre-referral testing
- Implementation of cancer champions
- Useful resources on CAMHs referrals
- Knowledge of diabetes treatment and use of Freestyle
- Writing a report for the coroner

### 1.14.12 You said, we did

Receiving feedback about local healthcare services from patients is very important and we believe that the most important part of our role is ensuring that the feedback we get helps to shape change and improved patient care. Full examples of how patient feedback has influenced our work during 2019-20 are published on the Get Involved section of the CCG’s website.

# 1.15 Reducing health inequalities

### 1.15.1 Introduction to our work to reduce health inequalities

The NHS Five Year Forward View sets out the need to address the health and wellbeing gap and prevent any further widening of health inequalities. To do so requires a move towards greater investment in health care in the areas of high deprivation. The CCG's strategic plan echoes the overarching ambition of the City of York's Joint Health and Wellbeing Strategy 2017-2022 to support the communities for whom health and wellbeing outcomes fall well short of those enjoyed by the majority.

- York's population is now estimated to be just over 208,000 people.
- The city has become more culturally and religiously diverse with a Black and Minority Ethnic (BME) population of 9.8% (non White British) compared to 4.9% in 2001.
- By 2025, it is estimated that the 65+ population in York will have increased by 16%; the 85+ population in York will have increased by 32%; and the 0-19 population will have risen by about 9%. York's population is on the whole healthy (in a recent survey, 83.9% stated that they are in very good or good health compared to 80% regionally and 81.2% nationally). But this is not true of all communities and groups.

We know in York that 4.61% of the population live in Lower Layer Super Output Areas (LSOAs) which are amongst the 20% most deprived in England. People living in more deprived areas are more likely to have both planned and unplanned hospital admission, have long term conditions, experience reduced healthy life expectancy, and early death. This data is a crucial indicator for projecting future need and informing commissioning decisions.

This year our Public Health and CYC partners carried out a study to map the health of our population with comorbidities. The study found that the most frequently occurring sets of three conditions amongst multi-morbid patients were: diabetes, hypertension and chronic kidney disease (4.7% of multi morbid population); diabetes, hypertension and coronary heart disease (4.0%); and chronic kidney disease, hypertension and coronary heart disease (3.8%). The onset of multimorbidity occurred 10–15 years earlier in people living in the most deprived areas and these diseases are often preventable.

It also found that although people in their 70s are healthier than people a decade ago, the changing age structure of the population does not explain for example the 4% grow in inpatient demand every year. Age is not a cause of ill health per se – but as people age co-morbidities accumulate. Ageing is not preventable, but we can delay chronic diseases in older people. Population projections translate to 10% more care packages, an 8% rise in caseload for community nursing teams, a 2.5% increase in GP patient numbers, and 3.5% more consultations (JSNA 2019). Work is taking place in communities to tackle these demographic challenges and inequalities and will be based on all services working together on small geographic footprints.

### 1.15.2 Primary Care Networks and their work to reduce health inequalities

To meet these needs, general practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas through Primary Care Networks (PCN). These care networks build on the core of current primary care services and enable more integrated health and social care. There are six PCNs in the Vale of York, 3 of which are based in the city of York, and they range in size from 30,000 to 150,000 patient list sizes.

A key role for the emerging PCNs is to provide local clinical leadership to tackle health inequalities. The PCNs are using local health data and working with partners to develop strategic plans. An examples of local intelligence was the development of a chronic disease prevalence dashboard by PCN using Quality Outcomes Framework (QoF) data. This dashboard revealed how high rates of disease are related to areas of deprivation. Higher rates of hypertension, diabetes, COPD and obesity are seen in general practices in Selby Town PCN as compared to the England benchmark. Similarly, South Hambleton & Ryedale (SHaR) PCN practices have high rates of hypertension and stroke. Central York PCN practices on the other hand appear to have high incidence of cancer and hypertension.

In response to this, SHaR PCN who cover a predominantly semi-rural population have employed care coordinators for cancer and dementia patients. This has had a positive impact of the delivery of care for their patients, and the PCN was nationally recognized, coming runner up as PCN of the year. In Selby town, Selby PCN has forged links with the local district council, voluntary sector as well as local health providers, with a view to establishing multi-agency joint working to tackle local priorities in common.

In the city of York, the three York PCNs lead the York Health and Care Collaborative, an evolution of the multi-agency Primary Care Home model. Working jointly with Public Health specialists at the City of York Council, they have conducted analysis of local health data to understand multi-morbidity trends and local population health inequalities. This would help partners target health interventions optimally.

The PCNs represent the future of primary care and are the building blocks for integrated health care delivery going forward. Consequently, their ongoing development and maturity is a key priority for the CCG. To this end, the CCG has invested senior staff input to supporting the organisational development for the PCNs.

### 1.15.3 The needs of marginalised groups in the local area and how they are being addressed

#### 1.15.3.1 Physical health checks for people with severe mental illness

Evidence shows that people with severe mental illness (SMI) die fifteen to twenty years younger than the average population. This is one of the greatest health inequalities in England.

A new target set by NHS England aims to increase the uptake of physical health checks for patients with SMI to 60% within 2019/20.

In March 2019, the CCG approved funding to implement a Local Enhanced Service (LES) contract in primary care to ensure that people with SMI receive a comprehensive physical health check at least annually. Twelve elements are included within the new physical health assessments. The LES contract was taken up by 19 practices and this has led to an improvement in health checks done from 13.2% in October 2018 to the current position of 27.3% as of December 2019.

Links are also being made with community substance misuse services to establish potential crossover and opportunities for joint working. Alcohol and drug misuse are very common among people with mental illness, and vice versa. Health checks are undertaken on all patients registered with the local substance misuse services and these align with the recommended physical health assessments for people with SMI undertaken in general practice. The CCG is working with the drug and alcohol service to streamline the delivery arrangements for these two processes where possible and identify and link the patient into the most appropriate treatment pathway and follow-up interventions.

### 1.15.3.2 People with a learning disability

The CCG fully participates in the North Yorkshire & York Transforming Care Partnership to ensure the principles of Building the Right Support are embedded. This is the national plan which outlines a framework to develop more community services for people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition, and close some inpatient facilities. This partnership with Local Authority and TEWV has built a Dynamic Support Register for adults and children who are at risk of admission or placement breakdown. The partnership supports a Positive Behaviour Support role and a Forensic Outreach Team along with a community support offer from TEWV. The CCG is engaged within this partnership and with local medicines management teams to support the STOMP/STAMP agenda. STOMP/STAMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the over use of these medicines.

In addition, the CCG is engaged with a specific housing development for individuals with behaviour that challenges to ensure environmental triggers are reduced and least restrictive care is provided. The CCG has secured a clinical health trainer post to support learning disability providers of care in the locality to deliver best practice. This includes for example promoting the importance of health checks.

### 1.15.3.3 The homeless population

In January 2019, figures released by the Ministry of Housing, Communities and Local Government showed there were 29 rough sleepers found in York during an annual street count in November 2017. This was up from 18 the previous year. The percentage increase was three times the average for Yorkshire and Humber.

In April 2018, the JSNA Homelessness Health Needs Assessment for York captured the views and perceptions of people who are homeless or at risk of homelessness in York, and the professional views of those who work in organisations that support them. Lack of access to specific services, notably primary care services and specialist mental health services, was discussed frequently by stakeholders. For primary care the main barrier was perceived to be difficulties in registering with a practice, although concerns were also raised about the level of flexibility for those who miss appointment slots or need longer appointment time.

To address some of the barriers faced by the homeless community the CCG currently commissions a GP led clinic at Changing Lives – Union Terrace. This is provided by the York Medical Group who hold a fortnightly GP clinic at Changing Lives - Union Terrace. This is a highly valuable resource for homeless individuals engaging with Changing Lives, enabling them to see a GP outside of the surgery environment and with much greater flexibility in terms of appointment time and duration. In 2019/2020 we widened the accessibility to the clinic to provide outreach to meet the health needs of the homeless population to those not engaged with Changing Lives – Union Terrace. This has been achieved through working with voluntary organisations throughout York that provide services to the homeless community. Through these links we were also able to promote open vaccination clinics (e.g. flu) and offer preventative health information.

The CCG also commissions a fortnightly tissue viability nurse-led wound care clinic at Changing Lives – Union Terrace. This is in addition to wound care currently provided at the York Medical Group city centre practice. The practice currently makes arrangements to offer later appointments to accommodate shorter waiting times and longer treatment time (35-45mins rather than 15mins).

In addition, the CCG commissions the ‘A Bed Ahead’ service. Based at Changing Lives-Union Terrace, the Hospital Liaison Officers work closely with York Hospital to ensure that homeless patients are accommodated following their discharge from hospital. These clients often have multiple, complex health issues which require various tests and investigations, often in outpatient clinics at the hospital. With the support of liaison workers who are aware of these appointments, they are then able to support attendance and advocate on the clients’ behalf. This significantly reduces ‘do not attend’ rates and ensures conditions are diagnosed and treated promptly.

### 1.15.4 The CCG’s use of data to inform strategic planning and commissioning decisions

The CCG uses the regularly updated York Health & Wellbeing Joint Strategic Needs Assessment (JSNA) reports to inform strategic planning and commissioning decisions. The JSNA team has also provided specific needs assessments related to homeless health needs, the needs of those experiencing poverty and the experiences of health and social care in York by the LGBT community.

The CCG also uses NHS RightCare for support in gathering intelligence, data, and evidence to help improve the way care is delivered for our patients and populations. Commissioners use this intelligence to highlight unwarranted variation and performance to identify priority areas that offer the best opportunities to improve healthcare for our population.

We are now using RAIDR, a healthcare intelligence tool, within primary care to underpin our approach to population health management providing us with strategic focused intelligence reports on high level trends and patient pathways. This system will also help us to drill down to specific at risk groups and those with long term conditions.

Our commissioning teams routinely look at the aforementioned data and intelligence sources and use them to support initiatives targeting identified needs. For example, we know mental ill health is a significant problem in the City of York, in particular autism and learning difficulties, and we are now investing in CAMHS and health checks for people with severe mental illness and learning disabilities. In the Pickering area, we are aware of high rates of cardiovascular disease and dementia, and we are supporting initiatives to improve dementia detection and care coordination there. We have also used feedback on the healthcare experience of the local homeless population to commission services that improve access to primary care.

### 1.15.5 Activity aimed at reducing health inequalities

It is the joint aim of the CCG and our partners to reduce inequalities in outcomes for particular groups, including those living in the poorer wards, and vulnerable groups such as the LGBT community, offer a range of support to help residents make good choices about their own health and wellbeing and help people to access the services to help them to help themselves.

The CCG has established a Population Health Working Group comprised of members of the CCG, Public Health, City of York Council and our voluntary sector partners to look more closely at cross sector health inequalities such as alcohol dependency, smoking cessation and weight management and develop a joint action strategy to address these issues.

This year the CCG brought Yorkshire MESMAC to run a number of training sessions around LGBT+ awareness and how we can ensure that we are an inclusive organisation when we commission services by better understanding the barriers to healthcare for this community. We opened the session up to our external partners, Healthwatch and voluntary organisations.

Selby Town PCN is commencing a 20 week intensive population health management programme run by the ICS. They will be using the data they collect to focus on their population health and inequalities needs. Selby town is the most deprived area in the CCG hence the focus here. Partnership workshops are being held to focus on our core priorities for Selby Town across local authorities, TEWV, Hospital, and the PCN to inform the work on addressing need and reducing inequalities.

### 1.15.6 National prevention strategies

The Vale of York CCG activity supports the delivery of national prevention strategies e.g. National Diabetes Prevention Programme; NHS Health Checks; Improving Access to Psychological Therapies and those priority areas set out in the Next Steps on the NHS Five Year Forward View e.g. Mental Health; Cancer; CVD prevention; Primary Care access and patient experience.

### 1.15.6.1 Diabetes

The CCG is working closely with NHSE colleagues to target practices with high incidence of diabetes to support patients accessing the National Diabetes Prevention Programme. The programme aims to prevent or delay Type 2 diabetes through support to make evidence-based lifestyle changes. The CCG will also be supporting the Very Low Calorie Diet (VLCD) pilot which ties into the NHS Long Term Plan to pilot low calorie diets for people with Type 2 diabetes. Medical research has shown that some obese people with Type 2 diabetes can achieve remission through adoption of a low calorie diet.

### 1.15.6.2 NHS Health Checks

The NHS Health Check programme is delivered by CYC which screens 40-74 year olds in York for cardiovascular risk factors. These are delivered from various locations across the City. Uptake of health checks by males in deprived areas is being monitored and locations are being reviewed in relation to the areas of greatest need.

### 1.15.6.3 Improving Access to Psychological Therapies (IAPT)

IAPT referrals have continued to increase through proactive marketing, self-referral and engagement with primary care. Joint work has been undertaken to explore options for IAPT case finding which has resulted in a sessional commitment from the IAPT service in the top four high prescribing practices and also a clinic at the University of York's Open Door service, with the aim of making access for students easier.

The service recognises that improved access to treatment is essential if access and recovery targets are to be achieved. In particular a number of actions are being undertaken or planned to improve the number of older adults engaging with the service as well as improving the use of technology to facilitate both easier access and improved drop-out rates. The access and recovery targets are currently being achieved and are on track to deliver in 2019/20.

Black, Asian and Ethnic Minority groups currently make up 3% of IAPT referrals. Targeted work aimed at these groups and the LGBT+ population is planned during 2020 and will include staff awareness and training.

### 1.15.6.4 Improving access to primary care

A number of projects have been launched and further developed during 2019/20 to Improve Access to Primary Care for patients across Vale of York CCG. The key service that has seen a steady rise in the number of appointments available at evenings and weekends is the 'Improving Access' service that routinely delivers in excess of 2,500 additional appointments per month in Practice 'hubs' across the area. This service provides access to a range of healthcare professionals including GP's, Practice nurses and healthcare assistants, and is

especially helpful to working age adults who may struggle to access appointments during normal working hours.

The CCG has also worked to support national projects on digital access to General Practice, and has enabled video consultations in all Practices, and is also making good progress with online consultations where patients can access healthcare advice and virtual consultations with a clinician, or access more routine help such as ordering repeat prescriptions or enquiring about test results.

Vale of York CCG Practices have also pioneered work around online access to patient records and appointment booking, and was one of the first CCG's to link the NHS App into Practice appointment systems in order to help patients access services through digital channels.

### 1.15.6.5 CVDPREVENT

From 2020, the national ***CVDPREVENT*** audit will automatically extract routinely held GP data covering diagnosis and management of six high risk conditions that cause stroke, heart attack and dementia: atrial fibrillation (AF), high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia and chronic kidney disease.

CVDPREVENT will provide a foundation for professionally led quality improvement in individual GP practices across Primary Care Networks (PCNs). It will support primary care in understanding how many patients with the high-risk conditions are potentially undiagnosed, under treated or over treated.

### 1.15.6.6 Patient engagement

The CCG's Patient Engagement Team is committed to addressing health inequalities and understands that some groups of people, including people with protected characteristics experience different access, experience and outcomes when they use NHS services. This last year we have made improvements in the way that we assess engagement in relation to the Equality Delivery System (EDS2). We have been using the EDS2 to help us to review and improve our equality and engagement performance for people with characteristics protected by the Equality Act 2010.

The CCG continues to look at how we can try different approaches to reach diverse communities to ensure all voices are heard. It is critical that we understand our population as this will help us to deliver services that are focused on meeting their needs and make a real difference to their health and wellbeing.

### 1.15.7 Reducing inequalities through Senior Manager level ownership

The CCG demonstrates a systematic approach to reducing inequalities through Senior Manager level ownership of both equality and health inequalities with regular reports to Board with information of the steps being taken or planned to ameliorate inequalities.

Members of the senior management team sit on the Health and Wellbeing Board who will require us to support and challenge organisations to align their work to the strategic direction we have set out and to show action-focused leadership if barriers exist and are preventing progress. This may include board members working to drive change in their own organisations, or looking together at how resources are used across different agencies and partners for maximum impact.

### 1.15.8 Health inequalities indicators in the CCG IAF

The national DES for Learning Disability Health Checks is promoted to general practice and tracking information is offered through our local business intelligence team.

The CCG is working on decreasing the rate of unplanned hospital admissions for chronic ambulatory care sensitive and urgent care sensitive conditions. However, the rate of unplanned admissions is not the same across the CCG's geography. This data is routinely collected and we are committed understanding the variation in admissions so that we can target resources more appropriately towards areas with the highest rates.

## 1.16 Health and wellbeing strategy

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.

### City of York Health and Wellbeing Board

Both the Clinical Chair and Executive Director for Primary Care and Population Health at the CCG attend health and wellbeing board meetings and make an active contribution. Outside of the formal meeting cycle they both meet regularly with the Chair of the Health and Wellbeing Board to update with progress and ongoing issues.

During the course of 2019-20 the CCG has contributed to the York Health and Wellbeing Board's Annual Report which details progress against delivering the priorities in the Joint Health and Wellbeing Strategy. The CCG is also a member of the local Joint Strategic Needs Assessment Working Group, the Mental Health Partnership, the Ageing Well Partnership and the YorOK Board. These are sub-groups that sit beneath the Health and Wellbeing Board that ensure delivery of the priorities in the strategy.

Representatives of the CCG also attend informal workshops outside of the formal Health and Wellbeing Board meeting cycle. Recent this has included a workshop on the subject of York Central which apprised Health and Wellbeing Board members and key colleagues of the ongoing work to develop the York Central site. The discussions focused around how best to design a sustainable mixed use environment that supports resident's physical and mental and

emotional wellbeing. Additionally there was some debate about what GP facilities and/or wellbeing hubs might be needed. Other workshops and sessions where the CCG have played an active and essential part were focused around the Humber, Coast and Vale Partnership's Long Term Plan and the refocusing of Health and Wellbeing Board's priorities.

More recently the Health and Wellbeing Board have agreed to the establishment of a Prevention and Population Health Programme Board which will take the lead on delivering the priorities that will be agreed within the Living and Working Well theme of the Joint Health and Wellbeing Strategy, to strengthen the focus on prevention and population health across public health, primary and secondary care and build strong relationships with the new Primary Care Networks. This new Programme Board will be chaired jointly by City of York Council's Director of Public Health and the CCG's Executive Director for Primary Care Population Health.

The Health and Wellbeing Board also receive regular updates on the Local Transformation Plan (Future in Mind) from CCG colleagues who keep the Health and Wellbeing Board Chair up to date with progress and developments around this agenda. Similarly the Health and Wellbeing Board receives a regular Better Care Fund updates from the Assistant Director of Joint Commissioning; a joint appointment between City of York Council and the CCG. The Chair of the Health and Wellbeing Board has approved the content of this section of the CCG's Annual Report.

The CCG's Clinical Chair also attends a bi-annual meeting of the Chairs of Health and Wellbeing Board, the Health and Adult Social Care Policy and Scrutiny Committee and Healthwatch York. This meeting focuses on the three bodies working better together.

**East Riding of Yorkshire Health and Wellbeing Board**

The CCG is represented on the East Riding HWB, and continues to attend meetings and work with the HWB to deliver against its strategic priorities.

**North Yorkshire Health and Wellbeing Board**

The CCG has a seat on the North Yorkshire HWB and is working with the HWB to ensure that joint priorities are delivered across the Vale of York footprint.

This year's work has included:

- contributing to continued implementation of the Joint Health and Wellbeing Strategy, including on-going implementation of Strategies for Dementia; Healthy Weight, Healthy Lives; Learning Disabilities and Young and Yorkshire;

- playing a positive role in the development and implementation of the Better Care Fund and the quarterly performance reporting undertaken;

- contributing effectively to the development of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment by participation in the respective working groups.

# 1.17 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 and Improvement.

### 1.17.1 Accounting policies

The CCG prepares the accounts under International Financial Reporting Standards 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.

### 1.17.2 Financing transactions

There have been no financing transactions undertaken by the CCG.

### 1.17.3 Cash

The CCG delivered its 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 also delivered throughout 2019-20.

### 1.17.4 Summary of expenditure

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

#### 1.17.4.1 Programme costs

A funding allocation is based on a weighted capitation formula that takes into account population and demographics, deprivation levels and estimates of health needs. This revenue funding covers direct payments for the provision of healthcare or healthcare-related services and is not spent on management costs.

The CCG's in-year allocation for programme costs was £486.0m in 2019-20 and total expenditure against this allocation was £505.2m, an overspend of £19.2m. This is before the allocation of additional sustainability funding.

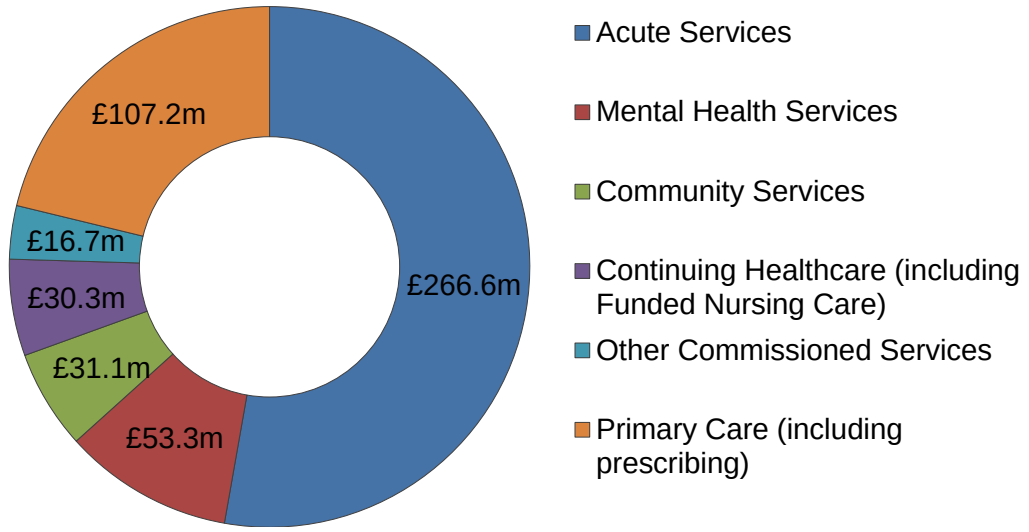



**Figure 3** - An analysis of 2019-20 programme expenditure

### 1.17.4.2 Running costs

Payment is allocated to CCGs based on £21.75 per head of the CCG's registered population. This is used to pay for non-clinical management and administrative support, including commissioning support services.

The CCG's allocation for running costs was £7.8m in 2019-20 and total expenditure against this allocation was £7.4m.

An underspend of £420k was achieved, and when taken together with the programme cost position equals the CCG's overall bottom line financial position of an £18.8m deficit. This is before the allocation of additional sustainability funding. When this is taken into account the CCG has achieved a break-even position for the year.

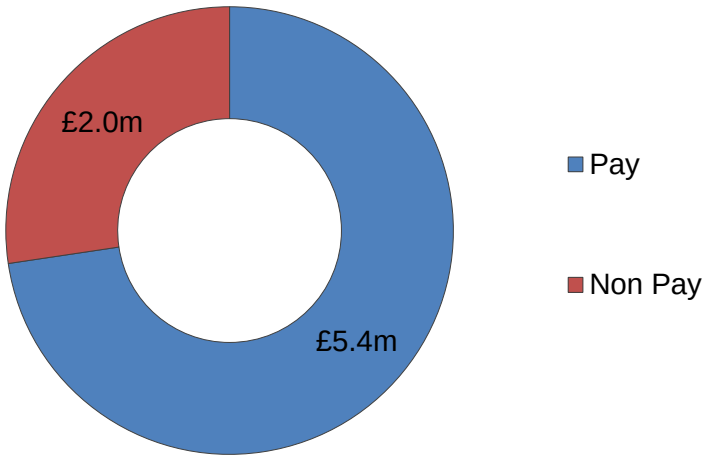



**Figure 4 -** An analysis of 2019-20 running costs expenditure

### 1.17.5 Underlying recurrent position

Excluding the effect of all non-recurrent income and expenditure in the 2019-20 position, and including the recurrent full year impact of the 2019-20 savings programme the CCG has an underlying recurrent deficit of £24.5m as it moves into 2020-21. The CCG's underlying position at the end of 2018-19 was £24.5m.

### 1.17.6 Quality, Innovation, Productivity and Prevention

The 2019-20 savings programme or Quality, Innovation, Productivity and Prevention (QIPP) programme delivered in-year efficiencies of £10.0m. This was an improvement of £2.2m on the £7.8m achieved in 2018-19.

The main programmes of work delivering in-year savings are:

- £2.4m cost reduction in bio-similar drugs delivered as part of the contract with the CCGs main provider of acute and community services
- £3.0m of cost reduction delivered as part of the contract with the CCGs main provider of acute and community services.
- £2.9m reduction in the cost of individual packages of care (mainly continuing healthcare packages).

### 1.17.7 Statement of going concern

As agreed with the CCG's Audit Committee, the annual accounts have been prepared on a going concern basis. The CCG's external auditors 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. NHS England and Improvement has subsequently provided additional funding which removed the potential breach.

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 as that entity or, in the event of its disestablishment, by a successor public sector entity.

### 1.17.8 Data quality

In 2019-20 the CCG received elements of its business intelligence service from eMBED Health Consortium. There were no concerns regarding the quality of data supplied by during the year.

### 1.17.9 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.

Details of compliance with the code are given in the notes to the financial statements and are summarised in the tables below for 2019-20.

| 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-19 | 768 | 747 | 97.27 | 11,226,291.12 | 11,181,563.12 | 99.60 |
| May-19 | 947 | 909 | 95.99 | 8,637,753.94 | 8,531,356.58 | 98.77 |
| Jun-19 | 1,079 | 1,053 | 97.59 | 15,276,699.34 | 15,216,192.50 | 99.60 |
| Jul-19 | 1,003 | 975 | 97.21 | 11,709,163.11 | 11,677,460.85 | 99.73 |
| Aug-19 | 860 | 845 | 98.26 | 10,307,812.79 | 10,264,177.62 | 99.58 |
| Sep-19 | 768 | 730 | 95.05 | 9,499,342.51 | 9,360,685.20 | 98.54 |
| Oct-19 | 892 | 876 | 98.21 | 10,873,039.84 | 10,813,419.73 | 99.45 |
| Nov-19 | 835 | 798 | 95.57 | 9,767,992.80 | 9,676,934.11 | 99.07 |
| Dec-19 | 778 | 756 | 97.17 | 10,614,274.59 | 10,485,322.30 | 98.79 |
| Jan-20 | 784 | 759 | 96.81 | 11,111,426.46 | 11,046,256.93 | 99.41 |
| Feb-20 | 792 | 758 | 95.71 | 9,341,388.99 | 9,244,524.63 | 98.96 |
| Mar-20 | 843 | 828 | 98.22 | 13,403,454.23 | 13,363,329.51 | 99.70 |
| **Totals** | **10,349** | **10,034** | **96.96** | **131,768,639.72** | **130,861,223.08** | **99.31** |

**Table 6 –** Payment of non-NHS invoices 2019-20

| NHS invoices | | | | | | |
|---|---|---|---|---|---|---|
| Month | Total invoices paid | Invoices paid on time | % Paid within target | Total value paid (£) | Value paid on time (£) | % Paid within target |
| Apr-19 | 290 | 281 | 96.90 | 27,172,059.57 | 27,066,222.72 | 99.61 |
| May-19 | 269 | 257 | 95.54 | 27,946,723.81 | 27,780,582.52 | 99.41 |
| Jun-19 | 321 | 319 | 99.38 | 27,980,723.46 | 27,975,035.59 | 99.98 |
| Jul-19 | 274 | 273 | 99.64 | 27,833,206.05 | 27,826,108.60 | 99.97 |
| Aug-19 | 224 | 222 | 99.11 | 27,497,016.62 | 27,470,206.55 | 99.90 |
| Sep-19 | 364 | 359 | 98.63 | 27,761,562.97 | 27,752,968.39 | 99.97 |
| Oct-19 | 215 | 210 | 97.67 | 27,696,286.94 | 27,691,940.86 | 99.98 |
| Nov-19 | 253 | 246 | 97.23 | 27,711,889.74 | 27,708,203.46 | 99.99 |
| Dec-19 | 238 | 236 | 99.16 | 27,691,547.02 | 27,687,250.53 | 99.98 |
| Jan-20 | 247 | 239 | 96.76 | 28,582,705.08 | 28,494,834.86 | 99.69 |
| Feb-20 | 315 | 314 | 99.68 | 27,709,765.65 | 27,695,446.65 | 99.95 |
| Mar-20 | 328 | 321 | 97.87 | 28,409,568.13 | 28,195,349.87 | 99.25 |
| | **3,338** | **3,277** | **98.17** | **333,993,055.04** | **333,344,150.60** | **99.81** |

**Table 7 –** Payment of NHS invoices 2019-20

# Accountability Report

**Phil Mettam**
Accountable Officer
23rd June 2020

# 2.1 Members Report

### 2.1.1 Council of Representatives attendance 2019-20

| Practice | 16 May 2019 | 19 September 2019 | 21 November 2019 | 20 February 2020 |
|---|---|---|---|---|
| Beech Tree Surgery | A (Ch) | A (Ch) | A (Ch) | A (Ch) |
| Dalton Terrace Surgery | Y(m) | Y(m) | A | Y(m) |
| East Parade Medical Practice | N | N | N | N |
| Elvington Medical Practice | Y(m) | Y(m) | Y(m) | A |
| Escrick Surgery | Y(f) | Y (f) | Y(f) | A |
| Front Street Surgery | Y(m) | Y(m) | Y(m) | Y(m) |
| Haxby Group Practice | Y(m) | Y(m) | Y(m) | Y(m) |
| Helmsley and Terrington Surgeries | Y(m) | Y(m) | Y(m) | Y(m) |
| Jorvik Gillygate Practice | Y(m) | Y(m) | Y(m) | Y(m) |
| Kirbymoorside Surgery | Y(f) | A | A | A |
| Millfield Surgery | Y(f) + GPR (m) | Y(f) | Y(f) | Y(f) |
| MyHealth | Y(m) | Y(m) | Y(m) | Y(m) |
| Old School Medical Practice | Y(m) | N | N | N |
| Pickering Medical Practice | Y(m) | Y(m) | Y(m) | Y(m) |
| Pocklington Group Practice | Y(m) | Y(m) | Y(m) | Y(m) |
| Posterngate Surgery | Y(m) | Y(m) | Y(m) | A |
| Priory Medical Group | Y(f) | Y(f) | Y(f) | Y(f) |
| Scott Road Medical Centre | Y(f) | Y(f) | Y(f) | Y(f) |
| Sherburn Practice | Y(m) | Y(f) | N | Y(m) |
| South Milford Surgery | Y(m) | Y(m) | Y(m) | N |
| Stillington Surgery | Y(m) | Y(m) | Y(m) | A |
| Tadcaster Medical Centre | Y(m) | Y(m) | Y(m) | Y(m) |
| Tollerton Surgery | N | Y(f) | Y(f) | Y(f) |
| Unity Health | N | Y(m) | Y(m) | N |
| York Medical Group | Y(f) | Y(f) | Y(f) | N |

**Key**

Y = Attended
A = Apologies
N = Neither attended nor sent apologies
Ch = Attendance as CCG Clinical Chair, not Practice representative
GPR = GP Registrar
m = male, f = female

### 2.1.2 Governing Body member attendances

The Governing Body met seven times in public and was quorate on each occasion. There were five Governing Body workshops, one of which focused on aspects of governance and

risk. Other sessions included: review of assurance in terms of the Governing Body and its committee structure; the Vale of York and Scarborough system recovery plan; wider scale transformation and options for Primary Care Networks; clinical strategy and engagement to support system priorities; an introductory session with the new Chief Executive of York Teaching Hospital NHS Foundation Trust; data security statutory and mandatory training; urgent care transformation; and clinically led improvement.

There was also a workshop with system partners 'Co-producing Future Care' attended by a number of CCG colleagues and representatives from two Primary Care Networks, City of York Council, North Yorkshire County Council, Humber Teaching NHS Foundation Trust and York Teaching Hospital NHS Foundation Trust.

| **Governing Body member** | **Governing Body role** | **Attendance** (public meetings) |
|---|---|---|
| Dr Nigel Wells | CCG Clinical Chair | 7/7 |
| Simon Bell | Chief Finance Officer | 5/7 |
| David Booker | Lay Member and Chair of Finance and Performance Committee | 5/7 |
| Michelle Carrington | Executive Director of Quality and Nursing | 6/7 |
| Dr Helena Ebbs | North Locality GP Representative | 6/7 |
| Phil Goatley | Lay Member and Audit Committee Chair; Remuneration Committee Chair from June 2019 | 6/7 |
| Julie Hastings from 1 September 2019 | Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee | 4/4 |
| Dr Andrew Lee from 1 May 2019 | Executive Director of Primary Care and Population Health | 6/6 |
| Phil Mettam | Accountable Officer | 6/7 |
| Denise Nightingale | Executive Director of Transformation, Complex Care and Mental Health | 7/7 |
| Keith Ramsay to 31 May 2019 | Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee | 2/2 |
| Dr Chris Stanley from 1 June 2019 | Central Locality GP Representative | 4/5 |
| Dr Ruth Walker | South Locality GP Representative | 7/7 |
| * See below | Secondary Care Doctor | 0 |

| Attendees non-voting | Governing Body role | Attendance (public meetings) |
|---|---|---|
| Dr Aaron Brown | Liaison Officer, YOR Local Medical Committee Vale of York Locality | 6/7 |
| Sharon Stoltz / Fiona Phillips | Director of Public Health / Deputy Director of Public Health, City of York Council | 5/7 |

* An appointment was made to the Secondary Care Doctor post with a scheduled start date of 1 September 2019. However, subsequently the appointee did not take up the post.

### 2.1.3 Governing Body member biographies

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

Nigel joined 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 is an experienced NHS leader who has worked across the East Midlands, South Yorkshire and now across Humber Coast and Vale. He has led organisations in both Nottinghamshire and Yorkshire, and chaired clinical networks including critical care and cancer.

A Chartered Secretary by profession, Phil recognised the importance of creating and sustaining strong relationships whilst working in industry. Personal interests involve sport, music, the natural world and wildlife

**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.

**Simon Bell**
**Chief Finance Officer**

Simon joined the CCG's Executive Team in August 2018. Prior to that he was the Chief Finance Officer and Deputy Accountable Officer in NHS Kernow CCG in Cornwall where he spent three years helping the CCG in a significant financial and governance turnaround.

Simon is a qualified accountant and graduate of the NHS Finance Management Training Scheme. He has worked in the NHS for 24 years across a number of provider and commissioning organisations including Chief Finance Officer roles in CCGs based in the South West of England.

**Dr Andrew Lee, Executive Director of Primary Care and Population Health**

Andrew, who initially trained in paediatrics before working as a humanitarian aid worker in Afghanistan, brings an enormous wealth of experience to the CCG.

Being trained in both general practice and public health, Andrew has worked for many years as a public health consultant in NHS organisations in Rotherham, Nottingham City and Bradford and Airedale. Andrew has also held two important roles at the Royal College of General Practitioners as Clinical Commissioning Champion and the Vice Chair at its Sheffield Faculty. Andrew is a practicing GP at an inner city practice in Sheffield. He is a Reader in Global Public Health at the University of 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 Chris Stanley**
**GP Representative for the York Locality**

Chris has been a GP for 5 years with the Haxby Group and works mainly at their Huntington site. He graduated from Barts and the London Medical School after completing a degree in Physics in Manchester. He then moved back to his native Yorkshire to join the York GP training scheme. He is member of the Local Medical Committee and areas of special interest include frailty, polypharmacy and digital innovation.

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

**Phil Goatley**
**Lay Member and Chair of the Audit Committee**

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.

**Julie Hastings**
**Lay Member for Patient and Public Involvement**

Julie joins the Governing Body following a career spanning more than 20 years of working in the NHS, local government and the voluntary sector. She has also worked with organisations as a consultant and a 'critical friend' providing emotional, creative problem solving and mental health first aid to teams during the development of Mental Health First Aid initiatives and the delivery of Mindful Employer support. Julie served three terms as a Governor for Humber Teaching NHS Foundation Trust and has very strong beliefs in the positive impact of partnership working to deliver meaningful outcomes.

**Members in attendance**

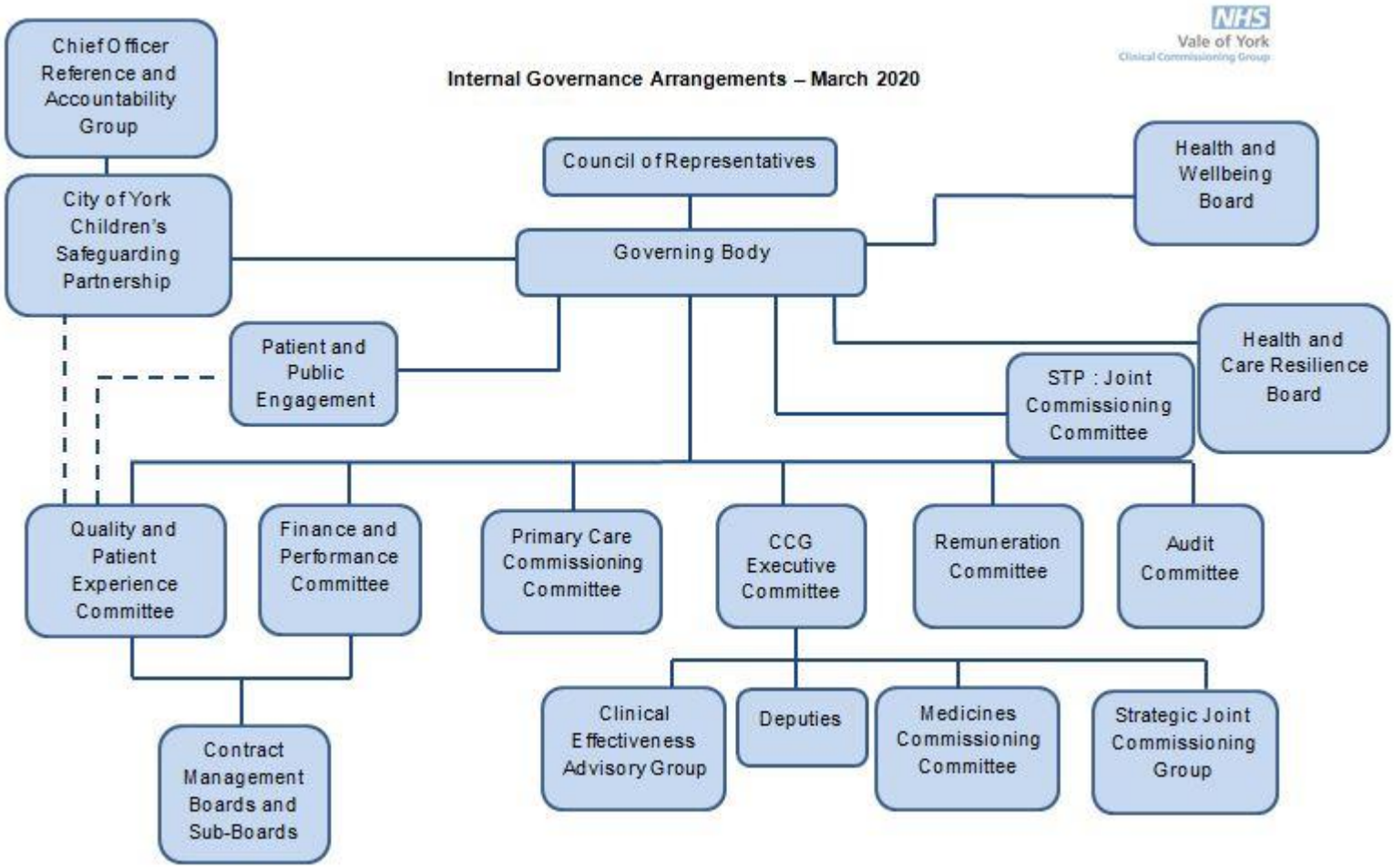
**Sharon Stoltz**
**Director of Public Health for City of York Council**

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 was elected to the position of Division Officer for the York and Selby division of the Local Medical Committee in 2017. He has served on the LMC for the last five years and thoroughly enjoys representing the profession of general practice for the area. He lives in York with his wife and two young children.

**Figure 5** – The CCG's internal governance arrangements



### 2.1.4 The role of the CCG's strategic committees

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 there is quoracy and clinical representation.

The performance and highlights for each Committee are also captured in the table below. The Finance and Performance Committee and Quality and Patient Experience Committee receive a risk report at each meeting. All committees undertake an annual review of their terms of reference.

**Table 8** – CCG strategic committees, their role and performance highlights in 2019-20

| Strategic 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.<br><br>The Committee met six times in 2019-20 and was quorate on each occasion. There is a schedule of preceding private meetings of members with internal and/or external audit who are represented at each meeting.<br><br>**Members**<br>Phil Goatley, Lay Member and Audit Committee Chair; Chair of Remuneration Committee from 1 June 2019<br>David Booker, Lay Member and Chair of Finance and Performance Committee<br>Secondary Care Doctor<br><br>**Performance / highlights**<br>Regular updates on progress against Financial Recovery Plan<br>Approval of Annual Report and Annual Accounts<br>Regular assurance from internal and external audit on reports issued to management<br>Approval of internal audit and external audit plans |

| Strategic committee | Role and performance highlights |
|---|---|
| | Monitoring the implementation of audit recommendations<br>Annual review of Internal Audit Charter and Working Together Protocol<br>Development of a Board Assurance Framework<br>Information Governance assurance<br>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<br>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).<br><br>The Committee convened eight times in 2019-20 and was quorate on each occasion.<br><br>**Members**<br>Keith Ramsay, Lay Member and Chair of Remuneration Committee, Primary Care Commissioning Committee and Quality and Patient Experience Committee to 31 May 2019<br>David Booker, Lay Member and Chair of Finance and Performance Committee<br>Phil Goatley, Lay Member and Audit Committee Chair; Chair of Remuneration Committee from 1 June 2019<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee from 1 September 2019 |

| Strategic committee | Role and performance highlights |
|---|---|
| | **Performance / highlights**<br>Substantive appointment of Executive Director of Transformation, Complex Care and Mental Health<br>Approval of Talent Management Plan<br>Business relating to the CCG's restructure<br>Review of Executive Team remuneration<br>Review of Clinical Lead remuneration<br>Review the Workforce Race Equality Standard data (2018-2019) for NHS Vale of York CCG<br>Establishment of a new process for approval of funding for staff training |
| **Finance and Performance Committee** | The paramount role of the Finance and Performance Committee, which met 12 times in 2019-20 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.<br><br>**Members**<br>David Booker, Lay Member and Committee Chair<br>Simon Bell, Chief Finance Officer<br>Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee from 1 September 2019<br>Dr Andrew Lee, Executive Director of Primary Care and Population Health, from 1 May 2019<br>Phil Mettam, Accountable Officer<br>Denise Nightingale, Executive Director of Transformation, Complex Care and Mental Health<br>Keith Ramsay, Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee to 31 May 2019<br><br>**In attendance (non-voting)**<br>Caroline Alexander, Assistant Director of Delivery and Performance, for performance related items<br>James Booth, Finance Lead, NHS England and NHS Improvement (North East and Yorkshire) from August 2019<br>Abigail Combes, Head of Legal and Governance, for risk report items<br>Phil Goatley, Lay Member and Audit Committee Chair; Chair of Remuneration Committee from 1 June 2019 |

| Strategic committee | Role and performance highlights |
|---|---|
| | Jon Swift, Director of Finance, NHS England North (or deputy) to 28 June 2019<br>Lee West, Assistant Head of Finance, NHS England and NHS Improvement (North East and Yorkshire) July 2019 meeting<br><br>**Performance / highlights**<br>Monthly Financial Performance Report<br>Monthly Integrated Performance Report<br>Updates from the System Programme Director/System Delivery Board<br>Resilience and winter planning updates<br>Unplanned Care Working Group progress reports; changed to Urgent Care Transformation Programme Updates from January<br>Approval of a number of contract awards/extensions<br>Financial planning 2020-21<br>Emphasis that Vale of York CCG is committed to lead on the development of collaborative working within the wider NHS and Local Authority systems, based on achievable financial plans |
| **Quality and Patient Experience Committee** | The Quality and Patient Experience Committee originally met bi-monthly until January 2020 when it commenced monthly meetings with the alternate months having a specific focus. The Committee met seven times in 2019-20 and was quorate on each occasion.<br><br>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 and NHS Improvement, to support primary medical and pharmacy services to deliver high quality primary care, including patient experience.<br><br>**Members**<br>Keith Ramsay, Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee to 31 May 2019<br>David Booker, Lay Member and Chair of Finance and Performance Committee; undertook the role of Chair of the Quality and Patient Experience Committee for the June and October 2019 meetings<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning |

| Strategic committee | Role and performance highlights |
|---|---|
| | Committee and Quality and Patient Experience Committee from 1 September 2019<br>Jenny Brandom, Deputy Chief Nurse/Deputy Executive Director of Quality and Nursing, to 16 August 2019<br>Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse (Director with responsibility for quality and patient experience)<br>Secondary Care Doctor<br>Dr Andrew Lee, Executive Director of Primary Care and Population Health, from 1 May 2019<br>Paula Middlebrook, Deputy Chief Nurse, from 7 October 2019<br>Dr Nigel Wells, CCG Clinical Chair<br><br>**In attendance (non-voting)**<br>Victoria Binks, Head of Engagement<br>Abigail Combes, Head of Legal and Governance<br>Barry Dane, Healthwatch representative<br>Karen Hedgley, Designated Nurse Safeguarding Children<br>Christine Pearson, Designated Nurse Safeguarding Adults<br>Gill Rogers, Patient Experience Officer<br>Debbie Winder, Head of Quality Assurance and Maternity, to 30 September 2019<br>Co-opted member of Scarborough Ryedale CCG as required<br><br>**Following review of the terms of reference at the January meeting the membership became**<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee (Chair)<br>Michelle Carrington, Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience)<br>Dr Andrew Lee, Executive Director of Primary Care and Population Health<br>Dr Nigel Wells, Clinical Chair of the Governing Body (Deputy Chair)<br>Secondary Care Doctor<br><br>**In attendance (non-voting)**<br>Victoria Binks, Head of Engagement<br>Abigail Combes, Head of Legal Services and Governance<br>Barry Dane, Healthwatch representative<br>Susan De Val, Senior Quality Lead: Children and Young People<br>Sarah Fiori, Head of Quality Improvement and Research<br>Karen Hedgley, Designated Nurse Safeguarding Children<br>Paula Middlebrook, Deputy Chief Nurse |

| Strategic committee | Role and performance highlights |
|---|---|
| | Christine Pearson Designated Nurse Safeguarding Adults<br>Gill Rogers, Patient Experience Lead<br><br>**Performance / highlights**<br>Patient stories<br>Quality and Patient Experience Report<br>Safeguarding Adults and Children updates<br>Approval of End of Life Care Strategy<br>Care Homes and Domiciliary Care Work Plan<br>Care Quality Commission Ready Programme Report<br>Draft Patient and Public Participation Annual Report 2018-19<br>Draft Communications and Engagement Strategy 2019-2023<br>Learning Disability Mortality Review (LeDeR) - Annual Report 2018-19<br>Slavery and Human Trafficking Statement<br>Safeguarding Adults in General Practice Policy<br>Primary care focused meeting<br>End of life care focused meeting |
| | The Primary Care Commissioning Committee met six times and was quorate on each occasion.<br><br>**Membership is NHS Vale of York CCG unless otherwise stated**<br><br>Keith Ramsay, Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee, to 31 May 2019<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee from 1 September 2019<br>Simon Bell, Chief Finance Officer<br>David Booker, Lay Member and Chair of Finance and Performance Committee; chaired July Primary Care Commissioning Committee<br>Chris Clarke, Senior Commissioning Manager / David Iley, Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber)<br>Phil Goatley, Lay Member and Audit Committee Chair; Chair of Remuneration Committee from 1 June 2019<br>Dr Andrew Lee, Executive Director of Primary Care and Population Health, from 1 May 2019<br>Phil Mettam, Accountable Officer<br>Stephanie Porter, Assistant Director of Primary Care |

| Strategic committee | Role and performance highlights |
|---|---|
| | **In attendance (non-voting) until the review of the terms of reference at the September meeting were**<br>Up to two GPs from each locality: Dr Paula Evans attended as North Locality GP Representative<br>Nigel Ayre, Healthwatch North Yorkshire representative<br>Dr Aaron Brown, Selby and York Local Medical Committee representative<br>Kathleen Briers / Lesley Pratt, Healthwatch York representative<br>Health and Wellbeing Board Representative<br>Sharon Stoltz, Director of Public Health, City of York Council<br>Practice Manager<br><br>**Following review of the terms of reference at the September 2019 meeting the committee membership comprised**<br>Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee<br>Simon Bell, Chief Finance Officer<br>David Booker, Lay Member and Chair of Finance and Performance Committee<br>Chris Clarke, Senior Commissioning Manager / David Iley, Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber)<br>Phil Goatley, Lay Member and Audit Committee Chair; Chair of Remuneration Committee<br>Dr Andrew Lee, Executive Director of Primary Care and Population Health<br>Phil Mettam, Accountable Officer<br><br>A representative from each of the Primary Care Networks (PCN) - Dr Paula Evans represented South Hambleton and Ryedale PCN, and Dr Tim Maycock represented Central York PCN; other PCN representatives to be advised<br>Nigel Ayre, Healthwatch North Yorkshire representative<br>Kathleen Briers / Lesley Pratt, Healthwatch York representative<br>Dr Aaron Brown, Selby and York Local Medical Committee representative<br>Stephanie Porter, Assistant Director of Primary Care<br>Sharon Stoltz, Director of Public Health, City of York Council<br>Practice Manager<br>Health and Wellbeing Board representative<br><br>**Performance / highlights**<br>Regular updates on development of Primary Care Networks |

| Strategic committee | Role and performance highlights |
|---|---|
| | Draft Humber, Coast and Vale Health and Care Partnership Primary Care Workforce Strategy<br>Reports on the Care Quality Commission Ready Programme<br>Progress report on estates capital investment proposals<br>Ongoing development of the CCG's Primary and Community Estates Strategy<br>Primary care resilience<br>Primary care updates from NHS England North<br>Update on Local Enhanced Services review<br>Update from the Humber, Coast and Vale Primary Care Workforce and Training Hub Hosted by Haxby Training and Freshney Green<br>Statin Optimisation Pilot Evaluation<br>Primary Care Commissioning Committee Annual Chair's Report |

### 2.1.5 Remuneration Committee

| Name | Role | Membership | Attendance |
|---|---|---|---|
| David Booker | Lay Member and Chair of Finance and Performance Committee | From 1 April 2019 | 7/8 |
| Phil Goatley | Lay Member and Chair of Audit Committee; Chair of Remuneration Committee from 1 June 2019 | From 1 April 2019 | 8/8 |
| Julie Hastings | Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee | From 1 September 2019 | 2/3 |
| Keith Ramsay | Lay Member and Chair of Remuneration Committee, Primary Care Commissioning Committee and Quality and Patient Experience Committee | From 1 April 2019 to 31 May 2019 | 2/2 |

**Table 9** – Remuneration Committee membership and attendances in 2019-20

### 2.1.5.1 Non Remuneration Committee member attendances

There were two people who provided advice to the Committee that materially assisted in their consideration of remuneration matters. They were Helen Darwin, Human Resources Business Partner who attended three meetings. Lucy Townend, Human Resources Manager attended two meetings. In addition, there were the following attendances:

Becky Blackburn, Human Resources Advisor, provided a range of general HR advice to the CCG during the 2019-20 financial year. The HR service was hosted by the North Yorkshire CCGs.

Phil Mettam, Accountable Officer, attended seven meetings.

Michelle Carrington, Executive Director of Quality and Nursing / Chief Nurse (Director with responsibility for HR and Organisational Development) attended five meetings.

Abigail Combes, Head of Legal and Governance, attended five meetings.

Helena Nowell, Planning and Assurance Manager, attended one meeting for a specific item.

### 2.1.6 Register of Interests

The CCG's registers of interest are published online and can be viewed on the CCG website at https://www.valeofyorkccg.nhs.uk/about-us/governance-and-committees/

### 2.1.7 Personal data related incidents

There have been no incidents that were reported to the Information Commissioner's Office during 2019-20.

### 2.1.8 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.

### 2.1.9 Modern Slavery Act

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.

### 2.1.10 Statement of the Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Phil Mettam, Accountable Officer, to be the Accountable Officer of 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 Government Financial Reporting Manual and in particular to:
- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts

and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, 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 CCG is subject to legal directions, the full text of which is set out in the Annual Governance Statement at p79 below.
- The current financial position is set out in the performance analysis at section 1.11 of this report at p. 29.

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.

## 2.2 Governance Statement

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

As at 1 April 2019, the clinical commissioning group is subject to directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006, which were updated with effect from 5 November 2019 as follows:

"

(1) These Directions are given to NHS Vale of York Clinical Commissioning Group ("Vale of York CCG")-.

(2) These Directions may be cited as the Vale of York CCG Directions 2019 and come

into force on 5 November 2019.

(3) These Directions apply until they are varied or revoked by the Board or 12 months from the date of commencement of these Directions, whichever is the sooner, and replace any Directions previously issued by the Board to Vale of York CCG.

**Financial Recovery Plan**

(4) The Board directs that:

(a) Within 2 weeks of the date of these Directions Vale of York CCG will put forward for consideration and approval by the Board a list of external stakeholders whom Vale of York CCG will work with to produce a financial recovery plan ("Financial Recovery Plan") taking into account the financial stability of all identified stakeholders;

(b) Vale of York CCG will produce the Financial Recovery Plan which includes but is not limited to:

(i) how Vale of York CCG and its stakeholders shall ensure that it operates within the financial envelope agreed with the Board for the financial year 2019-20;

(ii) how Vale of York CCG and its stakeholders shall ensure how it will operate within its annual budget for 2020-21 and for subsequent financial years thereafter;

(iii) confirmation that all facts, figures and projections within the Financial Recovery Plan have been subjected to scrutiny by the organisation approved by the Board;

(iv) development of options that can be consulted on for the long term sustainable delivery of clinical services for the population;

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

(vi) a consultation plan for engaging with the local population and stakeholders on the options for the future delivery of clinical services;

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

(viii) any other requirements stipulated by the Board;

(c) The Financial Recovery Plan and any amendments to the same, shall continue to be subject to the Board's approval;

(d) Vale of York CCG shall work with its stakeholders to implement the Financial Recovery Plan;

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

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

**Executive Team and Senior Appointments**

(5) The Board directs that:

(a) Vale of York CCG will notify the Board of the need to make any appointments to its Executive Team or its next tier of management; where it considers it necessary to do so, the Board will determine the process to be followed by Vale of York CCG in making appointments as referred to in paragraph 5(a);
(b) the appointment of any person to a position referred to in paragraph 5(a) and the terms of such appointment will be subject to prior approval by the Board; and
(c) Vale of York CCG will co-operate with the Board regarding the appointment of any person in accordance with paragraph 5(a), including but not limited to the prompt provision of information, documents and records requested by the Board and making senior officers available to meet with the Board.

**Compliance with these directions**

(6) The Board directs that Vale of York CCG shall co-operate with the Board regarding the Board's oversight of Vale of York CCG's compliance with these Directions, including but not limited to the prompt provision of information requested by the Board and making senior officers available to meet with the Board.

”

The text of the Directions can also be viewed on the NHS England website: https://www.england.nhs.uk/publication/directions-for-nhs-vale-of-york-clinical-commissioning-group/

### 2.2.2 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.

### 2.2.3 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. The CCG's Constitution sets out the arrangements for governance and can be viewed on the CCG website.

Information on the work of the Governing Body, its members and its committees, can be found in the Members' Report on p61.

The CCG has a nominated Freedom to Speak Up (FTSU) Guardian and arrangements in place for information received under FTSU processes to be considered.

### 2.2.4 UK Corporate Governance Code

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

### 2.2.5 Discharge of Statutory Functions

In light of recommendations of the 1983 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.

## 2.3 Risk management arrangements and effectiveness

### 2.3.1 Definitions

**Risk** is defined as the "effect of uncertainty on objectives" and an effect is a positive or negative deviation from what is expected.

**Risk Management -** Risk management refers to a coordinated set of activities and methods that is used to direct an organisation and to control the many risks that can affect its ability to achieve objectives. The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.

**Risk Management Process -** According to ISO 31000, a risk management process systematically applies management policies, procedures, and practices to a set of activities intended to establish the context, communicate and consult with stakeholders, and identify, analyse, evaluate, treat, monitor, record, report, and review risk**.**

**Risk Treatment (also referred to as Mitigation) -** Risk treatment is a risk modification process. It involves selecting and implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls.

### 2.3.2 The CCG's approach

The CCG recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits for local residents. In order to establish a consistent framework for the assessment and management of risk, the CCG has adopted a risk assessment tool and has determined the levels of authority at which risks should be addressed. Risks identified as being at the extreme end of high categories are regarded as significant risks and should be reported to the appropriate Committee.

The CCG will, however, as a general principle, seek to eliminate or reduce all identifiable risk to the lowest practicable level and control all risks which have the potential to: harm its staff, patients, visitors and other stakeholders; have a high potential for incidents to occur; would result in loss of public confidence in the CCG and/or its partner agencies; would have severe financial consequences which would prevent the CCG from carrying out its functions on behalf of its residents. The CCG is committed to achieving this through its holistic approach to risk management within the clinical and corporate governance agendas.

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.

All identified risks should be brought to the attention of the relevant member of the CCG Deputies group, and any member of staff has the authority to do this. The Deputies group will have the responsibility of assessing the risk in accordance with the risk assessment tool, and where appropriate adding newly identified risks to the relevant risk register.

### 2.3.3 Risk appetite

The CCG recognises the importance of having a documented statement that reflects its approach to risk appetite/tolerance in line with British Standard BS31100 which provides

direction and boundaries on the risk that can be accepted at various levels of the organisation and how the organisation responds to risk to ensure that the level of risk and any associated reward are to be balanced.

The CCG is not risk averse and recognises that decisions with the potential to improve services or performance can also carry risks. This should not deter from making the decision, but is considered when making the decision so that the decision is informed based on the risk assessment and a decision on the level of tolerance of any risks.

The CCG's approach to risk is that:

- The lower the appetite for risk, the less the CCG is willing to tolerate the consequence and there is a requirement for higher levels of controls and assurance to manage the risk.
- The higher the CCG appetite for risk, the more the CCG is willing to accept potential consequences in order to achieve objectives. The CCG will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls above all else.

The CCG has a risk appetite statement that is reviewed annually in line with the refresh of the CCG's Board Assurance Framework.

**2.3.4 Risk Appetite Statement**

The CCG's Risk Appetite Statement establishes risk tolerance in the following four categories:

i. **Safety risk** – The risk that the CCG will not be able to deliver services which are safe for patients.

**ii.** **Compliance risk** – The risk that the CCG will not comply with the requirements of **legislation and regulation including the NHS Constitution**.

iii. **Financial risk** – The risk that the CCG fails to operate within its allocation and therefore operate in deficit.

iv. **Service Delivery risk** – The risk that the CCG is unable to deliver services to patients and is linked to the risks above.

The CCG considered a number of factors to determine risk appetite. With due regard to the risk appetite, when a risk is recorded in the register, it will be categorised as high risk (red), medium risk (amber) or low risk (green) and will be based on an assessment of risk by staff in possession of this statement of risk appetite.

The CCG has an overall open/moderate risk appetite. The CCG will act in accordance with this risk appetite statement to support its strategic objectives.

### 2.3.5 Risk identification

Risk identification involves examining all sources of risk, from the perspective of all stakeholders, both internal and external. Within the CCG, risks are identified using a number of sources.

#### 2.3.5.1 Internal Methods of Identification

- Adverse Incidents, Serious Incidents (SIs), complaints, patient advisory liaison service (PALS) enquiries and claims reporting.
- Internal audit recommendations, identifying the CCG's gaps in control
- Self-assessment workshops
- Strategic level risks highlighted by CCG Governing Body, Senior Clinicians and Directors
- Risks highlighted via sub-committees of the Governing Body
- Patient satisfaction surveys
- Staff surveys
- Clinical audits, infection control audits, PEAT inspections etc.
- Risks highlighted by the Unions
- Risks highlighted by new activities and projects
- Risks highlighted via the Whistleblowing (Raising Concerns) Policy
- Risks highlighted through business and local development plans

#### 2.3.5.2 External Methods of Identification

- External Audit opinion
- Reports from assessments/inspections from external bodies i.e., Care Quality Commission, NHSLA Risk Management Assessors, Health and Safety Executive (HSE), etc.
- National reports and guidance
- Coroner's reports
- Media and public perception
- National Patient Safety Agency (NPSA) alerts
- Central Alerting System (CAS) alerts
- Health Ombudsman reports

Clear communication lines have to be established to enable all the systems above to report all risks and allow for the population of both the corporate and directorate and sub-committee risk registers.

### 2.3.6 Risk assessment

The methodology for the assessment of risk can be complex. Risk assessment involves examining the level of risk posed by a hazard, consideration of those in danger and evaluating whether risks are adequately controlled, taking into account any measures already in place. Risk assessment involves two distinct stages:

- Analysing risk, e.g. in terms of impact and likelihood;
- Evaluating risk in order to set priorities.

Risk assessment should identify the significant risks arising out of the tasks or activities undertaken within the organisation and assess their potential to:

- Cause injury or ill health to individuals;
- Result in civil claims or litigation;
- Result in enforcement action e.g. from the Health and Safety Executive or the Local Authority;
- Cause damage to the environment;
- Cause property damage/loss;
- Result in operational delays;
- Result in the loss of reputation.

Risk assessments will be carried out locally by identified staff.

The Governing Body has determined that their risk appetite will include a cohort of risks that should be reported to them where the impact score is significant even where the likelihood score is low. This means that they are sighted on the main risks to the organisation and can ensure appropriate mitigation is in place.

### 2.3.7 Risk analysis and evaluation

Risk analysis involves systematically using available information to determine how often specified events occur and the magnitude of their consequences. In order to grade the risks identified the CCG utilises the risk assessment tool.

Risk identification and risk assessment is a continuous process and should not be considered as a one off exercise. In order to ensure a well-structured systematic approach to the management of risk an action plan or work programme has been produced.

- Adverse incidents (including Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) incidents), PALS, complaints and claims are analysed on a six monthly basis.

- A report is produced annually on Risk Management issues, including clinical and non-clinical risk for the Governing Body.
- Risks are evaluated on a regular basis by the individual sub-committees of the Governing Body and escalated where agreed necessary.

**2.3.8 Current arrangements**

The CCG has moved to virtual meetings during the Covid-19 pandemic. It was resolved at Governing Body very early in the pandemic that because of the constraints of a virtual meeting the timings of those meeting may need to be limited and reporting and assurance would be focussed on the immediate priorities. It became apparent very quickly that those risks which were being reported and scored in accordance with the Risk Strategy and Policy the CCG had in place, would not be progressed as a result of the Covid-19 pandemic. Examples of this included the planned care waiting list prioritisation and infection control practices in the Acute Hospital. Whilst these remain concerns for the CCG they are monitored by officers but not routinely reported to Committees. Instead a Covid-19 dashboard has been produced and was provided to the Governing Body in the April 2020 meeting which sets out the priorities of the CCG during the pandemic and in the phases subsequent to the pandemic. This highlights matters which we cannot know at this stage, for example the financial position of the organisation and those which we have anticipated but have not yet quantified, for example the impact on mental health commissioning and primary care patient management.

In the background, risk reporting has been continued through reporting directly to the Head of Legal and Governance and where risks are reported these are recorded and escalated when required.

### 2.3.9 Major risks

The current high-level risks for the CCG are presented below.

**Table 10** – Major risks

| Risk reference | Title | Likelihood score | Impact score | Stable/ Improving/ Worsening |
|---|---|---|---|---|
| QN.15 | CQC in YTHFT | 4 | 5 | Stable |
| QN.07 | Initial health checks quality of service | 4 | 5 | Stable |
| QN.03 | Commissioned specialist children's nursing provision | 4 | 4 | Stable |
| QN.04 | 12 hour trolley breaches, safety/quality concerns | 4 | 4 | Stable |
| QN.05 | YTHFT Poor discharge standards | 4 | 4 | Stable |
| QN.06 | Infection control processes YTHFT | 4 | 4 | Stable |
| QN.08 | Planned care waiting list risk assessment YTHFT | 4 | 4 | Stable |
| QN.10 | Unexpected closure of nursing beds in CCG area | 2 | 4 | Improving |
| QN.12 | Failure to obtain pertussis vaccine in pregnancy | 2 | 4 | Stable |
| QN.13 | Commissioning issues with Hep B vaccine | 3 | 4 | Stable |
| QN.14 | Quality concerns surrounding a GP practice in VoYCCG area | 4 | 3 | Stable |
| JC.26a | CAMHs long waits | 3 | 4 | Stable |
| JC.26b | Children autism long waits diagnostics | 4 | 3 | Stable |
| JC.26c | Eating disorders waiting lists | 4 | 4 | Worsening |
| JC.30 | Dementia diagnosis primary care | 3 | 4 | Stable |
| ES.15 | Inability to deliver a sustainable financial plan | 3 | 4 | Stable |
| JC.19 | Cancer 62 day waits | 3 | 4 | Improving |
| PLC.04 | Planned care diagnostic target | 4 | 4 | Stable |
| IG.01 | Transition to new CCG/Primary care IT provider | 2 | 4 | Worsening |
| UPC.10 | 4 hour A&E target | 4 | 4 | Stable |
| PLC.05 | 18 week RTT target | 4 | 4 | Stable |
| PRC.11 | Estates and Technology Transformation Fund | 4 | 4 | Stable |
| MH.01 | Physical health checks LD and severe mental health | 4 | 4 | Stable |
| MH.02 | Waiting times adult ADHD/autism diagnosis | 4 | 4 | Stable |
| MH.03 | ADHD prescribing and medication reviews | 4 | 4 | Stable |
| MH.04 | Waits for autism and ADHD assessments | 4 | 4 | Stable |
| COR.01 | Increased HR service cost (hosted) | 3 | 2 | Increasing |
| PRC.12 | Evening and weekend GP cover | 4 | 2 | Stable |
| PRC.13 | Statutory CCG Primary Care staff capacity | 2 | 3 | Stable |
| ES.38 | CCG failure to deliver financial plan | 1 | 3 | Worsening |
| QN.11 | Woodlands neuro-rehabilitation unit safety concerns | 1 | 2 | Improving |

## 2.4 Other sources of assurance

### 2.4.1 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 use a Board Assurance Framework for the purposes of monitoring progress against each of the CCGs strategic objectives. The CCG currently has 11 strategic objectives based on five key attributes:

- Strengthen
- Improve
- Facilitate and influence
- Develop
- Deliver

Within each of these are some sub headings which the Governing Body has expanded upon to clarify its intentions, allowing for meaningful monitoring. Therefore the Board Assurance Framework reports on the following five headings:

- Strengthen Primary Care to meet demand out of hospital and support with the development of partnership working focussed on the patient pathway
- Improving Access and Quality of Mental Health Services for Adults and Children
- Facilitating and influencing partnership working to create high quality services for the population
- Improving access and quality of cancer services
- Investing in and developing leaders for the future of the system

Within each of these agreed five controls the CCG Directors populate the three or four greatest areas of time expenditure or risk that they are managing and the steps that are being taken to manage these along with an indication of whether the issue is stable, worsening or improving.

All of the CCG risks are then populated on the Board Assurance Framework to enable the Governing Body oversight of all of the risks and the direction of travel for these. The Head of

Legal and Governance attends the Committee to present the Board Assurance Framework and provides access to the full risk register in the event that any member of the Governing Body wishes to scrutinise the detail of a specific risk which, as a result of the risk assessment, is being managed by another committee.

### 2.4.2 Annual audit of conflicts of interest management

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

Auditors have completed their review of the CCG's conflicts of interest arrangements and their assessment is that significant assurance can be given that the CCG's arrangements are effective.

#### 2.4.2.1 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 2019-20 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.

#### 2.4.2.2 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The Data Security Toolkit was submitted and in full compliance for the 2019-20 year.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing / have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are 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.

### 2.4.2.3 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.

### 2.4.2.4 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 CCG's external auditors as part of the year-end audit.

In respect of the Capita SAR, due to Covid-19, NHSE has indicated the SAR will be delayed. This SAR was qualified in previous years and the CCG has ensured it has had adequate compensating controls in place. We understand the scope of controls is the same as the prior year, therefore we are satisfied we have sufficient assurance in respect of the 2019/20 year, despite the delay, due to the aforementioned compensating controls.

In respect of the NHS SBS SAR, due to Covid-19, the service auditor was unable to test controls for February and March 2020. We have noted the qualification in the service auditor's report, however we are satisfied we have sufficient assurance in respect of the 2019/20 year, due to the compensating controls in place at the CCG.

### 2.4.2.5 Control issues

In 2018-19 the CCG failed to deliver its financial plan, deteriorating from the planned deficit of £14.0m by £6.0m to a final deficit position of £20.0m. As part of its 2018-19 annual report the CCG reported several issues of internal control which contributed to this outcome.

During 2019-20 the CCG made several improvements in the exceptions identified around delivery of savings (QIPP), budgetary control, and planning and forecasting. The CCG now no longer considers there to be any financial control issues.

### 2.4.2.6 Review of economy, efficiency and effectiveness of the use of resources

In May 2019 the CCG submitted a financial plan which described a financial deficit of £18.8million. This plan was accepted by NHS England and NHS Improvement although it was not compliant with the published control total deficit of £14.0million. However, the Governing Body considered the plan to be achievable in the wider context of NHS service delivery, safety, and access and performance standards.

As part of the plan a fixed value contract was agreed with the CCG's main provider of acute and community services for the first time. This provided important and material financial stability which had previously not been achieved with other contract types. As part of that contract agreement, the hospital and CCG committed to a joint programme management approach to significant additional system savings plan, valued at £11.2million, and in excess of savings plans submitted in January in initial draft plans. Commitment was also made to take an equal share of any over or under achievement of that system savings plan.

In this context the CCG has continued to forecast delivery of this plan throughout the financial year and the Chief Finance Officer of the CCG provides regular detailed financial reports on financial performance against plan and other key financial duties to the CCG's Finance and Performance Committee, the Audit Committee, and the public meeting of the Governing Body and these are subject to independent scrutiny. These reports are also provided to internal and external auditors and to NHS England and NHS Improvement in its role as the CCG's regulatory body. The CCG continues to operate under legal directions from NHS England and NHS Improvement in regard to its deficit financial position.

Although the CCG has not delivered planned savings in prescribing spend, in part due to national changes in medicines pricing around category M drugs, and other supply issues (no cheaper stock obtainable), appropriate recovery actions were identified and agreed by the Executive Team in September, implemented, and which offset the increased prescribing spend.

The system savings plan achieved a further £2.8million savings which otherwise would not have been delivered. This did mean a shortfall in the original plan of £8.3million of which £2.8million fell to the CCG to resolve. As part of its initial planning the CCG had set a contingency reserve of £2.4million which in the main has offset this issue.

As such, the CCG has been able to maintain its improvement trajectory in bottom line financial performance and prior to any additional sustainability funding from NHS England and NHS Improvement delivered its agreed plan at £18.8million deficit in 2019-20, an improvement over 2018-19 where the deficit was £20.0million against a deficit plan of £14.0million. At the same

time the CCG has been able to invest in improvements in mental health services, and in primary care capacity in line with Governing Body commitments and national planning expectations.

In achieving this improvement in bottom line financial performance the CCG has made several improvements in aspects of financial control. Operational aspects of the exceptions identified last year around QIPP delivery, budget control, and planning and forecasting, which in part led to the failure to deliver the agreed financial plan, have been addressed and improved. Had the CCG agreed to the intended control total of £14.0million deficit for 2019-20 it would have had access to Commissioner Sustainability Funding of £14.0million and in effect been able to report a break-even position and importantly not add to its cumulative deficit. In not agreeing a plan compliant with control total the CCG lost access to that fund and that was the expected position throughout the year. At year-end however, NHS England and NHS Improvement reinstated access to the fund for the CCG which meant a further £14.0million of revenue resource was made available to the CCG improving the bottom line deficit to £4.8million. In addition to that, NHS England and NHS Improvement allocated an additional £4.8million to the CCG which resulted in an overall break-even position. This will be the first time since the 2014-15 financial year that the CCG has been able to report break-even.

However, the exit underlying position for 2018-19 was a deficit of £24.5m. The underlying position at the end of 2019-20 was the same deficit at £24.5m. While the CCG has successfully achieved an improved bottom line position overall, this was achieved non-recurrently. As such, maintaining financial control, and improving system delivery of clinically led change will continue to be a consistent feature of the medium term plan. This is recognised in the published financial recovery trajectory for the CCG which does not expect the CCG to break-even without additional financial recovery funding through the next four years to 2023-24.

The CCG’s internal audit function has carried out annual audits covering budgetary control and forecasting and gave the highest level of assurance possible to the CCG’s Audit Committee that a strong system of internal control is operating effectively. The draft Head of Internal Audit opinion for the year gives an overall rating of significant assurance that controls are effective and operating consistently across all aspects of the CCG’s functions.

The CCG’s external auditors 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.

### 2.4.2.7 Delegation of functions

The CCG has not delegated any of its functions during 2019-20.

### 2.4.2.8 Counter fraud arrangements

Over the past twenty years the Government has been operating a strategy to counter fraud in the NHS. Central to this strategy has been the establishment of the NHS Counter Fraud Service (superseded in November 2017 by the NHS Counter Fraud Authority) and the appointment of Local Counter Fraud Specialists for all NHS organisations. Audit Yorkshire are contracted to provide the CCG's LCFS function.

In order to ensure that counter fraud resources are effectively allocated to maximise coverage for each health body, the strategy requires that each organisation produce a Counter Fraud Plan and Annual Report.

In January 2020 NHS Counter Fraud Authority issued the updated Standards for commissioners – fraud, bribery and corruption to Local Counter Fraud Specialists and Chief Finance Officers. The standards are intended to outline an organisation's corporate responsibilities regarding counter fraud and the key principles for action. These are:

- 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 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 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 requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes, and seeking redress.

- For the CCG the Local Counter Fraud Specialists have reviewed the suggested standards and adapted them to suit the requirements of the organisation. The plan also satisfies the principles of the NHS's counter fraud strategy and complements the work of Internal Audit, without duplication of any work they may carry out.
- Eight days were agreed for the 19/20 financial year, in line with previous years. The LCFS has planned to allocate eight days for the different areas of proactive and strategic counter fraud work.

The Chief Finance Officer is the member of the Governing Body and Executive Lead responsible for tackling fraud, bribery and corruption. The CCG's counter fraud arrangements are in compliance with NHS Counter Fraud Authority's Standards for commissioners, including the appointment of the Chief Finance Officer as the lead for the organisation.

The CCG's Audit Committee reviews and approves the annual counter fraud plan and monitors progress against that plan throughout the year and reports on this to the public meetings of the CCG's Governing Body.

The Local Counter Fraud Specialists complete an annual self-assessment of compliance against the NHS Counter Fraud Authority Standards for commissioners, which is reviewed and approved by the Chief Finance Officer and presented to the Audit Committee prior to submission to NHS Counter Fraud Authority. The 2018-19 assessment was completed and submitted with an overall assessment of compliance (green) in year.

The National Fraud Initiative is a data matching exercise which matches electronic data within and between participating bodies to prevent and detect fraudulent and erroneous payments from the public purse. This includes NHS bodies, local authorities, government departments and other agencies and a number of private sector bodies.

Under the provisions of the above Act, CCGs are mandatory participants in NFI 2018-19. Work was undertaken in September 2019 to review the data matches for the CCG and no issues were identified.

## 2.5 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 2020**

**Roles and responsibilities**

The whole 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 Annual Governance Statement (AGS) is an annual statement by the Accounting Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accounting 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 AGS requirements.

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

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

**The Head of Internal Audit Opinion**

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS.

My opinion is set out as follows:

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

My **overall opinion** is that

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

The **basis** for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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

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

<u>The design and operation of the Assurance Framework and associated processes.</u>

The CCG has centralised and improved its risk management processes during the year, the format of which conforms to good practice. During the year the risk appetite was reviewed and agreed at a Governing Body workshop and the Risk Strategy was presented to both the Audit Committee and the Governing Body, Risk Management training for all CCG staff took place during 2019.

Extracts from risk registers are presented to the CCG's Committees for monitoring and discussion. The Board Assurance Framework has been improved and provides a more focused risk management process for the Governing Body.

The CCG has a Constitution approved by NHSE and has an effective governance structure in place, with meetings being quorate and key officers in attendance. Risk and significant issues are being reported through the sub-groups to the Governing Body with members provided with access to minutes from all the sub-group meetings. The discussions on risk have been noted in reviews of Governing Body meeting minutes.

There is clinical leadership through GP membership of the Governing Body and the Clinical Chair plus there is evidence of communication from Governing Body meetings to clinicians from these members.

An audit of the CCG's governance arrangements was reported in May 2019. This reviewed CCG's committee meetings and decision making; the constitution; governance structure; committee terms of reference; governance documents (e.g. scheme of delegation); framework

of policies and risk management strategy; and procedure and reporting performance of management of risks. Good arrangements were found to be in place.

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

Internal Audit work is planned using an Audit Needs Assessment (ANA). Such an assessment is undertaken every three years and generates a Strategic Audit Plan for those three years. The Audit committee approved the ANA and three year plan at the start of 2019/20. Annually the ANA is reviewed to provide an updated plan that takes into consideration the changing risk profile of the CCG. Both the three year plan and the annual plan are derived from a combination of the risks highlighted in the Assurance Framework and from a separate audit needs assessment undertaken in consultation with the Governing Body and the Audit Committee. This ensures that an audit plan is developed that is targeted towards the areas of greatest risk and allows Internal Audit to discharge its duties effectively.

Where variances from the plan have occurred these have been undertaken with the approval of the Chief Financial Officer and the Audit Committee. Whilst the impact of Covid-19 has resulted in some audits being deferred into 2020/21, no departures from the 2019/20 plan that are material for the purposes of this opinion have occurred.

Internal Audit reports are generated from the work highlighted in the plan. These reports are issued to Directors and to the Audit Committee. Progress in implementing agreed recommendations is reported to the Audit Committee by the CCG and internal audit undertakes an independent verification exercise to confirm their implementation.

Internal Audit reports carry one of four possible opinions. These give the recipient an indication of the level of assurance that can be taken that the processes of control within the area audited are adequate. The four opinions are “High Assurance”, “Significant Assurance”, “Limited Assurance” and “Low Assurance”. A report containing either a “High” or “Significant” opinion would generally be seen as satisfactory.

The outcome of the audit reports from the 2019/20 audit plan are summarised below. Taking into account the 4 audits that have been deferred into 2020/21, this table below confirms the final position for all audits planned in the year.

| Audit Area | Assurance Level |
|---|---|
| QIPP | Significant |
| Risk Management & Governance Arrangements | Significant |
| Coding of Programmes – cost Classification for Administration and Programme Costs | Significant |
| CAMHS Autism Waiting Lists | Significant |
| Primary Care Commissioning | Full |
| Continuing Healthcare | Deferred into 2020/21 – Covid 19 |
| Workforce & Organisational Development | Significant |
| Third Party Arrangements | Significant |

| | |
|---|---|
| Personal Healthcare Budgets | Deferred into 2020/21 – Covid 19 |
| Business Continuity and Emergency Planning | Postpone to 2020/21 |
| Children's Continuing Care | Deferred into 2020/21 – Covid 19 |
| Budgetary Control and Forecasting | High |
| QIPP Follow up | Significant |
| Conflicts of Interest | Significant |
| Data Security & Protection Toolkit | Significant |

**Limited Assurance Opinion Reports 2019/20**

Attention is drawn to the fact that **NO** final reports have been issued in 2019/20 with a "limited assurance" opinion.

**Looking Ahead**

In the last month of 2019/20 we have seen the significant impact of the Covid-19 virus. This has put an unprecedented level of pressure on NHS services and the impact will be substantial, both at the end of 2019/20 and throughout 2020/21. We have continually assessed the impact on our opinion for 2019/20 and will continually assess its impact on the delivery of our work in 2020/21. We have issued a Finance and Governance Checklist to assist Vale of York CCG in ensuring satisfactory controls remain in place, the responses to which have been agreed by all Directors and members of the Audit & Governance Committee. We will continue to consider events as they unfold and assess the adjustments being made by clients.

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
19 June 2020

# Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit

**Conclusion**

The control issues have been discussed at section 2.4.2.5 on page 91 above, and while the CCG remains under Legal Directions, the current financial position has improved.
Significant assurance has been given that there is a generally sound system of internal control that is designed to meet the organisation's objectives, and that controls are generally being applied consistently.

# Remuneration and Staff Report

# 3. Remuneration Report

### 3.1 Remuneration Committee

For details of the work of the Remuneration Committee and its membership, please see the Members' Report on p. 61.

### 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. HR advice has been provided to the Remuneration Committee from the shared HR service.

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.

## 3.1.3 Senior manager remuneration 2019-20 (including salary and pension entitlements) *(subject to audit)*

**Table 11 -** Senior manager remuneration 2019-20

| 2019-20 | | | | | | |
|---|---|---|---|---|---|---|
| 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) and (b) | 110-115 | 0 | | | 0 | 110-115 |
| P Mettam - Accountable Officer - see (c) | 115-120 | 0 | | | 0 | 115-120 |
| S Bell - Chief Finance Officer | 120-125 | 0 | | | 17.5-20 | 135-140 |
| M Carrington - Executive Director of Quality and Nursing | 90-95 | 0 | | | 7.5-10 | 100-105 |
| D Nightingale - Executive Director of Transformation, Complex Care and Mental Health | 75-80 | 0 | | | 0 | 75-80 |
| Dr A Lee - Executive Director of Primary Care and Population Health (from 1 May 2019) - see (d) | 70-75 | 0 | | | 250-252.5 | 320-325 |
| K Ramsay - Lay Member (to 31 May 2019) | 0-5 | 0 | | | 0 | 0-5 |
| D Booker - Lay Member | 10-15 | 0 | | | 0 | 10-15 |
| P Goatley - Lay Member | 10-15 | 1,100 | | | 0 | 10-15 |
| J Hastings - Lay Member (from 1 September 2019) | 5-10 | 0 | | | 0 | 5-10 |
| Dr H Ebbs - North Locality GP Governing Body member - see (a) | 5-10 | 0 | | | 0 | 5-10 |
| Dr C Stanley - Central Locality GP Governing Body Member (to 1 June 2019) - see (a) | 5-10 | 0 | | | 0 | 5-10 |
| 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 C Stanley 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 N Wells remuneration disclosed above is total remuneration from the CCG and includes his role as Clinical Chair (banded remuneration £75-80k) and his role as Named GP for Safeguarding in Primary Care (banded remuneration £35-40k).

(c) P Mettam is seconded to Humber, Coast and Vale Sustainability and Transformation Partnership for 1 day per week. The remuneration disclosed above relates to his CCG role of Accountable Officer only. Total remuneration in 2019-20 across both organisations was £125-130k.

(d) The pension related benefits disclosed above for Dr A Lee include benefits accrued through purchase of additional years in the NHS Pension Scheme.

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

(f) The post of Secondary Care Doctor has been vacant throughout 2019-20. An appointment was made with a scheduled start date of 1 September 2019, however the appointee did not subsequently take up the post.

(g) 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.

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

(i) 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.

## 3.1.4 Senior Manager Remuneration 2018-19 (including salary and pension benefits

**Table 12** – Senior Management Remuneration 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.

## 3.1.5 Pension benefits as at 31 March 2020 (subject to audit)

| 2019-20 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name and Title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 1 April 2019 £000 | Real Increase in Cash Equivalent Transfer Value £000 | Cash Equivalent Transfer Value at 31 March 2020 £000 | Employers Contribution to stakeholder pension £000 |
| P Mettam - Accountable Officer | 0-2.5 | 0-2.5 | 40-45 | 130-135 | 981 | 38 | 1,062 | 0 |
| S Bell - Chief Finance Officer | 0-2.5 | 0 | 40-45 | 95-100 | 727 | 18 | 780 | 0 |
| M Carrington - Executive Director of Quality and Nursing | 0-2.5 | 0 | 35-40 | 100-105 | 707 | 0 | 723 | 0 |
| D Nightingale - Executive Director of Transformation, Complex Care and Mental Health | 0 | 0 | 40-45 | 130-135 | 0 | 0 | 0 | 0 |
| Dr A Lee - Executive Director of Primary Care and Population Health (from 1 May 2019) - see (b) | 10-12.5 | 27.5-30 | 35-40 | 80-85 | 373 | 186 | 598 | 0 |

(a) Dr N Wells, Dr H Ebbs, Dr C Stanley 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 disclosure requirements do not apply to their role with the CCG.
(b) The pension related benefits disclosed above for Dr A Lee include benefits accrued through purchase of additional years in the NHS Pension Scheme.
(c) The post of Secondary Care Doctor has been vacant throughout 2019-20. An appointment was made with a scheduled start date of 1 September 2019, however the appointee did not subsequently take up the post.
(d) The method used to calculate CETVs has changed to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If an individual was entitled to a GMP, this will affect the calculation of the real increase in CETV which has been reported. This is more likely to affect individuals who are members of the 1995 Section and 2008 Section of the NHS Pension Scheme.
(e) Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

**Table 13** – Pension benefits as at 31 March 2020

## 3.1.6 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 pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2019 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2019) (bands of £5,000 | Cash Equivalent Transfer Value at 1 April 2018 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2019 | 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.

**Table 14** – Pension benefits as at 31 March 2019

### 3.1.7 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 values are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

### 3.1.8 Real increase in CETV

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

### 3.1.9 Compensation on early retirement or for loss of office (subject to audit)

There were no payments made for compensation on early retirement or for loss of office in 2019-20.

### 3.1.10 Payments to past directors (subject to audit)

There have been no payments to past directors in 2019-20.

### 3.1.11 Fair Pay Disclosure (subject to audit)

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

The banded remuneration of the highest paid director in NHS Vale of York CCG in the financial year 2019-20 was £175k - £180k (2018-19: £175k – 180k). This was 4.76 times (2018-19: 5.34) the median remuneration of the workforce, which was £37,267 (2018-19: £33,222).

The movement in the median remuneration for 2019-20 was as a result of an organisational restructure which came into effect from 1 October 2019.

In 2019-20, no employees (2018-19, no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £15k - £20k to £120k - £125k (2018-19: £15k - £20k to £125k - £130k).

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.

## 3.2 Staff Report

### 3.2.1 Number of senior managers (subject to audit)

| Pay band | Total |
|---|---|
| Band 8a | 11 |
| Band 8b | 5 |
| Band 8c | 5 |
| Band 8d | 5 |
| Band 9 | 0 |
| VSM | 5 |
| Governing body | 7 |
| Any other Spot Salary | 2 |

**Table 15 -** Senior managers by band

### 3.2.2 Staff numbers and costs (subject to audit)

### 3.2.2.1 Average number of people employed

| | 2019-20 | | | 2018-19 |
|---|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number | Total Number |
| **Total** | **112** | **4** | **116** | **121** |
| *Of the above:* Number of whole time equivalent people engaged on capital projects | **0** | **0** | **0** | **0** |

**Table 16** - Staff numbers

### 3.2.2.2 Salaries and Wages

| | 2019-20 | | |
|---|---|---|---|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| Salaries and wages | 4,857 | 269 | 5,126 |
| Social security costs | 477 | 0 | 477 |
| Employer contributions to NHS Pension scheme | 859 | 0 | 859 |
| Apprenticeship Levy | 8 | 0 | 8 |
| Termination benefits | 282 | 0 | 282 |
| **Total employee benefits expenditure** | **6,483** | **269** | **6,752** |

**Table 17** - Salaries and wages

### 3.2.3 Staff composition

| Gender | Female | Male |
|---|---|---|
| Band 8a | 7 | 4 |
| Band 8b | 3 | 2 |
| Band 8c | 5 | 0 |
| Band 8d | 3 | 2 |
| Band 9 | 0 | 0 |
| VSM | 2 | 3 |
| Governing body | 3 | 4 |
| Any other Spot Salary | 0 | 2 |
| All other employees (including apprentices) | 68 | 17 |
| **Total** | **91** | **34** |

**Table 18** - Staff composition

### 3.2.4 Sickness absence data

| Level of Absence for last 12 months (Absence Days) | % | Total Number of Full Time Equivalent Days Lost |
|---|---|---|
| **1,608** | **3.78%** | **1,557** |

**Table 19** - Sickness absence

### 3.2.5 Expenditure on consultancy

The CCG incurred expenditure of £166,938 on consultancy during 2019-20.

### 3.2.6 Off-payroll engagements

There were no off-payroll engagements during 2019-20.

### 3.2.7 Exit packages (subject to audit)

| | 2019-20 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Compulsory redundancies | | Other agreed departures | | Total exit packages | | Departures where special payments have been made | |
| | Number | £ | Number | £ | Number | £ | Number | £ |
| Less than £10,000 | 1 | 3,648 | 0 | 0 | 1 | 3,648 | 0 | 0 |
| £10,001 to £25,000 | 5 | 80,666 | 0 | 0 | 5 | 80,666 | 0 | 0 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 3 | 197,715 | 0 | 0 | 3 | 197,715 | 0 | 0 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 | 0 | 0 | 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** | **9** | **282,028** | **0** | **0** | **9** | **282,028** | **0** | **0** |

**Table 20** – Exit packages 2019-20

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 NHS Vale of York 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.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

### 3.2.8 Staff policies

The CCG maintains a range of policies to ensure fair treatment of staff, including those on equalities (see the more detailed equalities report below) which include provisions for staff with disabilities. The CCG is a member of the DWP's Disability Confident scheme, which replaces the former "Two Ticks" scheme, and is currently at the Disability Confident Committed level within that programme. The CCG's staff policies are published at www.valeofyork.nhs.net.

## 3.3 Equalities Report

### 3.3.1 Commitment to equalities, diversity and human rights

The CCG aims to commission health services that give protected and vulnerable groups across the Vale of York footprint, including those which are seldom heard and struggle to achieve equity of access, the same standards of access, quality and patient outcomes as those across the population as a whole. Detail of the CCG's work to reduce health inequalities is discussed above, and while some of the wider issues are outside the CCG's sphere of influence, the CCG is committed to working with partners to reduce inequalities of provision and access, agreeing areas of focus in line with areas identified in the Joint Strategic Needs Assessment assessing changes in service provision by means of a rigorous equalities impact assessment process, and engaging and communicating with patients in the shaping of services in order to reduce any barriers or inequities faced by members of protected and vulnerable groups.

### 3.3.2 The Equality Duty

The Equality Duty is a general duty set out in the Equality Act 2010, which applies to public bodies and others that carry out public functions. It ensures that public bodies consider the needs of all individuals in their day-to-day work in shaping policy, in delivering services, and in relation to their own employees.

The Public Sector Equality Duty has three aims. It requires public sector organisations to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010.

2. Advance equality of opportunity between people who share a protected characteristic and those who do not share it.

3. Foster good relations between people who share a protected characteristic and those who do not share it.

The protected characteristics covered by the Equality Duty are:

- age
- disability
- gender reassignment (transgender)
- marriage and civil partnership (to the extent that such status leads to unlawful discrimination)
- pregnancy and maternity
- ethnicity
- religion or belief, which includes lack of belief (atheism)
- sex
- sexual orientation

In addition the CCG considers the needs of carers and economically disadvantaged groups. The general Equality Duty is supported by two specific duties, which require public sector organisations including CCG's to:

- publish information to show their compliance with the Equality Duty;
- set and publish equality objectives, at least every 4 years.

The CCG monitors its progress against the NHS Equalities Delivery System 2 standard, and further information is published at https://www.england.nhs.uk/about/equality/equality-hub/eds/ .

The anticipated change to a revised NHS Equalities Delivery System 3 standard has not taken place during the last financial year, and the CCG therefore continues to align its work with the four domains of NHS Equalities Delivery System 2 standard:

- better health outcomes;
- improved patient access and experience;
- a representative and supported workforce;
- an inclusive Leadership.

Details of staff composition to show breakdown by gender are given in the Remuneration Report on p110.

The CCG is a member of the Disability Confident positive action scheme run from the Department of Work and Pensions, which replaced the former “Two Ticks” employment scheme. Under the terms of this scheme, the CCG provides work placements and opportunities for people with disabilities. The CCG’s finance team have been shortlisted for recognition by the HFMA for their work with a local education provider in providing work placements for young people.

### 3.3.3 Equalities goals 2019-20

An update on progress against the goals of the Equality, Inclusion and Human Rights Strategy 2017-21 is set out below. Targets achieved and goals completed in previous years have been omitted for clarity.

| | Goal | Progress to February 2020 |
|---|---|---|
| 1 | To ensure on-going involvement and engagement of protected groups and enable the participation of vulnerable groups in shaping our services | The CCG runs an extensive programme of outreach activity, including:<br>▪ Wheelchair service users forum<br>▪ Engaging with younger people on mental health access for 11-18 year olds – local youth council, leading to roll-out of Kooth online access for 11-18 age group<br>▪ Working with children with a disability to improve health services as part of the access for all scheme<br>▪ Learning Disability Strategy launch, working with York CVS Learning Disabilities Forum<br>▪ Ageing Well communities, engaging with older people in Selby and public health teams<br>▪ Accessible Information Standard work to make information widely available, which includes training for staff in producing Easy Read documentation |
| 2 | To work in partnership with public and voluntary sector bodies to ensure that the CCG engages with best practice in equalities and diversity, including regular attendance at regional NHS | The CCG continues to work with Healthwatch and the voluntary sector to respond to issues highlighted including those in Healthwatch reports.<br>▪ This year activity has focused on the response to the report on LGBT+ experiences, which has led to the launch of the Rainbow Badge initiative |

| | | |
|---|---|---|
| | group meetings | promoting LGBT awareness to staff. For further information see: https://www.valeofyorkccg.nhs.uk/about-us/equality-diversity-sustainability/nhs-rainbow-badge/<br>▪ A review of the transgender pathway for GP referrers is in progress.<br>▪ The CCG continues to attend regional NHS meetings to share best practice in equalities and diversity. |
| **3** | Contracts to have common Equalities and Diversity reporting for the WRES, Gender Pay Gap and from 1 April 2019 the WDES | ▪ Reporting from providers is made via NHS England reporting tools and form part of standard contracts. First WDES reports due summer 2020. |
| **4** | Work with the Business Intelligence Team to improve background data for protected characteristics over the Vale of York footprint | ▪ Complete, base level data incorporated into the revised QIA process which now includes the Equality Impact Assessment, to ensure consistency of decision-making. |
| **5** | Ensure that service improvement plans for maternity services takes into account the needs of protected groups | ▪ A smoking cessation in pregnancy service has focused on the more deprived areas of the CCG's footprint.<br>▪ The Maternity Voices Partnership, under the leadership of a new chair, continues to engage with service users in an inclusive manner, including engagement with fathers and in child friendly venues. The group recently conducted a survey of over 500 parents focusing on priorities and improvements for maternity services. |
| **6** | Improve screening and health-check uptake among protected groups, including regular health checks for people with learning | ▪ Work with GPs is continuing to increase the numbers of people with LD accessing health checks and screening, with the CCG's performance on health checks for people with LD now above the national mean which |

| | | |
|---|---|---|
| | disabilities | represents a significant improvement on the previous year's position.<br>▪ Further work on screening for the LD population to be presented to GPs at a Protected Learning Time Event in July 2020. |
| **7** | Ensure that service re-designs and policies give due regard to the Equalities Impact Assessment process | ▪ The revised Quality Impact Assessment (which incorporates the Equalities Impact Assessment) was launched in January 2020, and all policies and major service changes are required to complete the assessment as part of the approval process for change. |
| **8** | Update the CCG's data on declared disabilities of staff as part of the implementation of the Workforce Disabilities Equalities Standard | ▪ Staff are encouraged to keep their data (including equalities data) updated on the Electronic Staff Record. WDES reporting is not mandatory for CCGs but staff are encouraged to self-report disabilities. |
| **9** | Increase the completion rates among staff of the Equalities e-learning training module | ▪ 71.68% at 30 Nov 2019, an improvement on previous year's rate of 65% |
| **10** | Deliver annual face to face equality and diversity training as required | ▪ Training related to the Rainbow Badge initiative was delivered by MESMAC (local LGBT charity) to staff in October 2019.<br>▪ Accessible Information Standard – training on creating Easy Read documents delivered to communications and engagement staff. |
| **11** | To demonstrate effective leadership that values and prioritises equalities, inclusion and regard for human rights | ▪ Governing Body regularly discuss health inequalities, most recently in January 2020 with a presentation from the Director of Public Health from North Yorkshire CC on current issues. https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=2946 (Pp 20-60) |

**Table 21** - Equalities goals 2019-20

### 3.3.4 Trade Union Facility time reporting requirements

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:

### 3.3.5 Relevant union officials

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

**Table 22 -** 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 23** - 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 24** - 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 25** - Paid trade union activities

## 3.8 Other employee matters

### 3.8.1 Staff equalities

Staff equalities matters are included under “Staff policies” in the section above.
Staff wellbeing issues are addressed through the Staff Engagement Group (SEG) which meets on a monthly basis and is chaired by the Deputy Chief Nurse. The CCG encourages training and development for all its staff, and has introduced a talent management programme to increase opportunity within the organisation and to assist with succession planning.

### 3.8.2 Staff consultation

Recognising the benefits of partnership working, NHS Vale of York CCG has continued to work jointly with the locally established North Yorkshire and Humber Social Partnership Forum through a time of significant organisational change during 2019-20.

The aim of the Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Trade Unions to discuss and debate issues in an environment of mutual trust and respect. During 2019-20 the CCG has continued its commitment to work in partnership with trade unions, and to develop ongoing systems for joint working.

## 3.9 Parliamentary Accountability and Audit Report

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

# Annual accounts

## 2019-20

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

### Report on the financial statements

### 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 2020, 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 adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/2020, 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.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 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 2019/2020; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

### Basis for opinion

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

### Conclusions relating to going concern

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

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

**Other information**
The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.
In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

**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 Health and Social Care Act 2012; 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 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 7th February 2020 we issued a report to the Secretary of State for Health and Social Care under section 30 (a) of the Local Audit and Accountability Act 2014, for the expected breach of financial duties under:

- Section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2019/20; 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 2020.

### Qualified conclusion – Except for
On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2020, with the exception of the matters described in the 'Basis for qualified conclusion' paragraph below, we are 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 2020.

### Basis for qualified conclusion
The CCG has a large cumulative deficit and the five year financial plan does not show the cumulative deficit being eliminated within the life of the plan. The draft 2020/21 financial plan included unidentified savings of £7.5 million. 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.

### 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 April 2020, 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 2020. 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.

**Delay in certification of completion of the audit**
We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to issue:

- our independent auditor's statement to the Governing Body on the CCG Accounts Consolidation Template.
- the Non-sampled Group Return and supporting documents to the National Audit Office in respect of their audit of NHS England, the Department of Health and Social Care (DHSC) Group Accounts, and the Whole of Government Accounts (WGA).

We are satisfied that these matters would not have a material effect on the financial statements or on our conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Mark Kirkham
Partner
For and on behalf of Mazars LLP

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

24 June 2020

NHS Vale of York CCG - Annual Accounts 2019-20

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## Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

| | Note | 2019-20 £'000 | 2018-19 £'000 |
|---|---|---|---|
| Income from services | 2 | (677) | (716) |
| Other operating income | 2 | (1,455) | (1,180) |
| **Total operating income** | | **(2,132)** | **(1,896)** |
| Staff costs | 4 | 6,752 | 6,333 |
| Purchase of goods and services | 5 | 507,369 | 483,303 |
| Depreciation charges | 5 | 0 | 76 |
| Provision expense | 5 | 126 | 22 |
| Other operating expenditure | 5 | 206 | 131 |
| **Total operating expenditure** | | **514,453** | **489,865** |
| **Net operating expenditure** | | **512,321** | **487,969** |
| Finance expense | 7 | 302 | 0 |
| **Net expenditure for the year** | | **512,623** | **487,969** |
| **Comprehensive net expenditure for the year** | | **512,623** | **487,969** |

The notes on pages 5 to 29 form part of this statement.

## Statement of Financial Position as at 31 March 2020

| | Note | 2019-20 £'000 | 2018-19 £'000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Property, plant and equipment | 9 | 18 | 302 |
| **Total non-current assets** | | **18** | **302** |
| **Current assets** | | | |
| Trade and other receivables | 10 | 2,795 | 5,296 |
| Cash | 11 | 92 | 130 |
| **Total current assets** | | **2,887** | **5,426** |
| **Total assets** | | **2,905** | **5,728** |
| **Current liabilities** | | | |
| Trade and other payables | 12 | (26,467) | (28,394) |
| Provisions | 13 | (139) | (22) |
| **Total current liabilities** | | **(26,606)** | **(28,416)** |
| **Assets less liabilities** | | **(23,701)** | **(22,688)** |
| **Financed by taxpayers' equity** | | | |
| General fund | | (23,701) | (22,688) |
| **Total taxpayers' equity** | | **(23,701)** | **(22,688)** |

The notes on pages 5 to 29 form part of this statement

The financial statements on pages 1 to 29 were approved by the Audit Committee on behalf of the Governing Body on 21st May 2020 and signed on its behalf by:

Phil Mettam
Accountable Officer
23rd June 2020

## Statement of Changes In Taxpayers' Equity for the year ended 31 March 2020

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in taxpayers' equity for 2019-20** | | |
| **Balance at 1 April 2019** | **(22,688)** | **(22,688)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20** | | |
| Net operating expenditure for the financial year | (512,623) | (512,623) |
| Net funding | 511,610 | 511,610 |
| **Balance at 31 March 2020** | **(23,701)** | **(23,701)** |

| | 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)** |

The notes on pages 5 to 29 form part of this statement.

## Statement of Cash Flows for the year ended 31 March 2020

| | Note | 2019-20 £'000 | 2018-19 £'000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Net operating expenditure for the financial year | | (512,623) | (487,969) |
| Depreciation | 5 | 0 | 76 |
| Other gains and losses | 7 | 302 | 0 |
| (Increase)/decrease in trade and other receivables | 10 | 2,501 | (2,925) |
| Increase/(decrease) in trade and other payables | 12 | (1,927) | 4,607 |
| Provisions utilised | 13 | (9) | (124) |
| Increase in provisions | 13 | 126 | 22 |
| **Net cash outflow from operating activities** | | **(511,630)** | **(486,313)** |
| **Cash flows from investing activities** | | | |
| (Payments) for property, plant and equipment | 9 | (18) | 0 |
| **Net cash outflow from investing activities** | | **(18)** | **0** |
| **Net cash outflow before financing** | | **(511,648)** | **(486,313)** |
| **Cash flows from financing activities** | | | |
| Grant in aid funding received | | 511,610 | 486,348 |
| **Net cash inflow from financing activities** | | **511,610** | **486,348** |
| **Net increase/(decrease) in cash** | 11 | **(38)** | **35** |
| **Cash at the beginning of the financial year** | | **130** | **95** |
| **Cash at the end of the financial year** | | **92** | **130** |

The notes on pages 5 to 29 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 2019-20 (GAM) issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM 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

The Clinical Commissioning Group's annual report and accounts have been prepared on a going concern basis.

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

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

In March 2020, the World Health Organisation declared that Covid-19 was a global pandemic and lockdown measures began. Whilst this has had a National impact in the 2019-20 financial year, which will continue into 2020-21, this does not change the CCGs assessment of going concern.

#### 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 Joint Arrangements - Interests in Joint Operations

The Clinical Commissioning Group has entered into pooled budget arrangements with partner organisations in accordance with section 75 of the NHS 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 17 - 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 Morecambe Bay 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.

1.4 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• The Clinical Commissioning Group does 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 the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

• The Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.5 **Employee Benefits**

1.5.1 **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.

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 **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.

1.7 **Grants Payable**

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

1.8 **Property, Plant and Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to 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.

1.8.2 **Measurement**

All property, plant and equipment is 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.

IT equipment, furniture and fittings, and equipment that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.9 **Depreciation**

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 property, plant and equipment 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.

1.10 **Leases**

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

1.10.1 **The Clinical Commissioning Group as Lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **Cash**

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.

1.12 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.
A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

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

1.14 **Non-Clinical Risk Pooling**

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to 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.

1.15 **Contingent Liabilities**

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.

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

1.16 **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.

1.16.1 **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.

1.16.2 **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.

1.17 **Financial Liabilities**

Financial liabilities are recognised 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.

After initial recognition, all financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.18 **Value Added Tax**

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

1.19 **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).

1.20 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the Clinical Commissioning Group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical Accounting Judgements in Applying Accounting Policies**

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 are detailed in the relevant notes to the accounts.

1.20.2 **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 11 months of the year based upon historic prescribing patterns. Within the total reported prescribing expenditure for 2019-20, 9.46% is based on estimated figures. Due to the value of this, a review of the accuracy level for prescribing estimates throughout 2019-20 has been carried out and shows 97% accuracy.

• 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 2018-19. Payment for 2019-20 will be reconciled and paid to GP practices in May 2020.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2021 as adapted and interpreted by the FReM.

● 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.

The application of IFRS 16 Leases in 2021-22 will mean that building leases currently classified as operating leases will be brought on to the Statement of Financial Position. This will be recognised as a right-of-use asset offset by a lease liability representing the financing. The right-of-use asset will then be depreciated, with depreciation and interest being charged through the Statement of Comprehensive Net Expenditure. Were this standard applied in 2019-20, right-of-use assets of approximately £1.4m would be included on the Statement of Financial Position.

The application of the other standard is not expected to have a material impact on the accounts for 2019-20, if it were applied in year.

## 2. Operating Revenue

| | 2019-20 Total £'000 | 2018-19 Total £'000 |
|---|---|---|
| **Income from services (contracts)** | | |
| Non-patient care services to other bodies | 425 | 435 |
| Prescription fees and charges | 234 | 227 |
| Other contract income | 18 | 54 |
| Recoveries in respect of employee benefits | 0 | 0 |
| **Total income from services** | **677** | **716** |
| | | |
| **Other operating income** | | |
| Charitable and other contributions to revenue expenditure: non-NHS | 84 | 24 |
| Non-cash apprenticeship training grants revenue | 3 | 4 |
| Other non-contract revenue | 1,368 | 1,152 |
| **Total other operating income** | **1,455** | **1,180** |
| | | |
| **Total operating income** | **2,132** | **1,896** |

Income is from the supply of services. The Clinical Commissioning Group receives no income from the sale of goods.

## 3. Disaggregation of Income - Income from Services (Contracts)

| | 2019-20 | | | | 2018-19 |
|---|---|---|---|---|---|
| | Non-patient care services to other bodies £'000 | Prescription fees and charges £'000 | Other contract income £'000 | Total contract income £'000 | Total contract income £'000 |
| **Source of income** | | | | | |
| NHS | 0 | 0 | 0 | 0 | 0 |
| Non NHS | 425 | 234 | 18 | 677 | 716 |
| **Total** | **425** | **234** | **18** | **677** | **716** |

| | 2019-20 | | | | 2018-19 |
|---|---|---|---|---|---|
| | Non-patient care services to other bodies £'000 | Prescription fees and charges £'000 | Other contract income £'000 | Total contract income £'000 | Total contract income £'000 |
| **Timing of income** | | | | | |
| Point in time | 0 | 0 | 18 | 18 | 37 |
| Over time | 425 | 234 | 0 | 659 | 679 |
| **Total** | **425** | **234** | **18** | **677** | **716** |

## 4. Employee Benefits and Staff Numbers

### 4.1 Employee Benefits

| | 2019-20 | | |
|---|---|---|---|
| | Permanent employees £'000 | Other £'000 | Total £'000 |
| **Employee benefits** | | | |
| Salaries and wages | 4,857 | 269 | 5,126 |
| Social security costs | 477 | 0 | 477 |
| Employer contributions to NHS Pension scheme | 859 | 0 | 859 |
| Apprenticeship Levy | 8 | 0 | 8 |
| Termination benefits | 282 | 0 | 282 |
| **Total employee benefits expenditure** | **6,483** | **269** | **6,752** |

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

| | 2018-19 | | |
|---|---|---|---|
| | Permanent employees £'000 | Other £'000 | Total £'000 |
| **Employee benefits** | | | |
| 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** |

### 4.2 Average Number of People Employed

| | 2019-20 | | | 2018-19 |
|---|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number | Total Number |
| **Total** | **112** | **4** | **116** | 121 |

### 4.3 Exit Packages Agreed in the Financial Year

| | 2019-20 Compulsory redundancies | | 2019-20 Total | |
|---|---|---|---|---|
| | Number | £ | Number | £ |
| Less than £10,000 | 1 | 3,648 | 1 | 3,648 |
| £10,001 to £25,000 | 5 | 80,666 | 5 | 80,666 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 3 | 197,715 | 3 | 197,715 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 |
| **Total** | **9** | **282,029** | **9** | **282,029** |

| | 2018-19 Compulsory redundancies | | 2018-19 Total | |
|---|---|---|---|---|
| | Number | £ | Number | £ |
| Less than £10,000 | 1 | 2,492 | 1 | 2,492 |
| £10,001 to £25,000 | 2 | 36,464 | 2 | 36,464 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 0 | 0 | 0 | 0 |
| £100,001 to £150,000 | 1 | 129,155 | 1 | 129,155 |
| **Total** | **4** | **168,111** | **4** | **168,111** |

There were no payments for other agreed departures made in 2019-20 (2018-19: nil).

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of section 16 of the NHS Terms and Conditions of Service Handbook (Agenda for Change) for compulsory redundancies.

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

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 and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group 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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 to 20.68%, and the Scheme Regulations were amended accordingly.

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.

The employer contribution rate for NHS Pensions increased from 14.38% to 20.68% from 1st April 2019. For 2019-20, CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

For 2019-20, the Clinical Commissioning Group paid £603,638 of employers' contributions directly to the NHS Pensions Scheme (2018-19: £547,548) at the rate of 14.38% of pensionable pay. The Clinical Commissioning Group paid £584,419 in total for employers' contributions which includes contributions made by other organisations and recharged to the Clinical Commissioning Group (2018-19: £597,131). NHS England paid an additional 6.3% , £274,907, on behalf of the Clinical Commissioning Group, which is accounted for within the Clinical Commissioning Group accounts. These costs are included in the NHS Pension line of note 4.1.

## 5. Operating Expenses

| | 2019-20 Total £'000 | 2018-19 Total £'000 |
|---|---|---|
| **Purchase of goods and services** | | |
| Services from other CCGs and NHS England | 1,315 | 468 |
| Services from foundation trusts | 296,941 | 279,949 |
| Services from other NHS trusts | 30,979 | 28,879 |
| Purchase of healthcare from non-NHS bodies | 63,400 | 63,422 |
| Prescribing costs | 50,561 | 48,596 |
| General ophthalmic services | 140 | 127 |
| GMS, PMS and APMS | 47,590 | 45,913 |
| Rentals under operating leases | 201 | 1,365 |
| Supplies and services – clinical | 248 | 335 |
| Supplies and services – general | 10,930 | 10,713 |
| Consultancy services | 167 | 128 |
| Establishment | 1,534 | 841 |
| Transport | 2,186 | 2,249 |
| Premises | 933 | 109 |
| Audit fees | 52 | 52 |
| Other non statutory audit expenditure | | |
| · Internal audit services | 39 | 37 |
| · Other services* | 1 | 10 |
| Other professional fees | 8 | 53 |
| Legal fees | 56 | 10 |
| Education, training and conferences | 85 | 43 |
| Non cash apprenticeship training grants | 3 | 4 |
| **Total purchase of goods and services** | **507,369** | **483,303** |
| | | |
| **Depreciation charges** | | |
| Depreciation | 0 | 76 |
| **Total depreciation charges** | **0** | **76** |
| | | |
| **Provision expense** | | |
| Provisions | 126 | 22 |
| **Total provision expense** | **126** | **22** |
| | | |
| **Other operating expenditure** | | |
| Chair and Non-Executive Members | 130 | 106 |
| Research and development (excluding staff costs) | 33 | 0 |
| Expected credit loss on receivables | 35 | 14 |
| Other expenditure | 8 | 11 |
| **Total other operating expenditure** | **206** | **131** |
| | | |
| **Total operating expenditure** | **507,701** | **483,532** |

*Non-audit services are in respect of Mental Health Investment Standard assurance that NHS England requires Clinical Commissioning Groups to obtain from an independent reporting accountant, to demonstrate their investment in mental health expenditure rises at a faster rate than their overall published programme funding.

## 6. Better Payment Practice Code

| 6.1 Measure of compliance | 2019-20 Number | 2019-20 £'000 | 2018-19 Number | 2018-19 £'000 |
|---|---|---|---|---|
| **Non-NHS payables** | | | | |
| Total non-NHS trade invoices paid in the year | 10,349 | 131,769 | 10,398 | 120,381 |
| Total non-NHS trade invoices paid within target | 10,034 | 130,861 | 9,975 | 118,503 |
| **Percentage of non-NHS trade invoices paid within target** | **96.96%** | **99.31%** | **95.93%** | **98.44%** |
| | | | | |
| **NHS payables** | | | | |
| Total NHS trade invoices paid in the year | 3,338 | 333,955 | 3,625 | 320,185 |
| Total NHS trade invoices paid within target | 3,277 | 333,306 | 3,546 | 319,663 |
| **Percentage of NHS trade invoices paid within target** | **98.17%** | **99.81%** | **97.82%** | **99.84%** |

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

There were no payments made in the relation to the late payment of commercial debts (2018-19: nil).

## 7. Other Gains and Losses

| | 2019-20 £'000 | 2018-19 £'000 |
|---|---|---|
| Gain/(loss) on disposal of property, plant and equipment assets other than by sale | (302) | 0 |
| **Total** | **(302)** | **0** |

Obsolete plant and machinery assets have been disposed of in year.

## 8. Operating Leases

### 8.1 As Lessee

In 2019-20, 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.

In November 2019, the Clinical Commissioning Group took responsibility for another building lease which was previously recharged as part of a hosted service. 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 preparation for the implementation of IFRS 16 Leases, the nature of void and subsidy charges has been reviewed and they have not been deemed to meet the definition of a lease. In 2019-20, charges for void and subsidy costs of £614,839 have been included within premises expenditure. In 2018-19, charges of £880,785 were included within minimum lease payments in relation to void and subsidy costs.

In 2019-20, the Clinical Commissioning Group paid £169,812 (2018-19: £1,303,149) directly for rent. The Clinical Commissioning Group was charged £31,271 by other organisations in respect of rent for hosted services (2018-19: £61,348).

#### 8.1.1 Payments Recognised as an Expense

| | 2019-20 | | | 2018-19 | | |
|---|---|---|---|---|---|---|
| | Buildings £'000 | Other £'000 | Total £'000 | Buildings £'000 | Other £'000 | Total £'000 |
| **Payments recognised as an expense** | | | | | | |
| Minimum lease payments | 201 | 0 | **201** | 1,363 | 1 | **1,364** |
| **Total** | **201** | **0** | **201** | **1,363** | **1** | **1,364** |

Whilst the arrangement with City of York Council falls within the definition of an operating lease, rental charges for future years have not been agreed. Consequently this note does not include any future minimum lease payments for this arrangement.

## 9. Property, Plant and Equipment

| | 2019-20 | | | 2018-19 | | |
|---|---|---|---|---|---|---|
| | 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 | 0 | 756 | 756 | 5 | 761 |
| Additions purchased | 0 | 18 | 18 | 0 | 0 | 0 |
| Disposals other than by sale | (756) | 0 | (756) | 0 | (5) | (5) |
| **Cost or valuation at 31 March** | **0** | **18** | **18** | **756** | **0** | **756** |
| **Depreciation at 1 April** | 454 | 0 | 454 | 378 | 5 | 383 |
| Disposals other than by sale | (454) | 0 | (454) | 0 | (5) | (5) |
| Charged during the year | 0 | 0 | 0 | 76 | 0 | 76 |
| **Depreciation at 31 March** | **0** | **0** | **0** | **454** | **0** | **454** |
| **Net book value at 31 March** | **0** | **18** | **18** | **302** | **0** | **302** |
| Purchased | 0 | 18 | 18 | 302 | 0 | 302 |
| **Total at 31 March** | **0** | **18** | **18** | **302** | **0** | **302** |
| **Asset financing:** | | | | | | |
| Owned | 0 | 18 | 18 | 302 | 0 | 302 |
| **Total at 31 March** | **0** | **18** | **18** | **302** | **0** | **302** |

Plant and machinery assets were reviewed in year and deemed to be obsolete. They have been written off, resulting in a loss on disposal of £302,465.

### 9.1 Economic lives

| | Minimum Life (years) | Maximum Life (Years) |
|---|---|---|
| Plant and machinery | 5 | 10 |
| Information technology | 2 | 10 |

## 10. Trade and Other Receivables

| | Current 2019-20 £'000 | Current 2018-19 £'000 |
|---|---|---|
| NHS receivables: revenue | 515 | 3,013 |
| NHS prepayments | 954 | 922 |
| NHS accrued income | 509 | 646 |
| Non-NHS and other WGA* receivables: revenue | 92 | 115 |
| Non-NHS and other WGA prepayments | 445 | 130 |
| Non-NHS and other WGA accrued income | 37 | 363 |
| Non-NHS and other WGA contract receivable not yet invoiced / non-invoic | 216 | 39 |
| Expected credit loss allowance - receivables | (3) | (3) |
| VAT | 30 | 70 |
| Other receivables and accruals | 0 | 1 |
| **Total trade and other receivables** | **2,795** | **5,296** |

*Whole of Government Accounts

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

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

### 10.1 Receivables Past their Due Date but Not Impaired

| | 2019-20 | | 2018-19 | |
|---|---|---|---|---|
| | DHSC group bodies £'000 | Non DHSC group bodies £'000 | DHSC group bodies £'000 | Non DHSC group bodies £'000 |
| By up to three months | 0 | 8 | 47 | 33 |
| By three to six months | 0 | 21 | 48 | 3 |
| By more than six months | 18 | 7 | 18 | 6 |
| **Total** | **18** | **36** | **113** | **42** |

## 11. Cash

| | 2019-20 £'000 | 2018-19 £'000 |
|---|---|---|
| **Balance at 1 April** | 130 | 95 |
| Net change in year | (38) | 35 |
| **Balance at 31 March** | **92** | **130** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 92 | 130 |
| **Cash in statement of financial position** | **92** | **130** |
| | | |
| **Balance at 31 March** | **92** | **130** |

## 12. Trade and Other Payables

| | Current 2019-20 £'000 | Current 2018-19 £'000 |
|---|---|---|
| NHS payables: revenue | 1,060 | 2,848 |
| NHS accruals | 2,127 | 2,414 |
| NHS deferred income | 56 | 0 |
| Non-NHS and other WGA payables: revenue | 2,852 | 9,801 |
| Non-NHS and other WGA accruals | 18,988 | 12,272 |
| Non-NHS and other WGA deferred income | 0 | 24 |
| Social security costs | 67 | 64 |
| Tax | 54 | 51 |
| Other payables and accruals | 1,263 | 920 |
| **Total trade and other payables** | **26,467** | **28,394** |

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

Other payables include £86,830 outstanding pension contributions at 31 March 2020 (31 March 2019: £78,739).

## 13. Provisions

| | Current 2019-20 £'000 | Current 2018-19 £'000 |
|---|---|---|
| Restructuring | 98 | 0 |
| Continuing care | 41 | 22 |
| **Total** | **139** | **22** |

The Clinical Commissioning Group has no non-current provisions.

| | Restructuring £'000 | Continuing Care £'000 | Total £'000 |
|---|---|---|---|
| **Balance at 1 April 2019** | **0** | **22** | **22** |
| Arising during the year | 98 | 41 | **139** |
| Utilised during the year | 0 | (9) | **(9)** |
| Reversed unused | 0 | (13) | **(13)** |
| **Balance at 31 March 2020** | **98** | **41** | **139** |
| **Expected timing of cash flows:** | | | |
| Within one year | 98 | 41 | **139** |
| **Balance at 31 March 2020** | **98** | **41** | **139** |

The Clinical Commissioning Group has made a provision for a restructuring payment in 2019-20. The member of staff was put at risk as a result of a restructure in year however was seconded to another NHS organisation. The restructuring payment has been provided for as it is not yet known whether or not the Clinical Commissioning Group will be required to make this payment.

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.

## 14. Contingent Liabilities

Her Majesty's Revenue & Customs (HMRC) have contacted the Clinical Commissioning Group and a number of other Clinical Commissioning Groups across the region to inform them that they are reviewing the Value Added Tax (VAT) recovered in relation to the services provided by Kier (eMBED Commissioning Support Contract) that was procured under the national Lead Provider Framework arrangement.

NHS England are in discussion with HMRC in relation to this matter.

It is felt necessary to declare a contingent liability in this regard. The value of the contingent liability is estimated to be £766,000.

## 15. Financial Instruments

### 15.1 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. 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 Chief Finance Officer and internal auditors.

#### 15.1.1 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. The Clinical Commissioning Group does not borrow and therefore has low exposure to interest rate fluctuations.

#### 15.1.2 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.

#### 15.1.3 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.

## 15. Financial Instruments (continued)

### 15.2 Financial Assets

| | Financial assets measured at amortised cost 2019-20 £'000 | Total 2019-20 £'000 | Total 2018-19 £'000 |
|---|---|---|---|
| Trade and other receivables with NHSE bodies | 779 | 779 | 1,457 |
| Trade and other receivables with other DHSC group bodi | 257 | 257 | 2,202 |
| Trade and other receivables with external bodies | 334 | 334 | 516 |
| Other financial assets | 0 | 0 | 1 |
| Cash and cash equivalents | 92 | 92 | 130 |
| **Total at 31 March 2020** | **1,462** | **1,462** | **4,306** |

### 15.3 Financial Liabilities

| | Financial liabilities measured at amortised cost 2019-20 £'000 | Total 2019-20 £'000 | Total 2018-19 £'000 |
|---|---|---|---|
| Trade and other payables with NHSE bodies | 814 | **814** | 851 |
| Trade and other payables with other DHSC group bodies | 2,594 | **2,594** | 8,088 |
| Trade and other payables with external bodies | 21,619 | **21,619** | 18,396 |
| Other financial liabilities | 677 | **677** | 920 |
| **Total at 31 March 2020** | **25,704** | **25,704** | **28,255** |

## 16. Operating Segments

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

## 17. 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.

### 17.1 Interests in Joint Operations

| Name of arrangement | Parties to the arrangement | Description of principal activities | Amounts recognised in CCG accounts 2019-20 | | Amounts recognised in CCG accounts 2018-19 | |
|---|---|---|---|---|---|---|
| | | | Income | Expenditure | Income | Expenditure |
| | | | £'000 | £'000 | £'000 | £'000 |
| Better Care Fund - City of York Health and Wellbeing Board | NHS Vale of York CCG<br>City of York Council | Health and Social Care pooled commissioning budget | 0 | 12,124 | 286 | 11,903 |
| Better Care Fund - North Yorkshire Health and Wellbeing Board | NHS Vale of York CCG<br>NHS Airedale, Wharfedale and Craven CCG<br>NHS Scarborough and Ryedale CCG<br>NHS Hambleton, Richmondshire and Whitby CCG<br>NHS Harrogate and Rural District CCG<br>NHS Morecambe Bay CCG<br>North Yorkshire County Council | Health and Social Care pooled commissioning budget | 0 | 7,836 | 0 | 7,442 |
| Better Care Fund - East Riding Health and Wellbeing Board | NHS Vale of York CCG<br>NHS East Riding of Yorkshire CCG<br>East Riding of Yorkshire County Council | Health and Social Care pooled commissioning budget | 0 | 1,364 | 0 | 1,289 |

## 18. Related Party Transactions

**Details of related party transactions in 2019-20 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 | 4,966 | 11 | 2 | 2 |
| Dr Aaron Brown - Governing Body - Local Medical Liaison Officer, Selby and York - RSS Reviewer NHS Scarborough and Ryedale CCG | 255 | 1,321 | 445 | 282 |
| Denise Nightingale - Executive Committee and Governing Body - Executive Director of Transformation and Delivery - seconded from Bassetlaw CCG (to July 2019) | 27 | 0 | 0 | 0 |
| Sharon Stolz - Governing Body attendance - Interim Director of Public Health, City of York Council | 15,815 | 679 | 858 | 32 |
| Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Surgery | 2,679 | 0 | 39 | 0 |
| Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - Shield GP Limited | 4 | 0 | 0 | 1 |
| Business Intelligence Manager at eMBED Health Consortium (Kier Business Sevices Limited) until 18 November 2019 | 1,218 | 0 | 0 | 0 |
| Dr Helena Ebbs - Governing Body GP - GP Partner Pickering Medical Practice | 1,925 | 0 | 4 | 0 |
| Dr Helena Ebbs - Governing Body GP - Director of City and Vale GP Alliance | 535 | 0 | 0 | 0 |
| Dr Ruth Walker - Governing Body GP - GP Partner Scott Road Medical Practice | 1,176 | 0 | 1 | 0 |
| Dr Ruth Walker - Governing Body GP - Shield GP Limited | 4 | 0 | 0 | 1 |
| Dr Christopher Stanley - Governing Body GP - Haxby Group Practice | 4,152 | 2 | 33 | 0 |
| Dr Christopher Stanley - Governing Body GP - Nimbuscare Limited | 3,181 | 0 | 29 | 0 |
| Beech Tree Surgery | 2,679 | 0 | 39 | 0 |
| Dalton Terrace Surgery | 901 | 0 | 0 | 0 |
| East Parade Medical Practice | 281 | 0 | 0 | 0 |
| Terrington Surgery | 347 | 0 | 0 | 0 |
| Helmsley Medical Centre | 504 | 0 | 0 | 0 |
| Millfield Surgery | 1,186 | 0 | 0 | 0 |
| Tollerton Surgery | 921 | 0 | 16 | 0 |
| Stillington Surgery | 906 | 0 | 0 | 0 |
| Elvington Medical Practice | 1,794 | 2 | 0 | 2 |
| Escrick Surgery | 1,419 | 0 | 0 | 0 |
| Front Street Surgery | 974 | 0 | 5 | 0 |
| Haxby Group Practice | 4,152 | 2 | 33 | 0 |
| Jorvik Gillygate Practice | 2,377 | 0 | 1 | 0 |
| Kirkbymoorside Surgery | 904 | 7 | 0 | 0 |
| MyHealth | 2,628 | 2 | 0 | 1 |

| | | | | |
|---|---|---|---|---|
| The Old School Medical Practice | 913 | 1 | 0 | 0 |
| Pickering Medical Practice | 1,925 | 0 | 4 | 0 |
| Posterngate Surgery | 2,578 | 2 | 0 | 0 |
| Priory Medical Group | 7,009 | 6 | 99 | 0 |
| Scott Road Medical Centre | 1,176 | 0 | 1 | 0 |
| Sherburn Group Practice | 1,551 | 1 | 0 | 0 |
| South Milford Surgery | 2,154 | 2 | 0 | 0 |
| Tadcaster Medical Centre | 1,352 | 0 | 0 | 0 |
| Unity Health | 1,749 | 6 | 0 | 0 |
| York Medical Group | 4,966 | 11 | 2 | 2 |
| Pocklington Group Practice | 2,934 | 0 | 0 | 0 |

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

**Details of related party transactions in 2018-19 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 |
| 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 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 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 University Teaching 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.

## 19. 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.

## 20. Financial Performance Targets

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

The Clinical Commissioning Group's performance against those duties was as follows:

| | 2019-20 Target | 2019-20 Performance | 2018-19 Target | 2018-19 Performance |
|---|---|---|---|---|
| Expenditure not to exceed income | 518,386 | 518,385 | 471,225 | 489,865 |
| Capital resource use does not exceed the amount specified in Directions | 19 | 18 | 0 | 0 |
| Revenue resource use does not exceed the amount specified in Directions | 512,624 | 512,623 | 469,329 | 487,969 |
| 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 | 7,825 | 7,405 | 7,603 | 6,992 |

Note that in 2019-20 the target and performance figures for ‘Expenditure not to exceed income’ take account of income received for hosted service arrangements of £3.6m that has been netted off expenditure in the Statement of Comprehensive Net Expenditure.

## 21. Losses and Special Payments

### 21.1 Losses

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

| | Total number of cases 2019-20 Number | Total value of cases 2019-20 £'000 | Total number of cases 2018-19 Number | Total value of cases 2018-19 £'000 |
|---|---|---|---|---|
| Administrative write-offs | 55 | 35 | 22 | 11 |
| Cash losses | 0 | 0 | 1 | 10 |
| **Total** | **55** | **35** | **23** | **21** |

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.

### 21.2 Special Payments

| | Total number of cases 2019-20 Number | Total value of cases 2019-20 £'000 | Total number of cases 2018-19 Number | Total value of cases 2018-19 £'000 |
|---|---|---|---|---|
| Ex-gratia payments | 1 | 2 | 0 | 0 |
| **Total** | **1** | **2** | **0** | **0** |

The ex-gratia payment relates to a payment made to a patient's family in respect of a complaint.