NHS
Vale of York
Clinical Commissioning Group

Annual Report

2020-21

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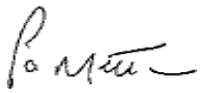


Phil Mettam

Accountable Officer

10th June 2021

Foreword

By Dr Nigel Wells, Clinical Chair

I can only begin this foreword by thanking every member of staff in our local health and care system for their hard work, expertise and dedication in fighting what has been an invisible enemy - COVID-19.

Just as the rest of the country, the virus hit the Vale of York hard, yet throughout the pandemic our health and care staff; whilst under intense pressure, responded boldly, with empathy and poise in the most difficult time the NHS has ever seen in its history. I congratulate and thank each and every one of them for their amazing work to treat and care for local patients.

December 2020 saw the rollout of the COVID-19 vaccine programme. Once again, our local health and care system stepped up and delivered much needed doses of the vaccine to patients, with the oldest and most vulnerable first in line. I am so proud of the hard work of the vaccinators, the leadership that enabled this huge task and every single member of our NHS and local voluntary and community sector that has made this vaccination rollout the great success that it is.

The pandemic has been a huge focus for the NHS across the country, but I am very pleased to report that our transformative work to improve better outcomes for our patients has continued throughout 2020-21. There continues to be a massive pressure on our primary care services, yet our Primary Care Networks have grown stronger, as to have our relationships with our partners.

The long-standing local money issues that have hung over the local area for more than a decade have been brought to balance in the last year and clinical sharing, learning and improvement still continues.

The next 18 months will deliver further transformative change where the NHS and local councils will work even closer to deliver shared goals to benefit the people that live locally and in the wider Humber, Coast and Vale Health and Care Partnership area. I look positively to the future and commit to putting the voices of our patients and service users at the centre of everything that we do to bring about change to meet their needs.

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

Accountable Officer's overview

The last year has been unlike any other that we have experienced.

I am immensely proud of the significant contribution that our CCG played in supporting our clinicians and all other professions in their care for the 360,000 people that live in the Vale of York.

Some examples of our work that stand out for me include our engagement with patients, the public and the clinical workforce, and the work to support those in our local community with complex health and care needs.

Important work to improve quality and safety continues at pace as does work to manage the local population's health through physical and mental health prevention and wellbeing strategies, and the reduction in health inequalities. There are many more examples of our progress, and you can read about these on pages 7 to 60 of this report.

I would like to place on record my thanks to all our CCG staff, our Governing Body, GP Council of Representatives, and all our partners for the important contribution that they made. It required professional and personal resilience, innovative thinking, energetic collaboration, a flexible and adaptable approach. Our team will have grown and learned professionally from this experience and I hope that this helps them to make an even stronger contribution throughout the rest of their career.

However, many of our team are understandably fatigued by the unprecedented demands placed on our CCG during the last year. The Governing Body and I will do what we can to support and develop our staff as they face a further period of NHS transition.

It was a year like no other, we should stand back, reflect, and be proud of the part that we played in delivering our statutory duties whilst supporting providers and other partners during the pandemic.

Phil Mettam

Accountable Officer

Performance overview

1. Performance summary 2020-21

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 365,000 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 eight primary care networks with list sizes of between 30,000 and 150,000 patients. Further details of the organisational structure are provided in the Members Report on page 62.

1.1.2 Overview of the CCG's assurance and performance work

Overall accountability for the delivery of NHS Constitution performance targets sits with the CCG Accountable Officer. The CCG's focus on performance and assurance is led by the Assistant Director of Performance and Delivery working with each Executive Director and their commissioning teams, alongside performance and Business Intelligence leads across the CCG and its provider organisations.

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 improvement being incorporated into their oversight and delivery programmes.

The work of the CCG to drive high performance in services delivered for local people is co-ordinated alongside the CCG's quality and safety work, and there is joint oversight of issues, mitigations, risk assessment and reporting across performance and quality with the Deputy Chief Nurse.

The CCG and partner's work to improve performance is overseen by the Finance and Performance Committee, a subcommittee of the Governing Body. The committee's objective is to ensure that commissioned services are accessible, and delivered effectively in line with national guidelines and waiting time targets in order for patients to have the best possible health outcomes. It also focuses on continuous performance improvement in line with the NHS Constitution (2011) and the CCG's Integrated Assurance Framework (2019-20) and emerging single NHS Oversight Framework (2020-21). Full roll-out on the latter has been delayed due to COVID-19.

The Finance and Performance Committee's membership includes eight Governing Body members – all three Lay Members of the Governing Body (one as Chair), the CCG

Accountable officer, the Chief Finance Officer, the Executive Director of Mental Health and Complex Care, 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 identifies and seeks assurance on key components to support performance improvement and planning to support further improvements. These include:

- Performance in Primary Care services.
- Performance in Acute Care services (elective, diagnostics, cancer and urgent-emergency care).
- Performance in Mental health, learning disability and autism services.
- Performance in Complex healthcare services.
- Performance against the NHS England CCG Integrated Assurance Framework standards.
- Planning as required for the CCG in response to national planning guidance and seasonal and service specific planning including winter planning.

The committee has always met monthly and receives both the validated performance position as reported for both CCG and provider partner organisations, alongside a verbal update of the latest performance position and mitigations.

Following the emergence of the COVID-19 pandemic, this approach has supported the committee in being able to focus on the immediate impact of the COVID-19 response on access and delivery of local services, as well as the consequences for this on health needs and quality and safety of services and patients.

In this way the committee is more closely linked than ever to the quality and patient experience committee and primary care commissioning committee in having single oversight of population health, health inequalities and the quality and safety of the CCG's commissioned services, and the work the CCG was undertaking working with partners during the COVID-19 to ensure patient safety, understand the emerging risks within the system and how these are being mitigated against.

The CCG's Governing Body developed and monitored a COVID-19 specific Board Assurance Framework which incorporated performance risks in order to ensure risks were captured and that the appropriate mitigation was in place as far as possible during these unprecedented times.

1.1.3 Monitoring performance intelligence and improvement during the COVID-19 pandemic

All service delivery is reviewed in relation to performance in line with the NHS Constitution and the NHS England CCG Integrated Assurance Framework.

The CCG works closely with all provider partners, other commissioning partners, the NHS England and NHS Improvement locality team and the Humber, Coast and Vale Integrated Care

System's (HCVICS) Executive to act on local intelligence and any NHS England and NHS Improvement escalations to provide assurance around the mitigating actions being delivered, and the impact on the outcomes for local people.

The emergence of the COVID-19 pandemic has resulted in a rapid shift to all partners needing to understand daily the impact of:

1. the response to COVID-19 by provider services on the local population, and
2. the subsequent mitigations to restore and recover non-COVID 19 services while continuing to manage an on-going pandemic into 2021-2022.

The committee therefore continued to monitor the formal validated performance against all NHS Constitutional targets, but focused monthly on the specific and iterative recovery and mitigating actions undertaken by all partners locally and across the ICS to deliver accessible and safe care and manage risks.

All CCG commissioned services have delivered a rapid, collaborative and patient-focused response to the delivery of COVID-19 care and the restoration of non COVID-19 care during unprecedented times and alongside a mass vaccination programme mobilised over the winter period. The effective escalation and co-ordination of surge plans by all provider partners across the local and HCV ICS has created resilience in delivery which has kept patients safe and with continuing care wherever this has been possible during the pandemic.

During the pandemic some services and pathways of care had to be stood down or adapted in line with national guidance for delivery of infection control compliant care and to create capacity for delivering COVID-19 care.

However, there has been a constant drive to safety-net patients who have had non COVID-19 care delayed and to continue to clinically review them. This has included supporting primary care with rapid and early clinical advice and guidance and clinically validating waiting lists to support prioritising those patients who needed their care most urgently.

Additionally, local independent sector and third sector partners have worked as part of the local health and care system to provide additional capacity for a range of different services and support alongside NHS and care sector partners.

Waiting lists and backlogs have grown in some services as an inevitable consequence of the COVID-19 response. The length of time which different cohorts of patients are waiting across all the clinical prioritisation levels in these waiting lists being the most critical issue to mitigate and avoid deterioration and potential clinical harm.

As such a key focus for the CCG and the committee has been on the size and composition of all waiting lists across all care areas. This has included monitoring referrals from GPs as a proxy of patient access and need throughout the COVID-19 pandemic and recognising the need to better understand the impact of waiting on health outcomes and inequalities supported by public health leads and intelligence locally, across the ICS and nationally.

1.1.4 Performance improvement driven by a population health approach

Public health colleagues in the CCG have focused on collating all intelligence and insight from deep dive and engagement work with patients to understand the need and experiences of local people living and waiting for care in a COVID-19 era.

This intelligence has provided all partners with a greater understanding of population health, health inequalities and need which has shaped the recovery work and will continue to help shape future collective improvement work over future years.

The collective understanding of why local people have not accessed support and care, and their experience and needs while waiting, are a fundamental part of all recovery and improvement planning which will drive performance improvement.

The ability of local people and patients to access and effectively use digital tools to access, receive and monitor care is a specific area of focus and all partners are working with local patients, carers and advocates to help develop digitally inclusive recovery plans.

The importance of understanding individual patients' needs through direct contact has never been more critical to planning how to improve performance, quality and safety, patient experience and in turn impact on health outcomes and avoid further exacerbation of health inequalities.

1.1.5 Performance Summary 2020-21

Current summary of performance March 2020 to December 2021 (validated performance position).

		Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
A&E	% of attendances where patient was discharged, admitted or transferred within 4 hours of arrival	≥95%	93.6%	92.9%	94.2%	92.2%	86.7%	82.3%	80.8%	83.5%	77.6%	76.2%	79.3%	80.6%
Diagnostics	% of patients waiting over 6 weeks for a Diagnostic test	≤1%	78.1%	75.5%	66.0%	54.2%	52.5%	47.3%	40.4%	35.6%	38.8%	45.0%	38.1%	35.9%
RTT	% of patients on incomplete pathways waiting no more than 18 weeks from referral	≥92%	61.2%	52.4%	45.2%	44.3%	54.2%	61.1%	66.4%	68.5%	67.9%	65.6%	63.5%	64.8%
	Total number of patients on incomplete pathways	-	15,137	15,089	14,941	15,183	15,892	16,504	17,298	17,117	17,500	17,184	17,238	17,960
Cancer	% seen within 14 days of urgent referral - all cancer types	≥93%	89.6%	97.3%	97.3%	94.2%	93.4%	90.4%	93.7%	93.2%	94.1%	89.5%	91.4%	90.6%
	% seen within 14 days of urgent referral - breast symptoms	≥93%	87.5%	100.0%	93.4%	97.2%	94.0%	92.9%	86.6%	90.1%	93.1%	81.9%	96.1%	92.4%
	% of patients receiving first definitive treatment within 31 days of	≥96%	99.4%	98.4%	98.4%	95.3%	96.8%	97.0%	97.5%	97.3%	95.9%	93.9%	97.5%	95.8%
	% of patients receiving second or subsequent treatment within 31 days	≥94%	78.9%	92.3%	76.7%	84.8%	84.4%	90.9%	85.2%	89.7%	92.9%	93.1%	95.5%	76.5%
	% of patients receiving second or subsequent treatment within 31 days	≥98%	100.0%	100.0%	100.0%	100.0%	98.2%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% of patients receiving second or subsequent treatment within 31 days	≥94%	100.0%	100.0%	96.2%	100.0%	93.3%	94.1%	100.0%	100.0%	98.0%	100.0%	97.9%	100.0%
	% of patients receiving first definitive treatment within 62 days of urgent	≥85%	80.2%	76.9%	82.1%	82.0%	81.4%	73.1%	63.6%	71.4%	75.5%	70.3%	68.6%	68.9%
	% of patients receiving first definitive treatment within 62 days of referral from an NHS cancer screening	≥90%	83.3%	25.0%	0.0%	0.0%	-	33.3%	90.0%	90.9%	75.0%	78.6%	90.0%	85.7%
IAPT	Improving Access to Psychological Therapies - Access Rate (3 month rolling basis)		3.7%	3.1%	3.0%	3.0%	3.4%	3.8%	4.1%	4.4%	4.4%	4.7%	4.7%	-
	Improving Access to Psychological Therapies - Recovery Rate (3 month rolling basis)	50%	50.7%	47.9%	48.9%	48.9%	49.6%	48.1%	48.2%	52.3%	54.2%	56.3%	54.8%	-
EIP	Early Intervention in Psychosis - % seen within 2 weeks (3 month rolling basis)	60% 2020/21	89.0%	85.0%	90.0%	-	85.0%	82.0%	79.0%	76.0%	72.0%	62.0%	63.0%	-

Table 1 - Local performance position for key NHS Constitution indicators

1.1.6 Performance Improvement moving forward

During 2020-21 and the COVID-19 pandemic the move to a single NHS Oversight Framework and the outcomes of the on-going review of some of the Clinical Standards commenced in Autumn 2019 were both paused.

NHS England and NHS Improvement locality teams embedded alongside the HCV ICS linking to the North East and Yorkshire region.

A new single NHS Oversight Framework has been released for consultation through to May 2021. The 2021-22 national planning guidance and new standard contract now incorporates all the performance standards and targets relevant for commissioners and providers for the first six months of 2021-22 (termed 'H1') to plan their recovery and improvement plans and associated trajectories against.

The transition to the new nationally mandated Integrated Care Systems means that performance improvement and assurance will continue locally for the CCG until 31 March 2022 but will be within an overarching single oversight and assurance framework (SOAF) for the HCV ICS.

The CCG as a partner will contribute towards the new North Yorkshire and York Geographical Partnership bi-monthly assurance reporting to the HCV ICS as well as a bi-annual 'place-based' assurance reporting framework which will commence in July 2021.

1.2 Financial performance overview 2020-21

1.2.1 An overview of 2020-21

Throughout 2020-21 the CCG has been operating under an interim financial framework put in place by NHS England and NHS Improvement in response to the COVID-19 pandemic. This was implemented in two different and distinct phases as follows:

- **H1 - April – September** – in the first half of the financial year, all NHS organisations were provided with funding equal to their expenditure, resulting in a break-even position. For CCGs, the required funding to cover COVID costs was provided together with a retrospective "top-up" allocation to break-even adjustment following an assurance process undertaken by NHS England and based on monthly expenditure returns.
- **H2 - October – March** – in the second half of the financial year, Integrated Care Systems were provided with a set financial envelope and were required to manage expenditure within this envelope including an allocation for COVID-19 related costs. Some specific areas of expenditure were deemed 'outside of envelope' and continued to be funded in full on top of the system envelope. The CCG was part of the North Yorkshire and York system financial envelope that included both CCGs and the two main acute hospital providers in this geography.

Throughout the financial year, several key changes were implemented which affected the CCG's expenditure on commissioned services, and these amendments were reflected in adjusted allocations.

- All NHS contracts were replaced by block payments, calculated centrally and based on 2019-20 values with an adjustment for growth. Charges to commissioners for non-contracted NHS activity were suspended.
- National contracts were put in place for many Independent Sector providers, with payment being made by NHS England and NHS Improvement rather than by CCGs.

The CCG has delivered a break-even position across the 2020-21 financial year.

For the second half of the financial year, funding envelopes were split into a baseline allocation linked to individual organisations, and an overall envelope to fund growth and COVID-19 related costs across the North Yorkshire and York system. Across the system all organisations were able to submit a break-even plan and subsequently deliver a break-even position at year end. This has provided further opportunity to strengthen our work and collaboration as a system.

Throughout the financial year, the CCG has continued to provide regular financial reporting and updates on the changing financial framework to the Finance and Performance Committee, Audit Committee, and at the public meeting of the Governing Body. In addition, regular reporting has been provided to NHS England and NHS Improvement in its role as the CCG's regulatory body, with a particular focus on costs related to the response to the COVID-19 pandemic. The CCG finance team has built on its sound financial management arrangements to ensure appropriate governance arrangements have been established to allow accurate reporting and prompt payment to providers.

The legal directions placed on the CCG by NHS England and NHS Improvement in regard to its deficit financial position were removed in December 2020. Key developments supporting the removal of directions were improved financial planning and delivery in 2019-20 and 2020-21, compliance with the requirements of the directions, and leadership and governance developments taken by the CCG.

The interim financial framework put in place by NHS England and NHS Improvement for 2020-21 meant that the Quality, Innovation, Productivity and Prevention (QIPP) schemes identified in the CCG's draft plan were largely suspended. These QIPP schemes were an integral part of addressing the CCG's underlying deficit and delivering the longer-term financial recovery trajectory. As such the like for like underlying deficit at the end of 2020-21 is £27.6m. This assessment is made on the CCG's current understanding of the recurrent resource limit. At the end of 2020-21 the underlying deficit was £24.5m.

The CCG has measured delivery of QIPP savings relating to Continuing Healthcare and Running Costs, where delivery has continued through normal operational efficiencies. Savings of £1.1m in Continuing Healthcare mean that this area of spend has fully delivered its planned QIPP savings identified in the CCG's draft financial plan. In addition, savings of £844k have been delivered within Running Costs budgets, against planned savings of £251k.

Throughout the 2020-21 financial year and the COVID-19 pandemic, the CCG has ensured that a robust system of financial control remained in place. Temporary amendments were made to the Scheme of Delegation in April 2020 to allow the CCG to flexibly respond to the evolving requirements of the pandemic response, without compromising formal assurance processes. Financial reporting was swiftly amended and expanded on for areas of expenditure that were new or saw a substantial change as a result of the pandemic. In addition, the CCG's internal audit function undertook a retrospective review of COVID-19 related expenditure in General Practice.

A key aspect of the COVID-19 pandemic response financial arrangements has been with regards to the Hospital Discharge Programme (HDP). The HDP was brought in to facilitate rapid and timely discharge from acute hospital providers to maximise available capacity for patients with COVID-19 and was funded outside of the system financial envelope. Working closely with York Teaching Hospital NHS Foundation Trust and City of York Council in particular, a discharge command centre was established with relevant staff and a number of schemes were put in place to avoid hospital admission or to facilitate rapid discharge. Funding was also provided for the first six weeks of all packages of care. In conjunction with City of York Council's finance team, the CCG has had to establish new financial management arrangements across health and social care and a revised Section 75 arrangement to cover over £10m of expenditure. It is testament to the close working relationships from both an operational and financial perspective that this has been done robustly, effectively and in line with the national requirements.

The CCG's internal audit function has carried out annual audits covering budgetary control and forecasting and for the third year in a row 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.

1.3 Financial Performance in 2020-21

1.3.1 Preparation of the Annual Accounts

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

1.3.2 Accounting policies

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

Additional detail in relation to provisions, critical judgements and sources of estimation of uncertainty has been added. These occur when management has made specific decisions in

applying the CCG's accounting policies and where these have had the most significant effect on the amounts recognised in the financial statements.

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

1.3.3 Financing transactions

There have been no financing transactions undertaken by the CCG.

1.3.4 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 2020-21.

1.3.5 Summary of expenditure

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

1.3.5.1 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.

However, for 2020-21 the in-year programme allocation was adjusted throughout the year in line with the interim financial arrangements. Programme allocation was adjusted to match actual costs for April to September, and was based on the system envelope approach for October to March. Additional allocation was received between October to March for expenditure deemed 'outside of envelope', the majority of this relating to the HDP.

The CCG's in-year allocation for programme costs was £533.3m in 2020-21 and total expenditure against this allocation was £533.6m. When combined with a £332k underspend on running costs, this resulted in a break-even financial position.

The graphs below show how the CCGs programme and running cost spend in 2020-21 was split across key areas, and also provides a comparison against spend in 2019-20.

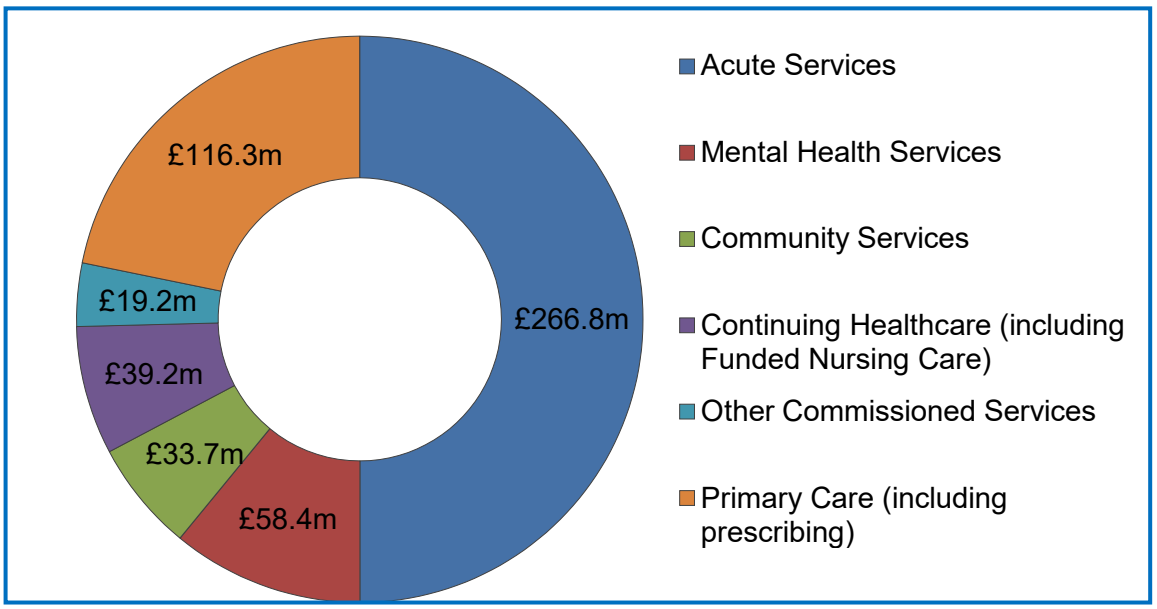


Fig 1 - An analysis of 2020-21 programme expenditure

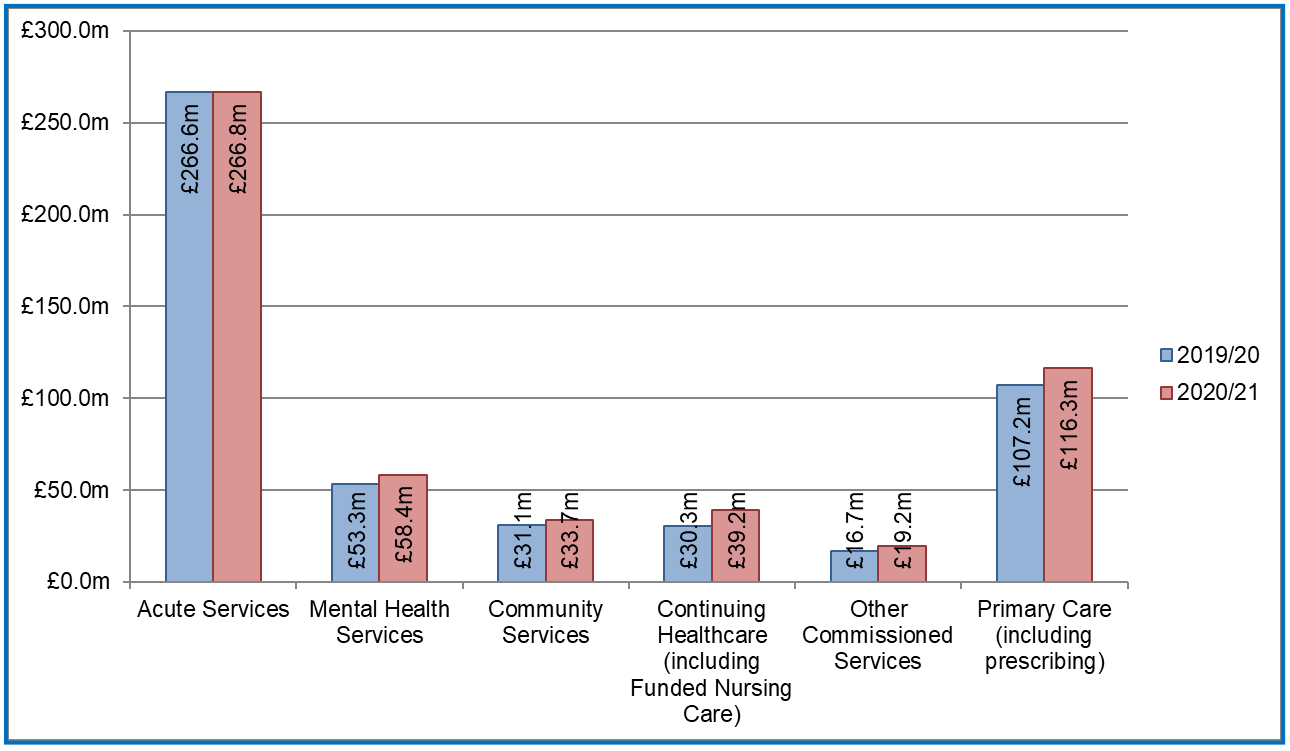


Fig 2 - An analysis of 2019-20 and 2020-21 programme expenditure

1.3.5.2 Running costs

Running cost allocations saw a planned 20% reduction from 2020-21 onwards. This funding was used to pay for non-clinical management and administrative support, including commissioning support services.

The CCG's allocation for running costs was £6.7m in 2020-21 and total expenditure against this allocation was £6.3m. An under-spend of £332k was achieved, and when taken together with the programme cost position equals the CCG's overall break-even financial position.

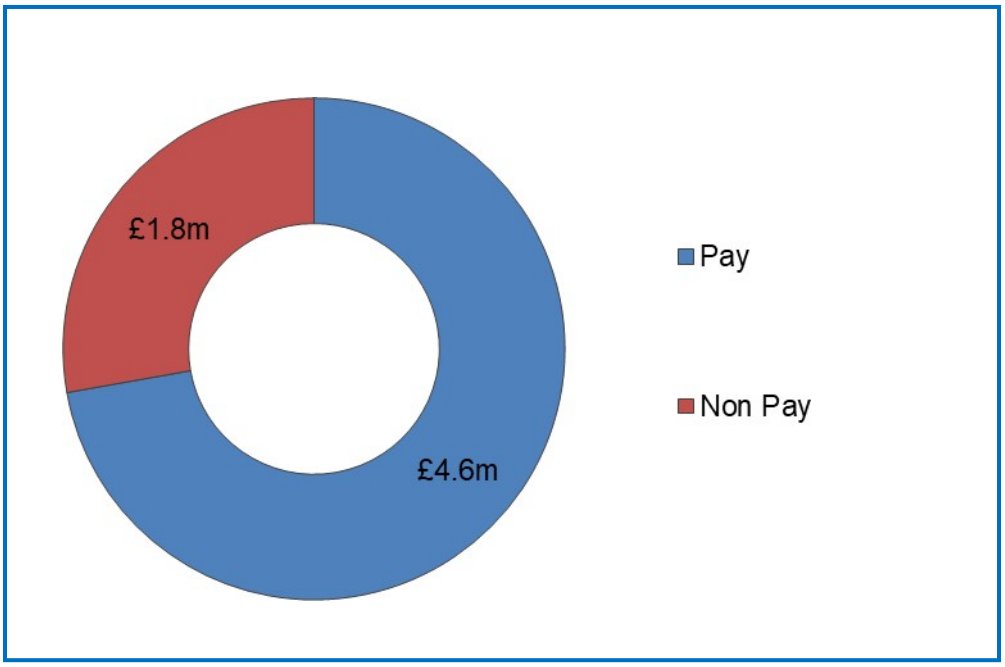


Fig 3 - An analysis of 2020-21 running costs expenditure

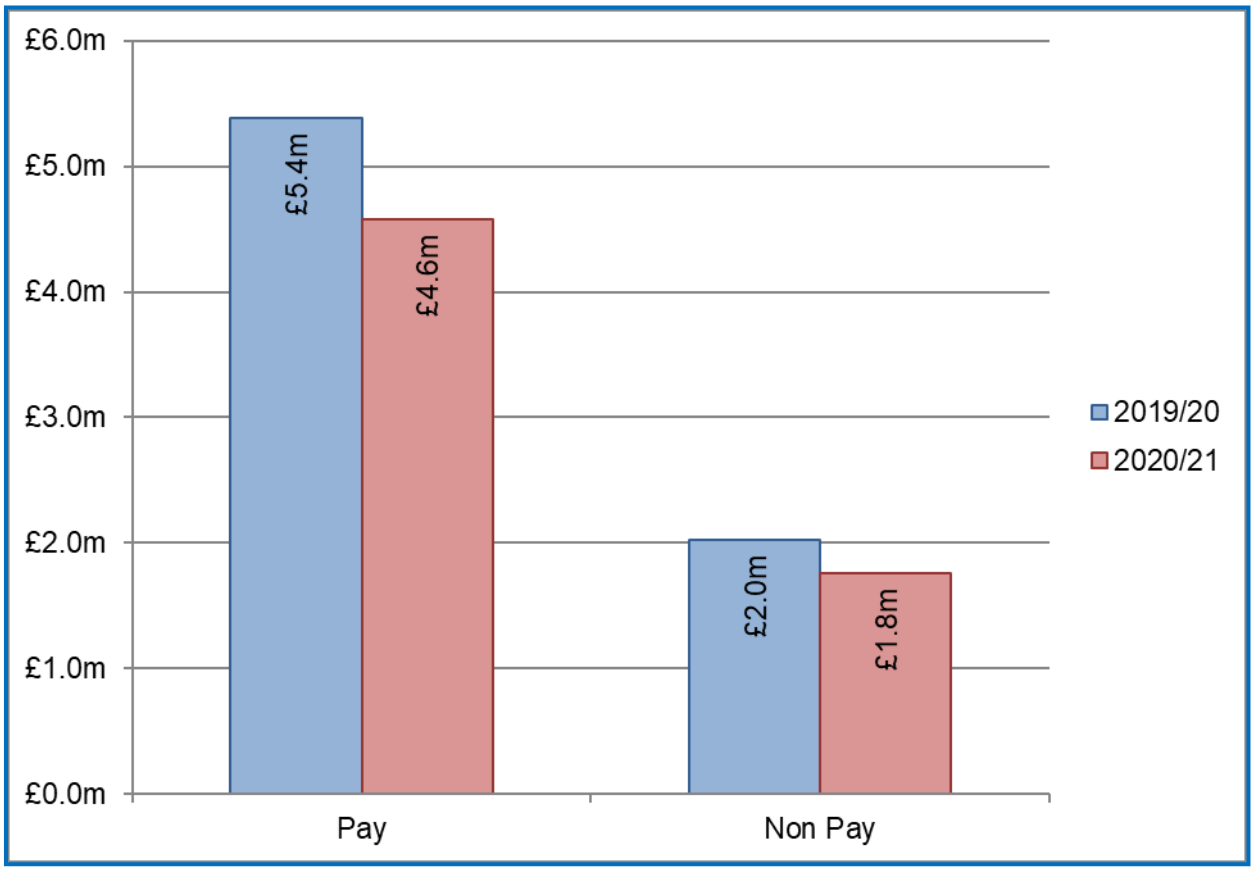


Fig 4 - An analysis of 2019-20 and 2020-21 running costs expenditure

1.3.5.3 Underlying recurrent position

Excluding the effect of all non-recurrent income and expenditure in the 2020-21 position, the CCG has an underlying recurrent deficit of £27.6m as it moves into 2020-21. The CCG's underlying position at the end of 2019-20 was £24.5m.

1.3.5.4 Quality, Innovation, Productivity and Prevention

The interim financial framework put in place by NHSE/I for 2020-21 meant that the Quality, Innovation, Productivity and Prevention (QIPP) schemes identified in the CCG's draft plan were largely suspended.

However, the CCG has measured delivery of QIPP savings relating to Continuing Healthcare and Running Costs, where delivery has continued through normal operational efficiencies. Savings of £1.1m in Continuing Healthcare mean that this area of spend has fully delivered its planned QIPP savings identified in the CCG's draft financial plan. In addition, savings of £844k have been delivered within Running Costs budgets, against planned savings of £251k.

1.3.5.5 Statement of Going Concern

As agreed with the CCG's Audit Committee, the CCG's annual accounts have been prepared on a going concern basis.

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

1.3.5.6 Data quality

In 2020-21 the CCG received elements of its business intelligence service from NHS North of England Commissioning Support. There were no concerns regarding the quality of data supplied by them during the year.

1.3.5.7 Better Payment Practice Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements and are summarised in the tables below for 2020-21.

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-20	859	842	98.02	12,112,645	12,003,817	99.10
May-20	824	785	95.27	12,622,836	12,509,758	99.10
Jun-20	1,049	1,005	95.81	10,692,686	10,500,151	98.20
Jul-20	858	843	98.25	8,524,518	8,515,122	99.89
Aug-20	797	785	98.49	9,784,526	9,715,433	99.29
Sep-20	863	835	96.76	11,679,545	10,937,790	93.65
Oct-20	1,021	1,011	99.02	8,993,191	8,933,968	99.34
Nov-20	876	864	98.63	10,565,864	9,894,951	93.65
Dec-20	725	711	98.07	10,334,898	10,264,974	99.32
Jan-21	819	783	95.60	12,165,568	11,704,280	96.21
Feb-21	886	857	96.73	12,058,207	11,944,850	99.06
Mar-21	906	879	97.02	10,277,917	10,205,710	99.30
Totals	**10,483**	**10,200**	**97.30**	**129,812,402**	**127,130,805**	**97.93**

Table 2 - Payment of Non-NHS invoices in 2020-21

NHS invoices						
Month	Total invoices paid	Invoices paid on time	% Paid within target	Total value paid (£)	Value paid on time (£)	% Paid within target
Apr-20	310	306	98.71	57,800,985	57,784,720	99.97
May-20	191	187	97.91	28,596,066	28,575,450	99.93
Jun-20	150	145	96.67	28,634,805	28,593,609	99.86
Jul-20	78	75	96.15	29,083,210	29,067,716	99.95
Aug-20	42	40	95.24	29,000,663	28,910,559	99.69
Sep-20	79	77	97.47	28,760,208	28,754,892	99.98
Oct-20	51	50	98.04	29,129,426	29,122,486	99.98
Nov-20	35	34	97.14	29,813,875	29,813,791	100.00
Dec-20	24	24	100.00	28,802,515	28,802,515	100.00
Jan-21	32	31	96.88	28,899,722	28,894,363	99.98
Feb-21	42	42	100.00	29,726,740	29,726,740	100.00
Mar-21	57	51	89.47	3,037,525	2,956,357	97.33
	1,091	**1,062**	**97.34**	**351,285,741**	**351,003,199**	**99.92**

Table 3 - Payment of NHS invoices in 2020-21

1.4 Sustainable Development

1.4.1 Our goals

In October 2020, the NHS published its sustainability goals in “Delivering a ‘Net Zero’ National Health Service”. The aspirations are:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

1.4.2 Our areas of focus

These are ambitious targets, and will require re-examining every aspect of service delivery, but the initial areas of national focus are:

1. Our care: By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.
2. Our medicines and supply chain: By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.
3. Our transport and travel: By working towards road-testing for what would be the world’s first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4. Our innovation: By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.
5. Our hospitals: By supporting the construction of 40 new ‘net zero hospitals’ as part of the government’s Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6. Our heating and lighting: By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7. Our adaptation efforts: By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months
8. Our values and our governance: By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme For a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

The CCG works with its providers and suppliers to ensure that sustainability targets are incorporated into contracts and monitored. The CCG is a signatory to local sustainability initiatives including One Planet York.

During the last year, during the COVID-19 pandemic, the majority of CCG staff worked from home, and the CCG's shared office space has been little used. We are therefore not reporting on carbon emissions from the CCG's premises for the current financial year as these do not accurately reflect normal usage. Longer-term, there is likely to be an increase in home working and therefore lower rates of travel to work, and office occupancy.

Primary care facilities have seen an increase in digital care as opposed to face-to-face meetings, with an associated decrease in travel to primary care premises.

1.5 Improving quality and safety

1.5.1 An overview of the CCG's work to improve quality and safety

The CCG's focus on quality and safety is led by the Quality and Nursing Team. The CCG actively seeks patient feedback on health services and engages with the population with the aim of using patient experience to improve 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 sub-committee 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 Quality and Nursing (Chief Nurse) and the Interim Executive Director of Primary Care and Population Health. The committee's report, which is discussed at the Governing Body meeting, describes how the CCG identifies and seeks 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 independent care providers;
- Mental health;
- Cancer;
- Children and young people;
- End of life care;
- Medicines management.

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 and work with system partners. Following the emergence of the COVID-19 pandemic, the committee focussed primarily upon the impact upon quality and safety of the CCG's commissioned services and work the CCG was undertaking working with partners to ensure patient safety, understand the emerging risks within the system and how these are being mitigated against.

The CCG's Governing Body developed and monitored a COVID-19 specific Board Assurance Framework in order to ensure risks were captured and appropriate mitigation was in place as far as possible during these unprecedented times.

1.5.2 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 their level of surveillance.

As part of the CCG's quality, risk and assurance monitoring the CCG uses a suite of documentation and intelligence in its decision making. This includes a Quality Impact Assessment for any changes to services which includes Patient and Public Participation Assessment and an Equality Impact Assessment.

The CCG acts on local intelligence and provides swift, effective support.

During 2020 a Patient Safety Group was established, chaired by NHS England and NHS Improvement to support York Teaching Hospitals NHS Foundation Trust to achieve improvements and gain assurance relating to safety following their CQC inspection. System partners engaged with the Patient Safety Group included both commissioners across the Vale of York and North Yorkshire, York Teaching Hospital NHS Foundation Trust, the Care Quality Commission, NHS England and NHS Improvement. As an output from this work the CCG's Patient Safety Specialist has collaborated with the York Teaching Hospital NHS Foundation Trust Governance and Patient Safety Team's to play an active role in the Serious Incident process and redesign.

The Quality Board was subsequently stood down in autumn 2020 following removal of the CQC regulatory action notices and has now returned to the former Quality and Safety sub-contract committee which will evolve as changes across the system develop to continue support improvements and assurance monitoring.

Primary care services have remained open for business during the pandemic with an increase in non-face to face appointments, giving general practice the opportunity to transform the future delivery of services. Face to face consultations have continued where necessary in an environment that complied with the required infection control standards for COVID-19.

Our commissioned services in primary care have delivered a high-quality active response to the delivery of COVID-19 vaccinations.

Our acute commissioned services have been required to focus on treating those with COVID-19 infections that needed an admission to hospital, and as such, some routine services have been stood down. This has led to an increase in the number of people waiting for elective routine appointments and procedures. The CCG has and continues to work with partners to ensure all waiting lists are reviewed and assessed against the clinical risk to the patient. The CCG also continues to work with system partners to ensure the elective recovery programme reduces waiting lists and finds ways to transform the way services are delivered in the future.

1.5.3 Mental health services

Mental health services continued to work throughout the pandemic, developing risk assessment and review systems to ensure that clinical risk was appropriately identified.

1.5.3.1 Children's mental health services

For children's services, most appointments have been conducted virtually, with only critical, high-risk patients being seen in clinic. Autism assessments have continued. Overall waiting lists for children's services have not risen significantly and the CCG is working with Tees, Esk and Wear Valleys NHS Foundation Trust and its wider system partners at approaches for future service delivery.

1.5.3.2 Adult mental health services

Whilst adapting to working differently and continuing to maintain quality and safety, the majority of services have continued to be delivered. Positive relationships have enabled the continuation of partnership working at commissioner, provider, local authority and voluntary sector levels.

1.5.3.3 Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT) service has responded to COVID-19 with a move to telephone or video conferencing for assessments and treatments. Waiting times for assessment are 1-2 weeks with people waiting for an assessment having been offered self-help and self-managed support through Silver Cloud. Capacity to treat however is impacted by staff absence due to COVID-19 and a reduction in CBT appointments, resulting in long waits for step 3 treatment. The CCG is working with the provider to address this.

The IAPT service is linked to the Long COVID-19 pathways and is accepting referrals and the IAPT Long-Term Condition pathway, pilot in the Selby area and integrated into respiratory rehabilitation physical care provision.

1.5.3.4 Crisis service

The 24-7 all age crisis line has been provided by Tees, Esk and Wear Valleys NHS Foundation Trust since the start of the pandemic and has been expanded to include a crisis response practitioner to determine and assess risk at the point of contact. The aim of the service is to reduce the likelihood of self-harm, potential Section 136 presentations and attendance to A&E. Community-based crisis alternatives have continued to provide support throughout the pandemic including at the York Safe Haven and York St. John Converge. Funding was also secured to expand the Mental Health First Aid Service in the Selby area to provide an additional practitioner and day time cover at weekends.

The Community Transformation Programme has continued at pace including the successful pilot of joint multi-disciplinary teams with primary care that has been rolled out across the Vale of York area.

1.5.3.5 Community Transformation Programme

The programme has continued at pace including the successful pilot of joint multi-disciplinary teams with primary care that has been rolled out across the Vale of York area.

1.5.6.1 Northern Quarter Project across the City of York
The project is progressing with a renewed vigour with the help of a successful bid for Community Mental Health Transformation funding which will not only bring investment into the work force but will strengthen multi agency partnership working across the City and the Vale of York.
There will be an emphasis on co- producing services with the people who use and need them. Some pump priming funding has enabled the recruitment of posts to support this work.
1.5.6.2 Selby transformation
A strong Mental Health Partnership is developing in Selby with the bringing together of specialist health service, primary care and the voluntary sector to think about how the whole system can better support people with emotional health and mental health needs.
Tees, Esk and Wear Valleys NHS Foundation will be employing Primary Mental Health Workers in partnership with Primary Care Networks to work within primary care and provide a direct service to people who need them. These roles will also provide a bridge between Primary care and specialist mental health services.
As part of the national plan the aim is for every PCN to have one Primary Mental Health worker in the first year growing to three over the next three years.

1.5.3.6 Adult Autism and ADHD

The CCG has secured funding for a waiting list initiative aimed at reducing long waiting times for adult autism and ADHD assessments.

1.5.3.7 Dementia

There has been a drop nationally in dementia diagnosis rates due to COVID-19 and social distancing which has changed the way that people are presenting for assessment, diagnosis and support. Remote consultations are being offered either by video or telephone however most people are opting to put assessments on-hold or to have home visits.

Plans to support recovery include successful bids for winter funding to commission an additional Dementia Co-ordinator post in York also an admission avoidance service working with City of York Council and third sector partners on a pathway to recovery scheme that aimed for admission avoidance and supportive discharge from hospital.

1.5.3.8 Resilience Hub

The CCG is the lead commissioner for the Resilience Hub on behalf of the Humber, Coast and Vale Integrated Care System. The Hub is provided by three provider partners with Tees, Esk and Wear Valleys NHS Foundation Trust as the lead provider.

1.5.3.9 Adult Eating Disorders

The CCG has commissioned Tees, Esk and Wear Valleys NHS Foundation Trust to deliver an interim solution to increase capacity within the Specialist Community Eating Disorder Service. This offers physical health checks to patients identified as high risk and / or unable to reliably adhere to physical health monitoring in primary care. Where patients were identified as high risk or unable to engage with primary care, the service regularly reviews and prioritises contact with patients assessed as highest risk and ensures that all patients are contacted. This has been particularly important during the lockdown period.

1.5.3.10 Continuing Healthcare and Section 117 Case Management

Prior to the pandemic the CCG was repeatedly delivering on the national performance expectations for Continuing Healthcare. National guidance was to cease undertaking eligibility assessments between March and September 2020. In line with other CCGs this resulted in a significant backlog of deferred assessments which were required to be completed by 31st March 2021. The CCG has achieved fully addressing this backlog.

Individuals in receipt of Continuing Healthcare have complex health and care needs and the CCG team have actively contacted people during COVID19 to ensure their health needs are stable, their package of care is meeting their needs, and to reach out to support these individuals. We have aided patients or their representatives who are employers of Personal assistants to signpost them to advice and guidance during the pandemic.

The vulnerable people's team have continued to support acute mental health discharges, undertake quality visits to patients out of area and support on-going virtual and face to face reviews.

1.5.3.9 Continuing Healthcare and the national Hospital Discharge Service: Policy and Operating Model

The CCG and Continuing Healthcare team had been actively involved with system partners in improving the timeliness of hospital discharge which the programme delivery during COVID-19 accelerated significantly
A new process for discharging patients from acute hospital beds has been implemented. Patients who may not return to their previous residence or who may require support to do so are now discharged to a safe care setting where rehabilitation or a period of recuperation and assessment of long-term care needs takes place.

A single discharge team comprised of social workers and nurses has been created and are co-located, which Continuing Healthcare are a part of this team and have provided input over a seven day period during the pandemic. This resulted in improved hospital flow and significant reduction in delayed discharges.

An enhanced community equipment service was available to rapidly provide suitable equipment seven days a week to help meet people needs at home and facilitate rapid discharge.

During the COVID-19 emergency response, the CCG worked with system partners to re-imagine the use of Continuing Healthcare Fast Track provision to provide a more integrated end of life care offer with the aim to facilitate more timely discharges from hospital and prevent avoidable hospital admissions. A whole pathway approach was developed which included the rapid transformation of community end of life services, including the development of a Single Point of Coordination (SPoC) which provided a single telephone number for those referring into the service providing clinical advice and triage as a front end to the local care offer.

The SPOC co-ordinated hospital discharges, triaging patients' clinical needs into either to home or hospice for patients requiring end of life care in the last days or few weeks of their life, or refers the patient to the Continuing Healthcare Fast Track team to for domiciliary care for those in the last few months of life. For those requesting to be cared for in a care home these were directed to the Continuing Healthcare fast track team to commission a bed and case manage.

The CCG has commissioned additional specialist capacity from St. Leonard’s Hospice to provide care that is more integrated for people in their last few days or short weeks of life using a proportion of the existing fast track budget.

This Continuing Healthcare Fast Track transformation project has resulted in the CCG winning a National award from the Continuing Healthcare Strategic Improvement Programme for the 'Best Project for Better Use of Resources in Continuing Healthcare '.

1.5.3.10 Personal Health Budgets

During the pandemic the CCG continued to take a proactive approach to personalised care and offered Personal Health Budgets as the default position for people who were eligible for Continuing Healthcare. The CCG worked with the community wheelchair service to adapt their approaches to continue to offer Personal Wheelchair Budgets (PWBs) as the service was required to offer some patients virtual assessments. This has resulted in the CCG delivering significantly more Personal Health Budgets than the previous financial year.

1.5.3.11 Digitisation of Continuing Healthcare

The CCG have been the first in the country to develop iChord - a web-based system - to fully digitise Continuing Healthcare processes. The project involved implementing a new web-based platform designed specifically for the effective management of Continuing Healthcare, Funded Nursing Care and Personal Health Budgets. iChord replaced and combined the old QA system for financial management and SystmOne for clinical and administrative purposes. The new system has provided many benefits, including improving efficiency to reduce workforce pressures, reducing financial risk and the improvement of data quality over time as the system becomes embedded into day-to-day operational processes.

With the development of pathways and workflows to be fully in line with the NHS Continuing Healthcare Framework it has helped to standardise the Continuing Healthcare offer, so patients receive a consistent, fair and transparent assessment and review process. It has improved the ability to react to changes in process. Evidenced by the CCG's ability to respond to changes due to COVID-19, the CCG was able to quickly update current processes to meet the needs of the service, including identify the most vulnerable patients and log welfare calls and capture the deferred assessments information required by NHS England and NHS Improvement.

1.5.4 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 through partnership working.

The CCG also works closely with its safeguarding partners, the Care Quality Commission, local authority partners, the Police and voluntary sector to ensure that timely information sharing takes place and any 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 CCG’s Head of Engagement provides an update on recent patient and public involvement work and future 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. Both the Quality and Patient Experience Committee and the Governing Body regularly hear patient stories, often from the

patients themselves and this helps to ensure that the CCG remains grounded in how its commissioned services are working for people.

1.5.4.1 Patient insight and feedback

The Engagement Team and Patient Relations Team meet each month to analyse patient insight to identify key themes of feedback. The Patient Relations Team has continued throughout the pandemic to be a conduit to elicit patient concerns relating to COVID-19 and assisting patients in the resolution of their individual concerns and to inform the wider CCG and its partners where there have been themes warranting partnership resolution.

1.5.4.2 Research and development

The Research and Development Manager works closely with the Yorkshire and Humber National Institute for Health Research Clinical Network, providing the conduit to general practice and community research to escalate and disseminate research priorities and ensure that local research projects adhere to the UK Policy Framework for Health and Social Care Research.

Our member practices have recruited participants to research studies, benefiting and supporting primary care patients. A total of 130 patients were recruited during this time resulting in the CCG being ranked as the third highest recruiting CCG in the Yorkshire and the Humber in 2020-21.

In March 2020 the Department of Health and Social Care issued a statement that, until further notice, the National Institute of Health Research was to pause all new or ongoing studies at that were not nationally prioritised as COVID- 19 studies. Any nationally prioritised COVID-19 studies would enable the gathering of clinical and epidemiological evidence to help inform national policy and enable new treatments, diagnostics, and vaccines to be developed and tested. In April 2020 a directive for England, Northern Ireland, Scotland and Wales was issued to request effort were focussed be placed on the enrolment patients in national priority clinical trials. The national priority trial for primary care was the PRINCIPLE Study (Platform randomised trial of interventions against COVID-19 in older people). This opened to practices in the Vale of York in April 2020 and recruited 49 participants.

1.5.5 Children and Young People

1.5.5.1 Special Educational Needs and Disabilities

The Vale of York has a complex geography and demographic however all partners are committed to embed good quality, equitable and consistent services. Areas of focus in 2020-21included the improvement of the quality compliance and consistency of the Education, Health and Care Plan (EHCP) processes, joint commissioning and wider engagement around co-production with children, young people and their families. Scrutiny around this work is overseen by executive and leadership boards for the York and North Yorkshire localities.

Key milestones to date include a co-produced model of partnership working, communication and engagement strategy, a quality assurance framework for EHCP's and a joint commissioning strategy. Further work on system data collection across services to better understand our population is ongoing. In terms of measuring impact of these developments, a co-produced outcomes framework has been developed and brings together seven key outcomes to demonstrate that children and young people with special educational needs and disabilities are living a good life. These are:

- I am safe;
- I am healthy;
- I have a choice and am heard;
- I am included;
- I achieve;
- I am resilient;
- I am becoming independent.

The CCG, along with partners at City of York Council, are further developing how to describe and measure this. This work has taken place with the families of children with special educational needs and disabilities.

The CCG‘s investment in services for children with special educational needs and disabilities significantly increased to support the improvements. This included the development of new Designated Clinical Officer posts in the CCG and within Community Nursing and Therapy Services. In addition, further investment to sustain the Special Educational Needs and Disabilities Information Advice and Support Service, and parent carer groups has been agreed.

In December 2019 Ofsted and the Care Quality Commission undertook a joint inspection of the local arrangements and services in place for children and young people with Special Educational Needs and Disabilities (SEND) against the statutory framework of the Children and Families Act 2014. This resulted in a Written Statement of Action being provided to the CCG and local authority requiring the submission of an action focussed response to address the areas of improvement that were required. The statement, clarifying that partnership working to improve the experiences and outcomes for children and young people with special educational needs and disabilities would take place throughout 2020-21 was accepted by the regulators.

1.5.5.2 Special school and community children's nursing

Over the past two years the CCG has been working closely with York Teaching Hospital NHS Foundation Trust to improve the quality of community services for children and special school nursing. A new service specification has been agreed and the reporting of quality standards has commenced recently to measure continual improvement. Nursing posts are being transferred from term time to full year, alongside an extended hours provision. This will allow specialist nurses to use their knowledge, skills, and experience to much more effectively benefit children and young people by supporting health promotion, disease prevention and avoiding complications arising due to complex health needs that may prevent children accessing education and short breaks. This will also provide a seamless Community Children's Nursing Service and help to avoid duplicity; something that parents have said is frustrating.

This positive shift will move away from traditional task orientated provision; and will require some adjustments. We are working closely with our partners and local schools to manage this transition effectively.

1.5.5.3 End of Life care for children and young people

The CCG has increased its investment into end-of-life care for children and young people. By working in partnership with York Teaching Hospital NHS Foundation Trust's Community Children's Team and Martin House Children's Hospice, the joint aim is to increase workforce skills and capacity to enable more children to be supported at home.

1.5.5.4 Quality improvement and supporting our Partners in Care

Our most vulnerable residents are those who have care needs whether they live in a care home or receive domiciliary care. In partnership with its health, social care and third sector partners, the CCG supports care homes and domiciliary care agencies to provide high quality, safe and effective care and experiences for residents. Work stream priorities have been influenced primarily through locally identified needs and the national framework and guidance for Enhanced Health in Care Homes but most predominantly over the past year, the needs arising from the pandemic.

A multi-agency response between the CCG, York Teaching Hospital NHS Foundation Trust, City of York Council, North Yorkshire County Council, Tees, Esk and Wear Valleys NHS Foundation Trust, independent care organisations, St. Leonards Hospice, North Yorkshire CCG, North of England Commissioning Support Unit, NHS Digital, the National Institute for Health Research and NHS Estates has improved resident experience by ensuring:

- a continuity of service across the care sector;
- reducing the impact of COVID through timely infection prevention and control advice and guidance;
- wellbeing support for health and social care staff;
- an increase in virtual consultations by health professionals to reduce footfall within homes;
- reduction in unnecessary admissions;
- timely hospital discharges;
- the supply of communication systems to all care homes, and some supported living settings (tablet devices, the local Capacity Tracker and NHS email accounts;
- the identification of a clinical primary care lead and community nursing lead for each care home.

Weekly bulletins and virtual meetings have continued to support care providers across the sector and virtual education sessions.

The CCG's Quality and Nursing Team established and oversaw a local COVID-19 test centre during the first wave and facilitated testing in the community and in care settings as required.

Quality assurance work and the implementation of action plans where necessary, either face to face or virtually, have been completed with care homes in the Vale of York geography alongside a number of other local providers. Emphasis was placed on proactive work to prevent the initial transmission of COVID-19. Providers that experienced outbreaks were visited by the team to ensure all interventions were in place and support to manage the fight against COVID-19. New priorities will emerge as visiting resumes and general restrictions are relaxed.

Drawing on learning from collaboration across the whole health and care system has focused on resident need. This work will continue to ensure the successful delivery of safe discharge, the Oximetry at Home service and the COVID-19 vaccination programme. These continue to be significant programmes of work.

1.5.5.5 Identifying deteriorating residents

Training and support has continued with independent care providers to recognise the early signs of deterioration in residents. This has been made possible by using a 'softer signs' Recognition and Responding to Deterioration tool that enables earlier conversations to be held with the health care team and person-centred plans to be put in place to meet the resident's needs. This helps to instigate earlier interventions to prevent further deterioration and transfers to hospital when they are not always necessary. This has been invaluable during the pandemic and extra training to support care staff in making physiological observations and the implementation of Pulse Oximeter equipment. All care settings have been provided with Pulse Oximeter equipment along with training to support the monitoring of residents, particularly those with, or a suspected COVID-19 diagnosis. This proactive approach to identify early intervention was recognised by the Nursing Times Awards scheme in 2020 resulting in the CCG achieving a finalist status.

1.5.5.6 The prevention of pressure ulcers - React to Red

The prevention of pressure ulcers remains a high priority in local care settings. The CCG has continued to support care homes and domiciliary care staff through the continued implementation of the React to Red programme. This work, identified as another proactive approach to health and care, was recognised the Health Service Journal in its Patient Safety Award Scheme.

1.5.5.7 Falls prevention work – React to Falls

Falls in health and care settings continues to be a threat to an individual's independence and quality of life. The CCG's leading work to reduce the risk of falls continues through its React to Falls Prevention' programme. Despite the pandemic, care homes have continued to request training and support and the CCG's Quality and Nursing Team has been a constant by

providing virtual or face to face support. The CCG's React to Falls work has seen a significant impact in reduction of avoidable harm and admission to hospital.

1.5.5.8 Maternity services

The CCG has worked closely with the Humber, Coast and Vale Local Maternity System (LMS) and the local provider to continue to embed quality and safety initiatives arising from 'Better Births'.

Continuity of Care for midwifery led care has continued to be developed at pace by York Teaching Hospital NHS Foundation Trust, despite the pandemic, with the Trust attaining the 2021 national target of 35% of women booked onto a continuity of carer pathway. This has been led by front line clinical teams to determine the model that is sustainable for both women and team members. Plans are in place for further team development in 2021 that will help to ensure improvements in quality and safety and more women receiving continuity in their care.

The CCG is working with the Local Maternity System and its safety working group to transition oversight and assurance of serious incidents to ensure there is expertise and the opportunity for wider scrutiny and learning. The Safety Working Group reports to the Local Maternity System Delivery Board and the Executive Oversight and Assurance Board at each of their meetings.

The first stage report of the Ockenden Review of Maternity Services was released in December 2020. Following its publication the CCG has gained assurance against the immediate priority 'must dos' of our provider's services in the Local Maternity System. A key priority moving forward into 2021-22 is the development of Maternal Medicine Networks to support women with most complex health needs.

1.5.5.9 Safeguarding

CCGs have a statutory responsibility to ensure that the organisation and its providers prioritise the safety and wellbeing of children and adults. This work is led by a small, established team of safeguarding nurses and doctors.

The CCG has appropriate systems in place for discharging its statutory safeguarding responsibilities in line with national guidance (HM Government, 2018; NHS E-I, 2019; Care Act 2014). These include:

- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements.
- An established Designated Professionals Team including a Designated Doctor and Nurse for Safeguarding Children and Children in Care, and a Designated Paediatrician for Child Deaths.
- Named GPs for Safeguarding Children and Adults and, as part of collaborative arrangements with Vale of York CCG, a Named Nurse and Specialist Nurse for Safeguarding in Primary Care (Children and Adults).

- Regular reporting into the CCG Quality and Patient Experience Committee from the Designated Professionals Team and the Primary Care Safeguarding Nurses.
- Appropriate arrangements in place to co-operate with local authorities and other partner agencies in the operation of City of York and North Yorkshire Safeguarding Children Partnerships and the City of York and North Yorkshire Safeguarding Adults Boards. The CCG Executive Nurse and Designated Professionals for Safeguarding are members of both the Partnership and Board.
- A staff training strategy to support recognition and effective response to safeguarding issues in line with statutory guidance.
- Representation on regional and national safeguarding forums via the Designated Professionals Team.
- Through contractual arrangements the CCG ensures that it commissions safe services and continues to be an active partner working with agencies to keep adults and children safe from abuse, neglect and harm.

Work undertaken by the Designated Professionals Team during 2020-21 includes:

- Supporting and protecting our children and young people has rarely been as important as during 2020-21 as families experience significant pressures and children become less visible to agencies during the COVID-19 pandemic. The Designated Professionals for Safeguarding Children have responded to the imperative to rethink and restructure our established Child Protection Systems, working closely with partner agencies to ensure systems continue to operate robustly during the COVID-19 Pandemic.
- The Designated Professionals for Safeguarding Adults worked together with partners to support care home organisations and residents at risk of abuse and neglect rapidly reconfiguring information sharing systems to identify and respond to emerging concerns and risks.
- The Designated Professionals for Safeguarding Children have worked closely with safeguarding partners across North Yorkshire and York to respond to an increased number of cases considered under the North Yorkshire and City of York Safeguarding Children Partnership Case Review and Learning and Improvement Framework. The Team have supported the identification of learning, agreeing actions and seeking assurance that such actions are embedded in practice.
- The Designated Professionals Teams have continued to provide a high level of support and professional leadership to safeguarding colleagues in NHS provider organisations during the pandemic. Safeguarding professionals network meetings have been moved online, frequent bulletins developed to ensure colleagues are kept informed of national and local safeguarding developments and increased offer of support and supervision during a particular busy year.
- The Designated Professionals have played an active role in the ongoing development of the Humber Coast and Vale Designated Professional Network. A joint action plan aims to support safeguarding developments across the Humber Coast and Vale footprint and

ensure safeguarding is integral to future commissioning arrangements across the Humber Coast and Vale Integrated Care System.

- Internal audits have been undertaken in respect of both Children and Adult Safeguarding teams. The outcome for the Children's team showed 'High Assurance'. The outcome for the Adult audit is still pending.
- Safeguarding Training across Primary Care: all training packages adapted to be delivered virtually; 747 Primary Care staff have been trained during 2020-21.
- Guidance for management of Children who are not taken to health appointments (' Was Not Brought') has been updated and disseminated to all GP practices to support effective identification of child neglect.
- Continued support offered to all practices with completion of NHS England's and NHS Improvement's safeguarding self-assessment tool. This tool provides assurance of compliance with safeguarding arrangements.

1.6 Engaging with patients and our communities

1.6.1 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.

This last year has been one of the most challenging for the NHS, with the COVID-19 pandemic. However, it has meant that partnership working has been stronger than ever to help keep our NHS going and support the vulnerable and protect lives. We could not have done this without the amazing support of our colleagues, partners and communities across the system and we want to thank you for determination to work in a collaborative way to help our population through this challenging time.

1.6.2 Our responsibilities

We are answerable to our patients, the public and our local communities. 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, 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 engagement toolkit provides 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. More information can be found on the 'get involved' section of our website.

1.6.3 Green star award for community engagement

In November 2020 the CCG was recognised nationally for its work to involve patients and the public and awarded the highest accolade of a 'Green Star' rating from NHS England and NHS Improvement.

The rating is prepared for annually as part of the national CCG Improvement and Assessment Framework (IAF) to assess how well a CCG has involved the public and demonstrated a commitment to supporting continuous improvement in public participation.

The rating was awarded after scores were collated from five assessment criteria including equalities and health inequalities, feedback and evaluation, day-to-day practice, annual reporting and governance.

1.6.4 Our engagement principles

Our engagement principles, provided in the table below, underpin all of the community involvement work that takes place across the CCG and wider system.

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 transparent	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.
Feedback and inform	Ensure that those who have given their contribution understand what difference it has made, and the feedback is provided in a timely manner.

Table 4 – Our engagement principles

1.6.5 How we engage

We have created 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.

In 2020-21, whilst considerate of those who are digitally excluded, we moved much more of our engagement online. We conducted interviews and phone conversations, issued hard copies of surveys directly to patients and worked with the voluntary sector and public facing clinicians to gather feedback. Building relationships with our partners across the health, care and the voluntary sector has been essential, and this has given us some of the most valuable insights into the views of our community. We use a variety of mechanisms and networks to involve the local population and gather feedback, including:

- Focus groups (online and face to face)
- Informal discussions
- Formal consultations
- Stalls and stands
- Public meetings
- Regular stakeholder newsletters
- Social media – Twitter, Facebook, Instagram, LinkedIn
- Surveys
- Press and media
- Meetings with voluntary groups and stakeholders
- Videos

Newsletters and social media platforms are some of our key communications channels. We have almost 7,000 followers on Twitter and almost 1,000 Facebook page likes. Both platforms have followers that include key stakeholders such as providers, partners, local MPs, councils and voluntary sector partners and members of the public.

During 2020-21 we expanded our presence on social media channels and used these to regularly post videos that have been viewed by thousands of people. During the vaccination

roll out, our Clinical Chair, Dr Nigel Wells, and other clinicians produced regular video updates about the COVID-19 vaccination programme and about keeping well during the pandemic. Some of the posts were seen over 17,000 times across social media channels and had a high level of engagement. Our range of videos can be viewed here: https:--www.valeofyorkccg.nhs.uk-videos-

1.6.6 Focusing on population health and the needs of our communities

While in the Vale of York we are considered to have the healthiest population in the North of England, there are still inequalities and we have growing numbers of older people. Although age does not cause ill health, as we age we accumulate disease. Chronic illness combined with mental health problems increases the need for health and care services.

To meet the challenges of an ageing population and an increasing number of people living with multiple conditions, we have focused on working in partnership with our communities, partners and stakeholders.

This year saw the continued growth of the influence of Primary Care Networks, which has brought general practices together to enable the greater provision of proactive, personalised, co-ordinated and more integrated health and social care.

Primary Care Networks are small enough to provide the personal care that is valued by both people and GPs, but large enough to have impact alongside better economies of scale through the collaboration between GP practices and local health and social care system providers.

Dedicated communications and engagement leads embedded within our Primary Care Networks provide support to help develop services around the specific needs of local patients. Through our work with the Primary Care Networks we have been able to focus on the population health needs of the community, and work across health and social care and the voluntary sector to improve patient experience and outcomes for that population. Some of examples of communication and engagement support for projects includes work to provide more care coordination for the vulnerable and frail facing rural health inequalities in the Hambleton and Ryedale area. An example of this is the Parkinson's' Nurse Specialist and Dementia Co-ordinators and working with particularly deprived wards in areas such as Selby to focus on smoking, mental health and social prescribing marketing and promotion.

1.6.7 Listening to our most vulnerable and seldom heard communities.

We are committed to addressing health inequalities across the Vale of York. We know that some groups, including people identified as being protected by existing equality legislation; the nine protected characteristics, have differing experiences and outcomes when accessing NHS services. We have looked at how we can try a range of approaches to reach diverse communities and ensure all voices are heard. It is critical that we understand our population, as this helps us to deliver services to meet their needs and make a real difference to their health and wellbeing.

Impacted by COVID-19, and the need to socially distance, we had to be more creative about the ways in which we could involve our community. Much of the engagement moved to online

platforms, which benefited many due to its convenience, and accessibility. However, cohorts of our population are digitally excluded and may have been unable to take part in online activities. That is why we tailored our approach to ensure they had the opportunity to take part. We have benefited from good partnership working and liaised with local Healthwatch organisations, local services and the voluntary sector to help listen to those who may not normally have their voices heard.

- We worked with Healthwatch York to access our most vulnerable and at risk communities to ask them about what they do if they have an urgent medical need. These conversations, curated by Healthwatch York, included those who used the welfare check in, Door 84 Youth Club, the multiple complex needs network and lifting voices up – a BAME network. Read the report here.
- We conducted telephone interviews with people and carers during the first COVID lockdown to find out how it had impacted their mental health and wellbeing. These were people with mental health conditions, disabilities and long-term conditions such as Dementia. Read the full engagement report.
- We listened to a migrant voices network to help understand the issues facing this group of people when accessing services, and the anxieties that they have around uptake of a vaccine.
- We focused efforts on improving co-production and engagement with our Special Educational Needs and Disabilities (SEND) community by hosting co-production workshops with families, young people and staff to feed into the newly named' joint partnership' model. The groups also help to shape the outcomes they wanted to see to help their children live the best possible life they can.

- We regularly attended carers forums to give updates about health services and the roll out of vaccinations during COVID-19. We listened to their feedback and worked with primary care to help raise the profile of carers and ensure that they are flagged on the GP system.
- We continued to host our regular wheelchair service user forum, which is attended by service users, commissioners and the providers.
- We developed relationships with local community leaders and faith groups to help tackle vaccine hesitancy and understand the barriers that people face.

1.6.8 Working with our local Healthwatch partners and forums

The CCG worked closely with colleagues at Healthwatch organisations in York, North Yorkshire and the East Riding of Yorkshire to seek the views of patients, carers and service users. Healthwatch's 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 received copies of the feedback and used these to work with providers in primary care, acute care and community services to improve the experience for patients. To represent the voice of patients,

a Healthwatch member sat on the CCG's Primary Care Commissioning Committee and the Quality and Patient Experience Committee.

1.6.9 Clinical engagement

In 2020-21, despite the pandemic, we managed to continue our Protected Learning Time sessions for our clinical stakeholders. These sessions helped to enhance the CCG's engagement with clinicians from our member practices. The sessions set aside dedicated time for primary care colleagues to learn and share best practice. Fundamentally the Protected Learning Time aims to improve patient care by providing a focused learning time for healthcare professionals. Two successful online events took place in July 2020 and October 2020 with over 300 health professionals taking part in each online event.

At the July 2020 event we were delighted to welcome Professor Rebecca Malby, a Professor in Health Systems Innovation at London South Bank University. Professor Malby led the keynote session. The purpose of the session was to develop a collective understanding of; and enthusiasm for, sustaining and improving innovation achieved in the pandemic and to ensure that we meet population health needs into the future.

The October 2020 session centred around the knowledge and resources needed to support healthcare professionals to recognise dementia, improve the quality of life and care of people who are concerned about their memory and support people with dementia, their families and carers. The event looked at opportunities to improve care, maximise the spread of what is going well, share learning and build relationships. It enabled participants to gain a unique insight into dementia through the stories from people with dementia and their carers too.

1.6.10 A year of engagement

The table below provides a snapshot of the CCG's engagement and involvement work in 2020-21.

April 2020	During the start of the first lockdown we wanted to rapidly assess the impacts, risks and unintended consequences of the COVID-19 response. We conducted a short survey (online and via phone) to find out how the restrictions to stop the spread of coronavirus (COVID-19) were affecting people's everyday lives and their mental and physical wellbeing. This may be in the way they accessed medical help or were able to carry out everyday activities for themselves or someone they were caring for. We also worked with the third sector to find out the public's worries and gather feedback about what they are hearing from the most vulnerable service users. Our Head of Engagement interviewed voluntary sector advocates and service users – including The Carers Centre, Mind. Dementia Forward, the deaf community, carers and service users with a disability. This work fed directly into the York and

	North Yorkshire local rapid health needs assessment of COVID-19 and the recovery plan for the Vale of York and supporting the vulnerable over the course of the pandemic.
May 2020	May saw the first online session of the Wheelchair Service User forum. During the forum NRS Healthcare (the wheelchair provider) gave updates on services operating during COVID-19, personal wheelchair budgets and new communications tools. Service users also feedback on their view of eligibility criteria and how customer satisfaction could be improved.
June 2020	In June we launched our engagement around urgent care services and what people do and where they go if they have an urgent care need. We received over 600 responses to our survey, held held a number of telephone interviews and commissioned Healthwatch to work with vulnerable and seldom heard groups. These conversations focused on how we can improve the patient pathway, create a more integrated approach to care and improve on patient experience, choice and access. Read the full engagement report here.
July 2020	During July the CCG and City of York Council (CYC) held four coproduction workshops with families, young people with Special Educational Needs and Disabilities (SEND) and staff to find out what people understood about the term co-production, the barriers and difficulties and how to successfully involve parents and families. The workshops were rich in feedback were used to develop a new coproduction model for York – which was renamed 'Joint Partnership' as it was felt to be plainer English and more relatable.
August 2020	In August we focused on raising awareness of the signs and symptoms of cancer. We encouraged or population to sign up for free one-hour Cancer Champion sessions, which teach people about the key facts, statistics, symptoms and screenings for a number of cancers. We worked with our networks to promote the new freephone line which will make it easier for people in mental distress to access urgent help. Open 24 hours a day, seven days a week, callers, including those with learning disabilities and-or autism, will be offered a series of options which will divert them to their local crisis service.

September 2020	This was the first YouTube live stream Annual General Meeting from the CCG. Viewers could listen to an update from each of the executive members and their reflections of the 2019-20 year. The session can be viewed here. We also held our second wheelchair services forum of the year and focused improving the delivery of clinical reviews. In September 2020, our Deputy Chief Nurse attended the York Carers Action Group to encourage carers to access their free flu jab. She talked about the benefits of the vaccination, and how carers could have the flu jab for free to help keep themselves and those who they care for safe.
October 2020	In October 2020, we focused our quarterly GP training session on improving the experience of those diagnosed with dementia. The event attracted over 300 healthcare professionals from across the Vale of York. The CCG invited Nicci Gerrard (novelist) and Damian Murphy and the Mind and Voices group, a support network for people who live with dementia, to lead the keynote sessions. This humorous and compassionate session enabled participants to gain a unique insight into dementia through the stories of people with dementia and their carers. Comments from GPs illustrated that they were positively impacted by the keynote session. The video can be watched here: https:--www.youtube.com-watch?v=0suQyAR6Ipg . We also attended health overview and scrutiny committees in East Riding, North Yorkshire and York to give an update about the work we are doing to improve urgent care services in the Vale of York. All committees were supportive of the diversity of engagement work carried out as part of the project and the efforts to seek views of a cross section of the population.
November 2020	This month, in partnership with City of York Council, our mental health provider and third sector we launched a new campaign #FeelRealYork, to signpost people to support to help benefit or maintain their mental fitness, and to share and use resources to support our wellbeing. Dr Nigel Wells gave an update about the impact of COVID-19 on GP appointments and on referrals to cancer services to the local scrutiny committee.

December 2020	Over 100 people (including clinicians, patients, community activists, voluntary sector and partner organisations) joined a Northern Quarter Project (NQP) online event on 9 December 2020 focusing on a community approach to mental health and wellbeing. Patient and public representatives, the CCG, York Teaching Hospital and local authority met to talk about the population health needs of the Easingwold area and future health and care needs of the community.
January 2021	As part of an engagement piece looking at the experience of people diagnosed with Parkinson's, we spoke to patients over the phone to ask them about their experience of care and the Parkinson's Nurse Specialist This feedback directly supported the decision to continue the Parkinson's Nurse Specialist role. This month we were delighted to announce the appointment of a new Maternity Voices Partnership Chair – Stacie Jackson-Ross. We met with her in January to discuss her role in linking in with the Local maternity System Maternity Voices Partnership group and focusing on the voices of seldom heard communities. In January 2021, our Head of Engagement attended the York Carers Action Group to give an update about the COVID-19 vaccination and the roll out across York. She talked about how people would be invited for the vaccination, where they would need to go and answered questions from carers. Lead clinicians and our Accountable Officer joined council leaders to participate in a live Q&A session on Facebook. They answered questions on the new lockdown and its impact on health, as well as giving the latest information on the roll out of the vaccinations.
February 2021	We worked with those supporting the migrant community to find out more about their anxieties around registering with GPs or getting the vaccination. People told us that they faced many barriers including access to interpreters, being asked for documentation and not understanding the health system. We worked with community groups and GP practices to increase awareness around registrations of migrant and asylum communities and promote the fact that people do not need to have proof of address or settlement status to join a GP practice.

	We held our third wheelchair service user forum of the financial year. Service users were pleased to find out more about the appointment of a new Personal Wheelchair Budget champion, who has been employed by NRS, the provider, to help people understand how to make the most of their Personal Wheelchair Budget.
March 2021	We worked with engagement leads and representatives across the system to set a framework for citizen engagement across the Humber, Coast and Vale. This will be a set of guiding principles which will set the gold standard for community engagement within the Integrated Care System. In March we held the first of our 'Model of Joint Partnership' recap training session (the first of three workshops). We looked at the model, asked how people how they are embedding it into work and showcased some positive patient stories and practical examples of coproduction. The managing director from York Inspirational Kids attended to talk about the positive difference that has been felt from the perspective parents and young people. We attended the North Yorkshire Disability forum to give an update about the work that is happening in the Vale of York to support wheelchair service users.

Table 5 – A snapshot of the CCG's engagement work in 2020-21

1.7 Reducing health inequality

1.7.1 Introduction to our work to reduce health inequalities

The NHS Long Term Plan 2019 promised more NHS action on prevention and health inequalities and set out a series of prevention measures and investments on issues like smoking, obesity, alcohol, air pollution and antimicrobial resistance. It also makes improving the health of the poorest a priority and tackling inequalities through the resources at the disposal of health and social care. This complements work done by local authorities and other services to address the unequal distribution of health assets and risks, which are the major drivers of inequality and unhealthy lives within the population.

These issues are of increasing concern, with recent high-profile work by Professor Michael Marmot at the UCL institute of Health Equity suggesting that the 2010s were, nationally, a 'lost decade' in which life expectancy improvement stalled, and in the more deprived deciles of the population life expectancy declined for the first time in generations, further widening the health inequalities gap in society.

Population health need is one of our key drivers as a CCG, and we intend to use health and social care commissioning and leadership resources we have at our disposal 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 prevention and delivering access to quality health care in the geographical areas of high deprivation.

To do this, there is a requirement for us to understand population health needs, and so the CCG's strategic plan echoes the overarching ambition set out in the three Joint Health and Wellbeing Strategies published by our Local Authority areas, together with their corresponding Joint Strategic Needs Assessments.

Some key features of our local population and health inequalities are:

- Since the CCG was created in 2013, its population (those registered to the CCG's member general practices) has grown by around 4.5%, from around 350 thousand people to over 365 thousand people.
- In February 2021, the Vale of York CCG had a registered population of 365,709 people, with 116,009 people living in the 'Vale' area of the CCG which lies within North Yorkshire County Council boundaries, and 249,700 living in the 'City' Area, which is mainly within City of York council area but also includes the registered population of Pocklington primary care practice within the East Riding of Yorkshire area.
- York city has become more culturally and religiously diverse over the last two decades, with a Black and Minority Ethnic (BME) population of 9.8% (non-White British) compared to 4.9% in 2001.
- Selby District has an area in Selby West ward with a population of 1,425 people that is in the 10% of the most deprived in England. Selby East and Selby West wards are both areas within the bottom 20% most deprived in England, and have the highest rates of income deprivation, children 0-15 living in poverty, households in poverty and benefit claimants in the Vale area, with rates higher than England's average.
- York has one area in Westfield ward with a population of 1,647 that is in the 10% most deprived in England, and 6 areas with a combined population of 9,479 within the bottom 20% most deprived in England.
- Across the two Local Authority areas where the majority of CCG patients live (North Yorkshire and York), there are large inequalities in health outcomes between the poorest and richest areas, and in some of the risk factors which explain these outcomes:
    - **Premature mortality**: a three- to five-fold difference in expected deaths from preventable causes.
    - **Life expectancy**: a gap between wards in York of 10.1 years (Male) and 7.9 years (Female), and in NY of 15.2 years (Male) and 12.4 years (Female).

- **Emergency admissions to hospital**: there is a 50% range (York) and 60% range (North Yorkshire) in the standardised admissions ratio between wards in each area.
- **Societal risk factors**: 9.9% of the population in North Yorkshire and 8.5% in York live in fuel poverty, whilst 14.4% in North Yorkshire and 12.9% in York live alone.
- **Health behaviours**: Smoking prevalence ranges from 8.4% in Hambleton to 14.4 in Harrogate (11.9% in York). In York 56.9% of adults are overweight or obese compared to 64.8% in Scarborough.

- Our population is slowly getting older. 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%. South Hambleton and Ryedale Primary Care Network (SHaR) has the highest proportion of its population over 65 years of all the Primary Care Networks within the Vale of York CCG, and this is the second highest level in North Yorkshire and York area. However, age is not a cause of ill health per se. As people age, co-morbidities tend to accumulate, and so while ageing is not preventable, we aim to delay the onset of chronic diseases across our population and 'compress' the number of years people live in an unhealthy state into as small a period as possible.
- In nearly all disease areas, there are proportionately more patients on registers in the Vale area of the CCG than City, with the exception being Depression and Severe Mental Illness where there are proportionately more patients on registers in City than Vale, and with smoking as a risk factor where proportions are similar. These comparisons use Quality Outcomes Framework (QOF) data, and it should be noted that this is not an unbiased estimation of disease prevalence as it can also indicate either over- or under-diagnosis.
- There are 1,153 people on a learning disability register in the Vale of York CCG area (0.3%), with 794 of them living in the 'City' area and 359 living in the 'Vale' area as of February 2021.

1.7.2 Primary Care Networks and their work to reduce health inequalities

Work within 'inclusion health' seeks to prevent and address health and social inequalities experienced by groups of people at risk of or living with extremely poor health as a result of deprivation, marginalisation, multi-morbidity and social exclusion.

Groups experiencing the worst health inequalities include:

- Gypsies, Roma and Travellers,
- people experiencing homelessness,
- vulnerable migrants,
- sex workers,
- people in contact with the criminal justice system,
- people with learning disabilities

Primary Care Networks were established in July 2019 and have an important role in addressing these health inequalities at a neighbourhood level. 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.

In February 2021, a new tool was developed by Friends, Families and Travellers, Homeless Link, Doctors of the World, National Ugly Mugs and Stonewall Housing, with input from Primary Care Network representatives, organisations specialising in work with Inclusion Health groups and people experiencing health inequalities. This resource was designed to support Primary Care Networks to assess and improve their work with Inclusion Health groups.

Primary Care Networks are asked to measure their performance across 22 metrics to assess the following:

- are all services systematically adapted to meet the needs of people most likely to experience health inequalities,
- do practices collect information from patients on how wider societal issues may put them at high risk of poor health or may affect outcomes of health interventions,
- do Primary Care Networks work collaboratively to identify and address issues across the wider determinants of health in your neighbourhood, and
- can all staff members within a Primary Care Network confidently signpost patients from inclusion health groups to relevant local voluntary sector organisations who can support them with their non-clinical health needs?

Once the Primary Care Network has completed the self-assessment, they are provided with a completely unique and tailored guide to support them to embed action on tackling health inequalities into everyday patient care.

South Hambleton and Ryedale Primary Care Network (SHaR) has completed the self-assessment and are using the report provided to develop an action plan. The CCG is working closely with the other Primary Care Networks in the Vale and the City of York to complete the tool.

In the city of York, the York Health and Care Collaborative - an evolution of the multi-agency Primary Care Home model - works with out of hospital providers on a number of population health priorities, including Frailty, Prevention and Mental Health. In 2019 public health specialists at the City of York Council conducted an analysis of local health data to understand trends in people living with multiple long-term conditions, to improve local population health inequalities and target health interventions optimally.

A similar approach is being taken by Selby Town Primary Care Network which was the first in the Vale of York to join the national population health management development programme, focussing work on people living with hypertension between the ages of 50 and 64.

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

1.7.3.1 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%.

The CCG has allocated investment to address this work since 2019-20 and a Local Enhanced Service (LES) has been offered to primary care. In 2020-21 the LES has been implemented by 24 practices. SMI Health checks in quarter one this year was 24.7%, a reduction from the previous quarter of 30%. This downward trend has continued and performance at Q3 was 21.2%.

At the start of the COVID-19 outbreak in March 2020, necessary steps were taken to safeguard the health system from being overwhelmed and to free-up and protect staff. It is suggested that ongoing challenges to restore activity to usual levels, as part of the third phase NHS COVID response from 1st August 2020, had a significant impact on demonstrating improvements. Catch-up initiatives to reach out proactively to clinically vulnerable people coincided with planning for the biggest ever flu vaccination programme, on top of on-going workload and workforce pressures. Social distancing measures also had an impact on individuals attending GP practices.

The Community Mental Health Transformation Programme is currently developing a project in the City of York to develop a new pathway for SMI, that is integrated and making every contact count across primary, secondary and third sector services. This will include a core offer of support services such as sport and activities that connect people to their environment that are evidenced to support good mental health and well-being.

1.7.3.2 People with a learning disability and autism

The North Yorkshire and York Transforming Care Partnership (TCP) continues to work ensure the principles of the Building the Right Support initiative are embedded. This national initiative outlines a framework to develop more community services for people with learning disabilities and or autism who display behaviour that challenges. People with a learning disability, autism; or both, and their families and carers play an important role in work to agree and deliver local plans for the programme.

This partnership with local authorities and our provider, Tees, Esk and Wear Valleys NHS Foundation Trust, continues to build a Dynamic Support Register for adults and children who are at risk of admission or placement breakdown. The partnership also supports a Positive Behaviour Support role and a Forensic Outreach Team along with a community support offer from Tees, Esk and Wear Valleys NHS Foundation Trust.

Following many of the programme's targets being achieved, or having made a positive progress towards achieving them, the partnership received an assurance rating of 'green' from NHS England and NHS Improvement. Examples of progress include long-term hospital attendance avoidance so patients can live in the community, with the right support and closer to home. We also undertook more community reviews, compared to other CCGs in the Yorkshire and the Humber area, resulting in admissions to hospital being prevented.
The North Yorkshire and York Care Education and Treatment Review process and protocols have been recognised nationally as best practice and are being adopted by other areas. We are currently supporting other TCPs to adopt the same processes not only Care Education and Treatment Reviews but also for our work to develop Dynamic Support Registers - registers to identify people with a learning disability, autism or both who are at risk of an unnecessary hospital admission, so we are able to provide care and support earlier.

The CCG continues to actively support the national STOMP-STAMP project in partnership with local medicines management teams. STOMP-STAMP stands for stopping over medication of people with a learning disability, autism; or both, with psychotropic medicines.

In addition, the CCG engaged with local partnership groups including the Learning Disabilities Partnership Group in York and the Live Well Live Longer Strategy Group in North Yorkshire, and with a specific housing development group for individuals with behaviour challenges to ensure environmental triggers are reduced and the least restrictive care is provided. The CCG secured a Clinical Health Trainer post to support learning disability providers of care in the locality to deliver best practice. This included promoting the importance of health checks.

The National Direct Enhanced Service for Annual Health Checks for People with Learning Disabilities was actively promoted to primary care through the CCG. The CCG has supported practices and Primary Care Networks to increase the uptake and quality of Annual Health Checks through the provision of more robust data monitoring and using this intelligence to provide targeted quality improvement support. The CCG provided an Annual Health Check training event to primary care that was delivered by local clinical champions to share best practice around improving the identification of individuals eligible and offering practical guidance to completing quality annual health checks.

Our CCG has made good progress increasing the uptake of annual health checks for people with learning disabilities. The CCG is achieving well above the national average for England and the North East and Yorkshire region.

The CCG was successful in bidding for Personalised Care Transformation funding. Primary Care Networks are developing plans to use the funding to implement more personalised approaches to Annual Health Checks by offering more personalised care coordination and support planning. This will also include building closer links with Social Prescribing Link Workers and the voluntary care sector to improve outcomes for our population.

1.7.3.3 Health care for individuals experiencing homelessness

To address some of the barriers that were continued to be faced by homeless individuals in 2020-21, the CCG continued with its commission of a fortnightly GP led clinic provided by the York Medical Group at Changing Lives in York. In addition, York Medical Group provided a fortnightly tissue viability nurse-led wound care clinic which was well received and well attended and has prevented serious complications from poorly managed wounds. This is in addition to wound care currently provided at York Medical Group's city centre practice.

The outreach element of this service aimed to make contact with homeless individuals not engaged with Changing Lives, York. This work was impacted by COVID-19 and social distancing but has still taken place and through the outreach work York Medical Group was able to promote seasonal flu vaccination clinics. This was made possible by joint funding from City of York Council through The Better Care Fund.

The CCG also continued to commission the 'A Bed Ahead' service through The Better Care Fund. This was managed by Changing Lives in York and York Hospital's Liaison Officers who ensured that homeless patients were accommodated and supported to attend follow-up appointment following their discharge from hospital.

1.7.3.4 COVID-19 vaccinations for Individuals experiencing homelessness in York and Selby

The CCG supported multiagency activities to increase the uptake of the COVID-19 vaccine with individuals experiencing homelessness. Work included intensifying the existing engagement activity and supporting health and partners to develop a localised plan for longer-term, strategic and systematic engagement.

Led by the CCG, GP practices in York and Selby; York Medical Group and Scott Road respectively, worked with local housing services and community providers to ensure that as many individuals as possible were supported to access vaccinations at their place of temporary residence including rough sleeper accommodation. This targeted vaccination programme commenced in early April 2021.

1.7.3.5 The CCG's use of data to inform strategic planning and commissioning decisions

Using data tools and analytics to inform strategic planning and commissioning decisions has become especially important during the 2020-21 COVID-19 pandemic. Commissioning activity and processes changed dramatically over the last 12 months as a result of the need to prioritise urgent hospital care for those who needs it, whilst maintaining as much planned care activity and access to GP services as possible.

Protecting NHS front line staff, some of whom are vulnerable and in at-risk groups, has also been a priority for NHS providers and commissioners during this time. The CCG has focussed its efforts on supporting NHS providers during the different phases of the pandemic. Activities such as implementation of the RAIDR 'Urgent Care Dashboard' enabled system leaders to

observe pressures in the urgent care system in 'real time' as different waves of the pandemic unfolded. A function of the RAIDR tool was to allow GP practices to report their 'OPEL' status regularly, indicating the capacity and demand pressures they were facing. This enabled the CCG to work with primary care to ensure that services could be adequately covered or diverted if appropriate.

We have continued the rollout of the RAIDR suite of dashboards to individual GP practices, CCG primary care teams and commissioning leads. The RAIDR suite of tools has been expanded to cover specific information relating to numbers of patients in COVID-19 'At Risk' Groups, such as those diagnosed with learning disabilities, those who have severe mental Illness and patients who either have or are likely to have dementia. It was also helped the CCG to plan the COVID-19 vaccine rollout more effectively, since the tool can highlight the numbers of people in At-Risk groups, and in different age bands.

The CCG continues to use the York Health and Wellbeing Joint Strategic Needs Assessment (JSNA) reports to inform strategic planning and commissioning decisions. However, the work of the JSNA has been prioritised during 2020-21, to evaluate the impact of COVID-19 on the population of York as a whole. This work considers the large number of people who have not been able to access primary care services, social services during the pandemic.

The work of the JSNA has been extremely important in helping commissioning managers from both Health and Social Care to work together and understand the impact that the pandemic has had for patients who have not been able to receive planned surgeries, or access healthcare during the year and the likely impact the pandemic has had on the population, including those residents living in more deprived areas, those with SMI-LD diagnoses, or residents from BAME communities.

The CCG commissioning team has been working very closely with hospital providers, both NHS and independent sector, to maintain planned levels of elective surgery activity after the initial wave of COVID-19. This year has seen a very large increase in the number of people waiting for planned surgery, and the CCG has put in place agreements between providers to clear backlogs as quickly and efficiently as possible, using the available hospital capacity that providers have, whilst maintaining COVID-safe working practices for all hospital staff. However, it is acknowledged that it will take time to work through this backlog, in addition to addressing those patients who never came forward to seek help and diagnosis during the key months of the lock down measures. All health and social care partners will be engaged with 'waiting well' initiatives to support this priority work.

As we move towards fewer social distancing restrictions, and greater numbers of the population having received the COVID-19 vaccine, the CCG have embarked on several 'Population Health Management accelerator' programmes in conjunction with NHS England and Optum.

This work has seen the implementation and analysis of 'linked' health and social care data for patients in the City of York and Selby Primary Care Network areas that encompass primary care, secondary care and social care data linked at an individual level. These datasets have

provided an extremely useful source of detail which has enabled the CCG to work with partner organisations including the voluntary sector in running pilot projects for specific groups of patients with either frailty or diabetes, stratified by age and population demographics.

This work has been a significant step forward in both data analytics and partnership working which will provide the health and social care systems in York and Selby with a framework in which to undertake population health analytics-led commissioning of services in the future, which takes into account the health and social care support needs of the population, with a focus on preventing ill health as well as specific and targeted interventions for groups of patients and residents with specific health and social care needs.

1.7.3.6 Activity aimed at reducing health inequalities

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

1.7.3.7 Complex Care Team

The York Medical Group Primary Care Network developed a Complex Care Team (CCT) consisting of two Assistant Practitioners, a Health Care Assistant and an administrator. The team has a wealth of knowledge and experience in dealing with patients with long term conditions and complex health needs, including learning disabilities (LD), severe mental illness (SMI) and dementia.

The CCT work closely with the LD-SMI and Dementia Lead Nurse and GP to identify patients and maintain a health check register. The register allows them to support patients in care homes, coordinate reviews, and organise multi-disciplinary team meetings (MDT). The team continually evaluates interventions and identifies where and when further support is needed.

Two part time Social Prescribers also work closely with the CCT and make regular welfare calls to vulnerable patients, helping to break down barriers to accessing health care. Social Prescribers also signpost to organisations that can provide support to address social and financial issues.

1.7.3.8 The Scott Road Smoking Project

Scott Road Medical Practice in the Selby Town Primary Care Network has the highest smoking prevalence in its patients of any practice in the CCG area, with 21.6% of patients on a register as currently smoking (an estimated 2,309 smokers).

A team from Public Health, clinicians from the practice, the practice link worker, Living Well Smoke Free (the local stop smoking service), and from North Yorkshire County Council’s Stronger Communities team came together to tackle this issue, and used a Population Health Management approach to understand the characteristics of smokers and target effective interventions.

Targeted texts messages were sent out to two selected groups of smokers at Scott Road Medical Practice using behavioural insights to encourage them towards cessation services. One message was sent to all smokers within the most deprived area with a focus on financial benefit of cessation. The other message was sent to all smokers registered at Scott Road Medical Practice with COVID-19 risk factors who also smoke, with a focus on COVID-19 safety and mortality. The project also teamed up two Polish members of staff within the group to address the large number of Polish smokers registered at the practice. They produced a Polish leaflet regarding the benefits of smoking cessation and details of living well smoke free. This leaflet had direct contact details for the Polish Cessation Advisor for Living Well Smoke Free. High levels of mental health needs were also identified in Scott Road Medical Practice's smokers and links were made with Improving Access to Psychological Therapies to open up the discussion with patients about smoking cessation.

Living Well Smoke Free collected referral data and successful cessation rates amongst their service users. The project group is working with them to determine if there has been an increase in referrals from these targeted groups and if service users find the programme effective.

Selby Town Primary Care Network also undertook a twenty-week intensive population health management programme overseen by the Humber, Coat and Vale Integrated Care System. The network has used the data collected to initially focus on the health needs of their 55+ community with mild to moderate frailty and a diagnosis of hypertension to offer greater support for aging well. Partnership workshops continue to be held to focus on core priorities for Selby Town across local authorities, Tees, Esk and Wear Valleys NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, and the Primary Care Network to inform the work on reducing inequalities. This programme builds on the work of Selby Health Matters, a multiagency partnership group which has been bringing organisations together over the last three years to focus on the health needs of the district.

1.8 National prevention strategies

The CCG activity supported the delivery of national prevention strategies including the National Diabetes Prevention Programme, NHS Health Checks and Improving Access to Psychological Therapies.

1.8.1 The National Diabetes Prevention Programme and Low Calorie Diet

Prevalence of Type 2 diabetes has been linked to lifestyle factors, obesity and social deprivation. It is often the first long term condition a person will develop prior to developing other conditions. For this reason, the CCG worked closely with practices throughout the Vale of York to support the referral of patients at risk of developing Type 2 diabetes to the National Diabetes Prevention Programme (NDPP). The programme aims to prevent or delay Type 2 diabetes through support to make evidence-based lifestyle changes through diet and exercise.

Due to COVID-19, all NDPP sessions were held remotely. The sessions still allowed for any questions to the coach and the interaction with other service users. Participants could also download an app to keep track of their own health goals and the support available to them throughout the programme.

The Low Calorie Diet project moved out of the pilot phase and was made available to all patients who met the eligibility criteria throughout the Vale of York. Medical research has shown that some obese people with Type 2 diabetes can achieve remission through adoption of a low calorie diet. Early analysis of data from the programme has been encouraging and the feedback from patients has been positive.

1.8.2 Population Health Management Diabetes Project

Supported by Optum and NHS England and NHS Improvement, partners in the City of York led by the CCG looked at adults aged 50-64 in the bottom 50% of postcode areas in the city according to the UK's key deprivation measure. These patients have diabetes and exhibited a lack of engagement with Primary Care in 2019-20. A working group across professional disciplines explored how health care providers engaged with this cohort of patients, what a multi-disciplinary team addressing their health and social care needs might look like and what interventions were available to patients both clinically and within the community. The findings of the project will help to shape a more effective and personalised way for patients to engage with primary care to manage their diabetes.

1.8.3 NHS Health Checks

The NHS Health Check was offered to all adults between the ages of 40 and 74 without pre-existing cardiovascular conditions. The check focuses on height, weight, blood pressure, alcohol consumption, physical activity, cardiovascular, cholesterol and diabetes risk. The rationale for a health check is that it aids the early detection of common long term health conditions such as cardiovascular disease, diabetes, high blood pressure. These conditions can usually be reversed or slowed through early diagnosis, treatment initiation and lifestyle modification.

NHS Health Checks have been provided in York by the City of York Council's Health Trainer Service since 2016, alongside smoking cessation services and health behavioural change intervention services. During the COVID-19 pandemic there was a national directive to stop Health Check delivery, consequently no Health Checks were delivered since March 2020. This pause in health checks has given City of York Council the opportunity to discuss the future model of this service. The City of York Public Health Team intends to move the model of a health check in York closer to primary care during 2021-22.

1.8.4 Improving Access to Psychological Therapies

The service prepared for increased demand due to COVID-19; both for the immediate and the future, to meet the anticipated need to address, as examples, the impact of self-isolation, Post-Traumatic Stress Disorder and bereavement trauma.

Currently black, Asian and ethnic minority groups make up 3% of Improving Access to Psychological Therapies referrals. Targeted work aimed at these groups and the LGBTQ+ population is planned during 2021-22 and will include staff awareness and training.

In addition, Improving Access to Psychological Therapies has focused on access to perinatal, student and older adult services. The older adult champions made links with Age Concern, and the York Older People's Assembly. They also worked with GPs to promote the benefits of Improving Access to Psychological Therapies for older adults. The service continues to work with the CCG and public health teams on local population profiles to enable work to address inequalities and target interventions accordingly. The service is linked to the Long COVID-19 pathways and is now accepting referrals. An Improving Access to Psychological Therapies Long Term Condition Service has been piloted in the Selby District area and this is integrated with respiratory rehabilitation and physical care provision.

1.8.5 Learning disabilities and Autism

The North Yorkshire and York Transforming Care Partnership received an assurance rating of 'green' from NHS England and NHS Improvement with many of the partnership's programme targets being achieved or having made a positive progress towards achieving them. The partnership made good progress supporting more people that have been in a long-term hospital setting so they can live in the community, with the right support, closer to home. We also undertook more community reviews compared to other CCGs within Yorkshire and the Humber, which has resulted in admissions to hospital being avoided.

The North Yorkshire and York Care Education and Treatment Review process and protocols were also recognised nationally as best practice and are being adopted by other areas. This led to the CCG supporting other Transforming Care Partnership's to adopt its Education and Treatment Review best practice and its work to develop Dynamic Support Registers. These are registers to identify people with a learning disability, autism or both who are at risk of an unnecessary hospital admission, so we are able to provide care and support earlier.

Our CCG in particular made good progress to increase the uptake of Annual Health Checks for people with learning disabilities. Nationally, this work was recognised as a challenge, however the CCG exceeded its trajectories and has achieved well above the national average for England and in the North East and Yorkshire region.

1.8.6 Maintaining good access to Primary Care services during the COVID-19 pandemic

Several projects were launched during 2020-21 to help to maintain good access to Primary Care services for patients across Vale of York.

During the first national lockdown, all practices were required to move to a 'Total Triage' access model to minimise the spread of COVID-19. This meant that all patients were first triaged via a telephone call in order to clinically assess whether they needed to attend the practice for a consultation, or to ascertain whether their needs could be met via a telephone consultation. All Vale of York members practices quickly moved to offer their patients both video consultations where a patient needed-wanted to 'see' a clinician, and online consultations where the patient could access clinical advice via a web-based application on a smartphone or computer.

The CCG also deployed over one hundred 10" screen tablets to care homes to enable care home residents to have video consultations with their GP helping to reduce the risk infection.

The 'Improving Access' service, available in the evenings from 6:30pm to 8:00pm, and at weekends, has continued to operate and offer additional appointments to patients across the Vale of York, including telephone appointments for ease of access during periods of national lockdown. Some of these appointments have also been repurposed in accordance with national guidance to offer other services such as phlebotomy, and to provide additional capacity for the COVID-19 vaccination programme.

With general practice now moving back to 'business as usual' and working extremely hard to catch up on the backlog that has resulted from the national lockdowns the CCG continues to support practices in the use of digital access platforms to ensure that patients can access the services that they need.

In addition to the above, the CCG helped practices to develop more resilient business continuity capabilities through the provision of over one hundred laptop devices that enable practice staff to work from home with the ability to access patient records and hold video consultations.

1.8.7 Patient engagement

The CCG’s Communications and 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.

We used the Equality Delivery System (EDS2) to help 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 it can explore 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.

1.8.8 Improving services for children with Special Educational Needs and Disability

In partnership with City of York Council, the CCG facilitated six training sessions in July 2020 and October 2020 to explore the understanding of co-production and establish a common definition and model for this work in York. The sessions looked at addressing the key challenges and successes young people and families may face and facilitated a discussion around how to embed co-production within everyday activities. Read more about this work at (SEND Communication and Engagement Strategy August 2020)

In March 2021 the first of our 'Model of Joint Partnership' recap training sessions, the first of three sessions, took place. Together we looked at the model, asked how this approach was being embedded into work and projects. The session also gave the opportunity to showcase positive patient stories and practical examples of co-production. The Managing Director of York Inspirational Kids attended the session to talk about the positive difference that has been felt from the perspective of parents and young people, and the relationship and trust that was being built as a result of the focus on co-production. More information can be found on our website here.

1.8.9 Barriers and concerns around the COVID-19 vaccination for our BAME communities

Colleagues across the CCG established a Health Inequalities Group and worked in partnership with local authorities, our Business Intelligence Team, Healthwatch, community groups and leaders to understand vaccine hesitancy where there are lower levels of uptake, and how by working together we could remove barriers and address concerns.

The group worked with Refugee Action York and leaders of the local mosque to gather views and understand concerns. Other important work included talking with migrant forums, our links with the local traveller community, rough sleepers and disability groups. An example of a targeted piece of work was to support people of Muslim faith, where needed, to amend their vaccine appointment if it was scheduled to take place during Ramadan.

We also worked with community groups and GP practices to increase awareness around the registration of migrant and asylum communities and to promote the fact that people do not need to have proof of address, nor a settlement status to register with a GP practice.

1.8.10 Understanding vulnerable and at risk communities' experience of urgent care

As part of the Urgent Care Engagement Project, we committed to ensure that we represented the views of our diverse population. The CCG worked with Healthwatch organisations in York and North Yorkshire, and the voluntary sector to access seldom heard communities including some of the most vulnerable people in our population with multiple and complex needs. A number of interviews took place with the Door 84 Youth Centre, The Good Organisation that supports people affected by homelessness, Lifting Voices up York, York CVS and the Complex

Needs Network. The project used its links with youth groups and spoke to those who were receiving welfare checks. View the full Healthwatch report on people's understanding of urgent care.

1.8.11 The impact of COVID-19 on vulnerable, seldom heard communities

In April 2020, as the pandemic set in, the CCG conducted a short survey to find out how the restrictions to stop the spread of COVID-19 were affecting people's everyday lives and their mental and physical wellbeing. This could have been in the way they accessed medical help or were able to carry out everyday activities for themselves, or someone they were caring for. There was a particular focus on reaching those who might be most vulnerable to the effects of the current crisis: those with health conditions or disabilities, carers, visually impaired people or those with a hearing loss, people who feel socially isolated or have cognitive impairment, dementia, and people with a mental illness. This survey was part of a wider piece of work within York and North Yorkshire to look at the impact and consequences COVID-19 and the support that would be needed to be put in place the appropriate help for recovery. This work fed directly into the Vale of York recovery plan and rapid health needs assessment.

To ensure that we reached a diverse section of our population, including vulnerable and at risk groups, we worked in collaboration with our networks to gather feedback and conversations about what they were hearing within their communities. The Engagement Team arranged telephone interviews with advocates, carers and service users. Through this outreach we received rich feedback from Healthwatch York and North Yorkshire, Dementia Forward, advocates for deaf people, York Carers Centre, York Mind, patient participation groups, carers, and service users with disabilities and mental health conditions.

Through our equality monitoring data, we were able to assess that we had reached the intended target groups as 40.1% of participants stated they had a disability or mental health condition and 41% stated that they cared for a friend or family member. This is a much higher proportion of the local population than that stated in 2011 census which was recorded as 9.8% at the time.

1.8.12 Health inequalities in rural communities and supporting a frail population

1.8.12.1 Parkinson's Nurse Specialist

In January 2021, in an engagement project in the South Hambleton and Ryedale, Tadcaster and Rural Selby and Selby Town Primary Care Network areas, the CCG conducted engagement work to understand the experiences of care from patients with Parkinson's Disease as well as their families and carers.

The feedback received indicated that for many people the Parkinson's Nurse Specialist role is a very important source of professional support. The nurse offers advice on lifestyle, medication, local support groups and general day-to-day support. Many found the Parkinson's Nurse Specialist friendly, approachable and easy to access. By providing care in local

settings, whether at home, care homes or in nurse-led clinics, the Parkinson's Nurse Specialist kept care closer to home and provided support for patients and carers – and this is vital for those who are frail and elderly and living in rural and isolated communities. As a result of the engagement activity, the funding for the Parkinson's Nurse Specialist has been secured on a permanent basis.

1.8.12.2 Health inequalities indicators

The national Direct Enhanced Service for Learning Disability Health Checks continued to be a priority for GP practices and Primary Care Networks, especially so during the pandemic where nationally it was observed that patients with learning disabilities are far more likely to suffer ill health or even die as a result of contracting COVID-19.

Whilst it was difficult for GP practices to carry out Learning Disability Health Checks during the first six months of the pandemic, the latter six months saw the largest number of Learning Disability Health Checks completed in the whole of the CCG's history. CCG analytics and commissioning colleagues worked directly with Primary Care Networks to share performance and intelligence information with GP practices to help them identify patients who were possibly undiagnosed with a learning disability, and to ensure that all patients had a health check offered and completed.

1.9 Health and wellbeing strategy

1.9.1 City of York Health and Wellbeing Board

Dr Nigel Wells, the CCG's Clinical Chair is also the Vice Chair of the York Health and Wellbeing Board where he plays a very active role.

Prior to his departure from the CCG in October 2020, Dr Andrew Lee, the Executive Director for Primary Care Population was also a proactive member of the York Health and Wellbeing Board, making excellent contributions at its meetings and workshops. Outside of the formal meeting cycle he met regularly with the Chair of the Health and Wellbeing Board to keep her up to date on emerging issues.

In November 2020, Dr Lee's role was replaced on the board by the CCG's Interim Executive Director of Primary Care who too has played an active role at Health and Wellbeing Board meetings; particularly in relation to the COVID-19 vaccination programme.

In October 2020 the York Health and Wellbeing Board invited Dr Emma Broughton to become a member with Dr Rebecca Field as her substitute. Dr Broughton and Dr Field co-chair the York Health and Care Collaborative and the Health and Wellbeing Board gave consideration to the relationship between the board and the work of the York Health and Care Collaborative. The alignment of priorities and aspirations of the York Health and Care Collaborative and York Health and Wellbeing Board, in areas such as Ageing Well and Mental Health were identified in February 2020 and this led to inviting the Chair of the York Health and Care Collaborative to

sit on the Board and to provide quarterly progress reports. This work further strengthened working relationships.

The CCG also played an active role in the local Joint Strategic Needs Assessment Working Group and both the Health and Wellbeing Board's Ageing Well and Mental Health Partnerships, that focused on delivery against the priorities in the Board's Joint Health and Wellbeing Strategy.

The York Health and Wellbeing Board Ageing Well Partnership has been co-chaired by both City of York Council and the CCG when it reconvened in October 2020 and this led to even further integrated working, particularly around progressing the Age Friendly York project, work to develop a Dementia Strategy for the city and the exploring of deconditioning and how the partnership could influence ongoing work.

The CCG played an active part in the work of the Health and Wellbeing Board Mental Health Partnership at all levels, but a particular area to highlight is the CCG's Accountable Officer and his close working with the Independent Chair of the Mental Health Partnership that resulted in a very well attended Mental Health Summit in 2021 and its subsequent work to drive forward an emerging action plan.

The CCG's Accountable Officer also updated the York Health and Wellbeing Board on the new York Health and Care Alliance Board which will operate in shadow form in 2021 as a sub-committee of the York Health and Wellbeing Board.

1.9.2 North Yorkshire Health and Wellbeing Board

The North Yorkshire Health and Wellbeing Board is a partnership between local CCGs, North Yorkshire County Council and other stakeholders to improve the health and wellbeing of its local communities. In 2020-21 it brought together partners to encourage integrated working and commissioning between health and social care that delivered the right care, in the right place and at the right time for people in North Yorkshire.

The CCG had a seat on the Board and is represented by the Accountable Officer.

In 2020-21, the Health and Wellbeing Board met just once due to the COVID-19 pandemic. The reason for this was a decision by the Chair and Vice-Chair who each recognised that the priority of colleagues on the Health and Wellbeing Board was to manage the day-to-day response to the pandemic and to prepare for recovery.

The CCG continued to contribute to the Health and Wellbeing Board objective, to improve the health and wellbeing of the local population in a number of ways outside of the formal Health and Wellbeing Board environment. Examples include:

- being a key player in the Mental Health and Learning Disabilities Partnership that comprises of Tees, Esk and Wear Valleys NHS Foundation Trust and North Yorkshire County Council;
- its contribution to the ongoing development of the Joint Strategic Needs Assessment;

- playing a key role in the Learning Disabilities Autism Group and its area groups and leading on transformation that resulted in good progress on discharges from hospital;
- proactively contributed to initiatives on Delayed Transfers of Care and reflecting the requirements of the Right to Reside Discharge Policy

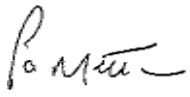
Whilst it has not met regularly as an entity, the Health and Wellbeing Board has been kept appraised of developments and key partners briefed.

In what has been an unprecedented period, the CCG's main contribution to health and wellbeing during the last year has been in its proactive response, with partners, to the pandemic. Examples include:

- leading on the vaccination programme in North Yorkshire and York.
- The liaison with partners on the North Yorkshire County Council Weekly COVID-19 Gold Sessions that focussed on the review of data and priority areas including the Testing and Tracing Strategy, enforcement and compliance
- as part of the Health Protection Coronavirus Regulations, the CCG played a fundamental role in the Strategic Co-ordinating Group of the North Yorkshire Local Resilience Forum, a partnership of local agencies working together to manage emergencies. The CCG was part of the risk conversations, and important work to identify where it could support organisations with their regulatory requirements. The CCG's Accountable Officer attended the North Yorkshire Local Resilience Forum press conferences and the CCG continues to support multiagency communications that includes specifically relating to the vaccine rollout as well as counteracting misinformation.

Looking ahead, now that the North Yorkshire Health and Wellbeing Board has resumed its meetings, the CCG will continue to contribute to the revised Joint Health and Wellbeing Strategy including the ongoing implementation of strategies for Dementia, Healthy Weight-Healthy Lives, Learning Disabilities, and Young and Yorkshire. It will also contribute to the development and implementation of the Board's priorities.

Accountability Report



Phil Mettam

Accountable Officer

10th June 2021

2. Members Report

2.1 Our Council of Representatives in 2020-21

Y = Attended
A = Apologies m = male, f = female
N = Neither attended nor sent apologies
Ch = Attendance as CCG Clinical Chair, not Practice representative
MP = Managing Partner attended with member

Practice	21 May	17 September
Beech Tree Surgery	A (Ch)	A (Ch)
Dalton Terrace Surgery	Y(m)	Y(m)
East Parade Medical Practice (Merged with Jorvik Gillygate Practice 1 July 2020)	A	N-A
Elvington Medical Practice	Y(m)	Y(m)
Escrick Surgery	A	N
Front Street Surgery	Y(m)	A
Haxby Group Practice	Y(m)	Y(m)
Helmsley and Terrington Surgeries	N	Y(m)
Jorvik Gillygate Practice	Y(m)	Y(f)
Kirbymoorside Surgery	Y(m)	A
Millfield Surgery	Y(f)	A
MyHealth	Y(m)	Y(m)
Old School Medical Practice	Y(m)	Y(m)
Pickering Medical Practice	N	Y(m) + Y(f)
Pocklington Group Practice	Y(m)	Y(m)
Posterngate Surgery	N	Y(m)
Priory Medical Group	Y(f)	Y(f)
Scott Road Medical Centre	Y(f)	Y(f)
Sherburn Group Practice	Y(m) + MP(f)	Y(f)
South Milford Surgery	Y(m)	Y(m)
Stillington Surgery	Y(m)	Y(m)
Tadcaster Medical Centre	Y(m)	A
Tollerton Surgery	Y(f)	Y(f)
Unity Health	N	N
York Medical Group	Y(f)	Y(f)

Table 6 - Council of Representatives meeting attendances in 2020-21

The Council of Representatives met twice formally in 2020-21. Monthly update sessions were held from June 2020. All meetings and updates were held as virtual sessions.

At the April meeting, which was not in public, the Governing Body adopted interim governance arrangements in response to the COVID-19 pandemic and did not meet in public until November 2020. From then the three remaining 2020-21 scheduled meetings in public were held on the Zoom platform and broadcast live on the CCG's You Tube channel. All seven meetings were quorate and the papers for all were published on the website.

There were six Governing Body workshops. Topics included: Medium to long term transformation opportunities; COVID-19 response; 'Place' development; Organisation development and people; Integrated Care System arrangements and the statutory role of CCGs; and the new 'landscape'. The Governing Body also received a North Yorkshire Devolution briefing from the Chief Executive of North Yorkshire County Council, met with the Tees, Esk and Wear Valleys NHS Foundation Trust Deputy Medical Director for North Yorkshire and York when discussion focused on opportunities to enhance partnership working, and received the statutory safeguarding training from the Designated Nurse Safeguarding Adults and Designated Nurse Safeguarding Children.

Governing Body member	Governing Body role	Attendance (public meetings)
Dr Nigel Wells	CCG Clinical Chair	6-7
Simon Bell	Chief Finance Officer	4-7
David Booker	Lay Member and Chair of Finance and Performance Committee	6-7
Michelle Carrington	Executive Director of Quality and Nursing - Chief Nurse	7-7
Dr Helena Ebbs	North Locality GP Representative	7-7
Phil Goatley	Lay Member and Chair of Audit Committee and Remuneration Committee	6-7
Julie Hastings	Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee	7-7

Dr Andrew Lee to 31 October 2020	Executive Director of Primary Care and Population Health	4-4
Phil Mettam	Accountable Officer	7-7
Denise Nightingale	Executive Director of Transformation, Complex Care and Mental Health	7-7
Stephanie Porter from 1 November 2020	Interim Executive Director of Primary Care and Population Health	3-3
Dr Chris Stanley	Central Locality GP Representative	6-7
Dr Ruth Walker	South Locality GP Representative	7-7
Vacant	Secondary Care Doctor	N-A
In attendance – non voting		
Dr Aaron Brown - Dr Andrew Moriarty	YOR Local Medical Committee Representative	5-7
Sharon Stoltz	Director of Public Health, City of York Council	5-7

Table 7 – Governing Body meeting attendances in 2020-21

2.2 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.

Nigel is currently the Clinical Lead for Humber, Coast and Vale ICS.

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 35 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.

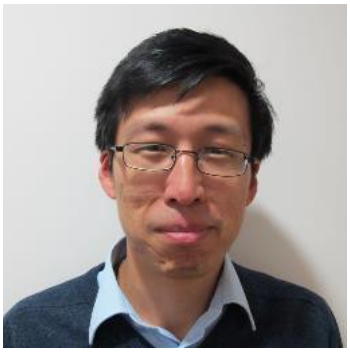
Michelle joined the CCG in September 2014 as Head of Quality Assurance and has been the Executive Director of Quality and Nursing since March 2015. She is also the Interim Director of Nursing - Quality Lead for the Humber Coast and Vale ICS.

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

Denise joins the CCG 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 for Primary Care and Population Health (to 31 October 2020)
Andrew initially trained in paediatrics before working as a humanitarian aid worker in Afghanistan. Being trained in both general practice and public health, Andrew worked for many years as a public health consultant in NHS organisations in Rotherham, Nottingham City and Bradford and Airedale where he focused on topics such as sexual health, cardiovascular disease prevention, integrated health and social care, tuberculosis control and emergency planning. He is a Reader in Global Public Health at the University of Sheffield and teaches in Masters of Public Health and Executive Masters of Business Administration programmes. His research interests are in the areas of health inequalities and health protection.

Stephanie Porter
Interim Executive Director for Primary Care and Population Health (from 1 November 2020)
Stephanie has been working in the York and North Yorkshire health system since 2008 and joined the CCG in 2019 in a technical, specialist role in estates and capital planning. In a career spanning over 30 years, she has worked in all types of health organisations, including NHS England in an approval role and provider services, at York Hospital Trust. She has been responsible for several medium sized new hospital builds, including the new Selby Community Hospital and more recently has been responsible for a number of primary care premises schemes. With specialist training in Project Management and Contracting she is supporting the Primary Care functions to deliver change and sustainable services with CCG and Primary Care colleagues.

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 work as a GP. She has an interest in population health and rural general practice. She has led improvement work in Cancer care, Frailty, Dementia and Mental Health.

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. Chris is a member of the Strategic Digital Board for HCV ICS 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.

2.2.1 Members in attendance – non voting

Sharon Stoltz
Director of Public Health for City of York Council

Sharon began her NHS career by training as a nurse and midwife in South Wales before moving to Nottingham to train as a health visitor. She worked for a number of years as a health visitor before specialising in Public Health, graduating with a Masters' Degree from the University of Nottingham in 1998. Sharon has held senior roles in Public Health for over 20 years working in the East Midlands, Cambridgeshire and South Yorkshire and Bassetlaw areas before moving to join City of York Council in 2015, initially as an interim Consultant in Public Health before being appointed as Director of Public Health in 2016. Sharon is a Fellow of the Faculty in Public Health and holds professional registration with the Nursing and Midwifery Council (NMC) and the UK Public Health Register (UKPHR).

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.

Dr Andrew Moriarty
Local Medical Committee Liaison Officer for Vale of York

Andrew is a GP in York and has been a Partner at his practice since 2018. He enjoys representing local GPs and working with the CCG to improve services and outcomes for patients across the locality. Alongside his clinical work, Andrew is also involved with primary care and mental health research at the University of York and Hull York Medical School. He lives with his family in York.

2.3 Internal governance arrangements

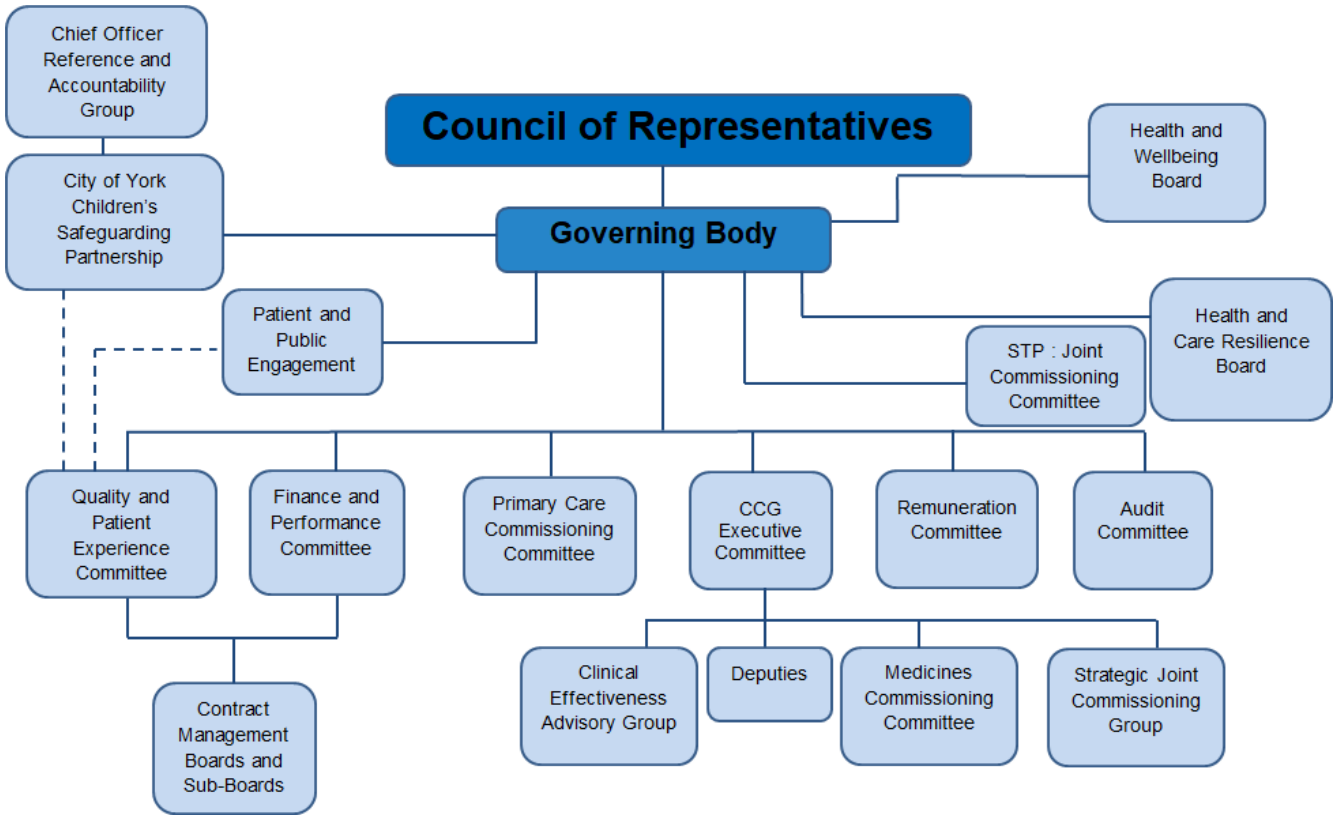


Fig 5 – Internal governance arrangements in 2020-21

2.3.1 The CCG's committee structure and highlights

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

The Finance and Performance Committee and Quality and Patient Experience Committee receive a risk report at each meeting; the Primary Care Commissioning Committee agreed at its November meeting that an exception-based risk report be included on the agenda. All Committees undertake an annual review of their terms of reference and effectiveness. An approach of assurance through exception-based reporting was adopted during the interim governance arrangements in response to the COVID-19 pandemic as referred to above in relation to Governing Body meetings.

Committee	Role and performance highlights
Strategic Committees	
Audit Committee	Chaired by the Lay Member with the lead role in governance and conflict of interest, the Audit Committee provides the Governing Body with independent assurance through critically reviewing the CCG's financial reporting and internal control principles and ensuring an appropriate relationship with both internal and external auditors is maintained. It has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control; internal audit; external audit; reviewing the findings of other significant assurance functions including counter fraud and security management and financial reporting. The Committee met six times in 2020-21 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. Members: Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee David Booker, Lay Member and Chair of Finance and Performance Committee Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee from July 2020 Secondary Care Doctor - Vacant Performance-Highlights: • Regular updates on progress against Financial Recovery Plan • Approval of Annual Report and Annual Accounts • Regular assurance from internal and external audit on reports issued to management • Approval of internal audit and external audit plans • Monitoring the implementation of audit recommendations • Annual review of Internal Audit Charter and Working Together Protocol • Development of a Board Assurance Framework • Information Governance assurance • Regular updates on counter fraud and security including approval of annual work plan and review of the organisation's annual self-assessment against NHS Counter Fraud Authority's Standards for Commissioners • Processes for review of Committee effectiveness, internal audit effectiveness, counter fraud and security effectiveness, and external audit effectiveness

Remuneration Committee	The Remuneration Committee makes recommendations to the Governing Body on: terms and conditions of employment for the CCG's Governing Body members; pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG; recruitment and retention premia and annual salary awards where applicable; allowances under any pension scheme it might establish as an alternative to the NHS pension scheme; severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money'; policies and instructions relating to remuneration; and any significant amendments to the terms and conditions of employment which affects all employees of the CCG generally (for example changes to the Agenda for Change terms and conditions). The Committee convened three times in 2020-21 and was quorate on each occasion. Members considered a further item via email. Members: Phil Goatley, Lay Member and Chair of Remuneration Committee and Audit Committee David Booker, Lay Member and Chair of Finance and Performance Committee Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Performance - highlights: • NHS People Plan including appointing a Health and Wellbeing Guardian for the CCG • Review of the Talent Management Processes regarding training and appraisals • Training report • Annual review of Committee terms of reference • 2020-21 Annual pay increase recommendation for Very Senior Managers

Finance and Performance Committee	The paramount role of the Committee, which met 12 times in 2020-21 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. The legal Directions were removed in December 2020 however the Committee continued to meet monthly to maintain scrutiny. Members: David Booker, Lay Member and Finance and Performance Committee Chair Simon Bell, Chief Finance Officer Michelle Carrington, Executive Director of Quality and Nursing-Chief Nurse Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Dr Andrew Lee, Executive Director of Primary Care and Population Health, to 31 October 2020 Phil Mettam, Accountable Officer Denise Nightingale, Executive Director of Transformation, Complex Care and Mental Health Stephanie Porter, Interim Executive Director of Primary Care and Population Health, from 1 November 2020 In attendance (non-voting): Caroline Alexander, Assistant Director of Delivery and Performance, for performance related items. Abigail Combes, Head of Legal and Governance, for specific items. Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee. Darren Williams, Senior Finance Manager, NHS England and NHS Improvement (North East and Yorkshire) Performance - highlights: • Monthly Financial Performance Report • Monthly Integrated Performance Report • Resilience and winter planning updates • Unplanned Care Working Group progress reports; changed to Urgent Care Transformation Programme with updates from January • Approval of a number of contract awards-extensions • Financial planning 2020-21 • 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 met twelve times in 2020-21 and was quorate on each occasion. The approach of meetings with a specific focus in alternate months was re-introduced from November. 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. Members: Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Michelle Carrington, Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience) Dr Andrew Lee, Executive Director of Primary Care and Population Health, to 31 October 2020 Dr Nigel Wells, Clinical Chair of the Governing Body (Deputy Chair) Secondary Care Doctor - Vacant In attendance (non-voting) reduced during COVID-19: Victoria Binks, Head of Engagement Abigail Combes, Head of Legal and Governance Sarah Fiori, Head of Quality Improvement and Research Jacqui Hourigan, Designated Nurse Safeguarding Children Karen McNicholas, Senior Quality Lead, Children and Young People Paula Middlebrook, Deputy Chief Nurse Christine Pearson Designated Nurse Safeguarding Adults Performance - highlights: • Patient stories • Quality and Patient Experience Report • Safeguarding Adults and Children updates • Report on Impact of COVID-19 on the Health and Wellbeing of our Population • COVID-19 and Staff Risk Assessment

	• Learning Disability Mortality Review (LeDeR) - Annual Report 2019-20 • Visiting professionals to care homes aide memoire • Medicine Safety Governance Processes in Primary Care • The Impact of Proactive Health Coaching on Primary and Secondary Care Activity and Patient Reported Outcomes • North Yorkshire and York CCG Safeguarding and Looked after Children Annual Report 2019-20 • North Yorkshire and York Safeguarding Adults Annual Report 2019-20 • MAPPA (Multi Agency Public Protection Arrangements) Annual Report 2019-20 • Focused meetings on Dementia, Eating Disorders and Wheelchair services

Primary Care Commissioning Committee	The committee met six times and was quorate on each occasion. Membership is NHS Vale of York CCG unless otherwise stated: Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Simon Bell, Chief Finance Officer David Booker, Lay Member and Chair of Finance and Performance Committee Chris Clarke, Senior Commissioning Manager - David Iley, Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber) Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee Dr Andrew Lee, Executive Director of Primary Care and Population Health, to 31 October 2020 Phil Mettam, Accountable Officer Stephanie Porter, Interim Executive Director of Primary Care and Population Health, from 1 November 2020 In attendance (non-voting): A representative from each of the Primary Care Networks - Dr Paula Evans represented South Hambleton and (North) Ryedale and Dr Tim Maycock represented Central York Healthwatch North Yorkshire representative Kathleen Briers - Lesley Pratt, Healthwatch York representative Dr Aaron Brown - Dr Andrew Moriarty, YOR Local Medical Committee representative

	Stephanie Porter, Assistant Director of Primary Care, to 31 October 2020 Sharon Stoltz, Director of Public Health, City of York Council Practice Manager Health and Wellbeing Board representative Performance - highlights: • Regular updates on development of Primary Care Networks • Regular updates on Coronavirus COVID-19 • Primary Care IT – COVID Response in Primary Care • Primary Care Intravenous Pilot • Three Month Social Prescribing Impact Report from York CVS • Medicines Safety Governance Processes in Primary Care • Primary care updates from NHS England and NHS Improvement North • Primary Care Commissioning Committee Annual Chair's Report

Table 8 – The CCG's strategic committees and highlights in 2020-21

2.3.1.1 Remuneration Committee attendances

Name	Role	Membership from	Attendance
David Booker	Lay Member and Chair of Finance and Performance Committee	1 April 2020	3-3
Phil Goatley	Lay Member and Chair of Audit Committee and Remuneration Committee	1 April 2020	3-3
Julie Hastings	Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee	1 April 2020	3-3

Table 9 – Remuneration Committee and member attendances in 2020-21

A further item was considered by members via email.

2.3.1.2 Non Remuneration Committee member attendances

Senior Human Resources Manager, Helen Darwin provided advice to the Committee that materially assisted in their consideration of remuneration matters and attended three meetings.

In addition to Helen Darwin, Lucy Townend, Human Resources Manager and Becky Blackburn, Human Resources Advisor, provided a range of general HR advice to the CCG during the 2020-21 financial year. The HR service was hosted by North Yorkshire CCG.

Phil Mettam, Accountable Officer, attended two meetings.

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

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

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

2.4 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-publications- and searching for "register".

2.5 Personal data related incidents

There have been no incidents that were reported to the Information Commissioner's Office during 2020-21.

2.6 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.

2.7 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.

2.8 Statement of Accountable Officer's Responsibilities

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

As the 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 NHS Vale of York CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

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.

2.9 Governance Statement

2.9.1 Introduction and context

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

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

As of December 2020, the Clinical Commissioning Group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. Directions in place prior to that point have been removed from the NHS England website but relate to issues around financial controls and governance arrangements, and the full text can be found in the CCG's annual report for 2019-20.

2.9.2 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.

2.9.3 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 page 62.

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

2.9.4 UK Corporate Governance Code

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

2.9.5 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.

2.9.6 Risk management arrangements and effectiveness

2.9.6.1 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.

2.9.7 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.

The CCG, in April 2020, agreed an interim governance position which suspended the use of the Risk Policy and Strategy during the COVID-19 pandemic. Whilst risk would still form part of the reports to the committees, particularly Finance and Performance Committee and Quality and Patient Experience Committee, the focus of all of the CCG time and resource was on matters related to the pandemic. This was initially on the local response to the pandemic including testing, hospital

capacity and community support and in the medium term looking at recovery work and ensuring that services could be delivered effectively going forward.

To this end the CCG agreed a position between April 2020 and November 2020 where risk was reported to Governing Body in a specific COVID-19 Board Assurance Framework which set out all risks related to the handling of the pandemic and was overseen by each relevant Director.

In November 2020 we returned to risk reporting in accordance with the policy and the review of that policy was delayed to April 2021 (from January 2021) to allow for the learning from the pandemic and the effectiveness review of committees to form part of the new policy if required.

2.9.8 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 so that the decision made is an informed one 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.

2.9.9 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.

2.9.10 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.

2.9.11 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, Patient Environment Action Team 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.

2.9.12 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, etc.
- National reports and guidance.
- Coroner's reports.
- Media and public perception.
- National Patient Safety Agency alerts.
- Central Alerting System 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.

2.9.13 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 are 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.

2.9.14 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.

2.9.15 Major risks

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

Red risks (score of 25 – 20)	L= Likelihood I = Impact	Amber risks (score of 20-10)	L= Likelihood I = Impact	Green risks (Score 10 and below)	L= Likelihood I = Impact
QN.09 SEND Inspection significant improvements needed	L – 5 I - 4	MH.04 Significant waiting times for ADHD and autism assessments	L – 4 I – 3	JC.26c Children's eating disorder provision	L – 2 I - 3
QN.18 Impact of changes to NYCC healthy child programme	L – 4 I - 4	JC.26a non compliance with CYP eating disorder wait requirements	L – 5 I – 3	ES.15 Create sustainable financial plans	L – 1 I – 2
QN.16 Initial health checks LAC	L – 4 I – 4	QN.20 Risk to patient safety due to increased nosicomial infection	L – 3 I - 4	ES.22 Cash Balance availability	L – 2 I – 3
QN.08 Planned care waiting list quality assessment	L – 4 I – 4	MH.01 Health checks in mental health patients not being done	L – 3 I - 4	ES.38 Failure to deliver a sustainable financial plan	L – 1 I – 2
QN.05 Poor discharge standards	L – 4 I – 4	MH.04 Excess waiting times for autism and ADHD diagnosis	L – 4 I - 4	IG.01 data may be compromised in the NECS transition	L – 1 I – 4
QN.06 Quality of IPC practices at the Trust	L – 2 I – 4	QN.03 Specialist nursing service quality	L – 3 I - 4	JC.30 Dementia diagnosis rates	L – 3 I – 3
QN.07 Referral for initial health checks processes	L – 3 I – 5	QN.13 Dispute over delivery of Hep C vaccine	L – 3 I - 4	QN.04 12 hour ED breaches	L – 3 I – 3
QN.12 Missed pertussis vaccine	L – 2 I – 4	JC.26b Children's Autims Assessments: Long waiting lists and non-compliance with NICE guidance for diagnostic process	L – 4 I - 3	QN.21 Therapies	L – 3 I – 3
COR.5 Staffing issues and resilience in the face of a restructure and potential recruitment freeze	L- 3 I – 4	QN.19 Risk to quality and safety to residents in care homes due to normal oversight and assurance frameworks not in place.	L – 3 I - 4		

Table 10 – Major risks

2.9.16 Other sources of assurance

2.9.16.1 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 uses a Board Assurance Framework for the purposes of monitoring progress against each of the CCGs strategic objectives. The CCG currently has 8 strategic objectives which the Board Assurance Framework reports on:

- Support General Practice and the wider primary care system to maintain a level of resilience to deliver safe and sustainable services;
- Supporting innovation and transformation in the development of sustainable mental health and complex care services;
- Working with partners to deliver the recovery of acute care across elective diagnostic, cancer and emergency care;
- Achieving and supporting system financial sustainability;
- Work with system partners to ensure provision of high quality, safe services;
- Work as partners to safeguard the vulnerable in our communities to prevent harm;
- Support the wellbeing of our staff and manage and develop the talent of those staff;
- Work with partners to tackle health inequalities and improve population health in the Vale of York.

Within each of these agreed seven 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.

2.9.16.2 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.

The CCG's annual Conflicts of Interest Audit has been completed, with a recommendation to publish up to date registers of interest, which has been completed.

2.9.17 Data Quality

The CCG receives a Business Intelligence service via North East 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.

2.9.18 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 year to date, with the 2020-21 submission requirements extended until autumn 2021.

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.

2.9.19 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.

2.9.20 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.

The Service Auditor's Reports have all identified control weaknesses to be addressed. Due to the nature of the services provided by third-party organisations, no information is provided from these organisations that is relied upon during preparation of the CCG's financial statements, and the CCG is satisfied that it has sufficient assurance in place. The content of the Service Auditor's Reports does not therefore affect the audit opinion of the CCG's external auditors.

2.9.21 Control issues

The CCG does not consider there to be any financial control issues.

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

Throughout 2019-20 the CCG saw stabilisation in both the CCG's in-year and underlying position. In February 2020 the CCG submitted a draft financial plan for 2020-21 which described a financial deficit of £16.3m and was compliant with the Financial Recovery Trajectory. This plan also demonstrated an improvement to the CCG's underlying position with a recurrent planned deficit of £15.4m.

However, the Covid-19 pandemic resulted in an interim financial framework being implemented to support financial stability and the operational pressures across the NHS. Although this supported the CCG's in-year financial position, the assessed underlying position at the end of 2020-21 is now a £27.6m deficit. This is largely due to many of the work streams underpinning the CCG's QIPP savings and transformational programmes being postponed during the pandemic response.

One of the key changes in 2020-21 was a move to block contracts with NHS providers. This has released considerable resource from contract negotiation and monitoring and has allowed the CCG and partner organisations to continue to build collaborative relationships which set the North Yorkshire and York system in good stead as we begin to develop an Integrated Care Partnership and Place in line with the draft NHS White Paper published in 2021.

The CCG has delivered on key investment commitments including mental health services and primary care capacity, in line with Governing Body commitments and national planning expectations.

Throughout 2020-21 the CCG has maintained its rigour in financial reporting, forecasting and assessment of financial risk. The CCG has been forecasting delivery of a break-even position 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 NHSE/I in its role as the CCG's regulatory body.

During the course of the Covid-19 pandemic, the CCG has ensured that a robust system of financial control remained in place. Temporary amendments were made to the Scheme of Delegation in April 2020 to allow the CCG to flexibly respond to the evolving requirements of the pandemic response, without compromising formal assurance processes. Financial reporting was swiftly amended and expanded on for areas of expenditure that were new or saw substantial change as a result of the pandemic. In addition, the CCG's internal audit function undertook a retrospective review of Covid-19 related expenditure in General Practice.

A key aspect of the Covid-19 pandemic response financial arrangements has been with regards to the Hospital Discharge Programme (HDP). The HDP was brought in to facilitate rapid and timely discharge from acute hospital providers to maximise available capacity for patients with Covid and was funded outside of the system financial envelope. Working closely with York Teaching Hospital NHS Foundation Trust and City of York Council in particular a discharge command centre was established with relevant staff, a number of schemes were put in place to avoid hospital admission or facilitate rapid discharge and funding was provided for the first 6 weeks of all packages of care. In conjunction with City of York Council finance team the CCG has had to establish new financial management arrangements across health and social care and a revised Section 75 arrangement to cover over £10m of expenditure. It is testament to the close working relationships from both an operational and financial perspective that this has been done robustly, effectively and in line with the national requirements.

The CCG's internal audit function has carried out annual audits covering budgetary control and forecasting and for the third year in a row 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 CCGs functions.

2.9.23 Delegation of functions

The CCG has not delegated any of its functions during 2020-21.

2.9.24 Counter fraud arrangements

The CCG has a team of accredited Counter Fraud Specialists (LCFS) that are contracted to undertake counter fraud work proportionate to identified risks.

In January 2020 the NHS Counter Fraud Authority (NHSCFA) issued Standards for commissioners – fraud, bribery and corruption to LCFSs and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In May 2020 the LCFS produced an annual counter fraud plan aligned to the standards.

The CCG's Audit Committee reviews and approves the annual counter fraud plan identifying the actions to be undertaken to promote an anti-fraud culture, prevent and deter fraud and investigate suspicions of fraud. The LCFS also produces an annual report for the CCG and regular progress reports for the review and consideration of the Chief Finance Officer and the Audit Committee.

The Chief Finance Officer for the CCG is proactively and demonstrably responsible for tackling fraud, bribery and corruption and the LCFS regularly attends the Audit Committee. The CCG has also appointed an officer at the CCG as a Counter Fraud Champion to assist and support the work of the LCFS.

The CCG's counter fraud arrangements are currently in compliance with NHSCFA's Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the appointment of the LCFSs, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud. However, it should be noted that these standards have subsequently been superseded by the Government Functional Standard GovS 013: Counter Fraud (Functional Standard), which was formally introduced in February 2021.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's Standards for commissioners: fraud, bribery and corruption, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA. The 2019-20 assessments for the three North

Yorkshire CCGs were completed and submitted in May 2020 with an overall assessment of green. This self-assessment process will be undertaken on behalf of the CCG in April 2021 against the new Functional Standard.

2.10 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 2021

1. Introduction

The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable 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 assist the Governing Body in the completion of its Annual Governance Statement, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS have faced unprecedented challenges due to COVID-19.

2. Executive Summary

This Head of Audit Opinion forms part of the Annual Report for NHS Vale of York Clinical Commissioning Group, in which the planned internal audit coverage and outputs during 2020/21 and Audit Yorkshire's Key Performance Indicators (KPIs) are detailed.

Key Area	Summary
Head of Internal Audit Opinion & the Role of Internal Audit	The overall opinion for the period 1st April 2020 to 31st March 2021 provides Significant Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Key Area	Summary
During the Pandemic	The Internal Audit Standards Advisory Board (IASAB) issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020). All our work has continued to be delivered in full compliance with the PSIAS. Audit Yorkshire adopted a pragmatic approach to the delivery of your Internal Audit Service during 20/21, with the focus on the delivery of your Head of Internal Audit Opinion. This again, was in line with the IASAB guidance. We supported you through the provision of a wide range of briefings, updates and benchmarking materials focused on helping you manage the challenges of COVID-19. We also supported the wider NHS systems across Audit Yorkshire's client base / geographies through the redeployment of our staff to maintain the effective delivery of services.
Planned Audit Coverage and Outputs	The 2020/21 Internal Audit Plan has been delivered with the focus on completion of high priority or 'must do' audits to support the provision of a meaningful Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. The impact on the organisation of COVID-19 required us to review your internal audit risk assessment and plan for 2020/21 on a regular basis, in liaison with yourselves. As part of this assessment we took account of the following: • How the organisation has implemented NHSE/I guidance, issued to support them in responding to COVID-19, whilst still discharging their stewardship responsibilities; • Any revisions to the organisation's strategic priorities as well as liaising with you to review areas for internal audit focus; and • Mandated review requirements and audits which from a professional internal audit perspective are pre-requisite to ensuring sufficient coverage for a robust Head of Internal Audit Opinion. Therefore review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; and • A range of individual risk-based assurance reviews. No limited coverage of any area of the plan occurred due to the impact of the pandemic.

Key Area	Summary
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

3. 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 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 Annual Governance Statement 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 Annual Governance Statement.

4. The Opinion

My opinion is set out as follows:

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

3. Opinion Definitions
4. Commentary.
5. Considerations for your Annual Governance Statement
6. Looking Ahead

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

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- 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.
- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Unless explicitly detailed within our reports, third party assurances have not been relied upon.

2. Overall Opinion

Our **overall opinion** for the period 1 April 2020 to 31 March 2021 is:

Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

3. Opinion Definitions

The following potential opinion levels are available when determining the overall Head of Internal Opinion. These levels link closely with our standard definitions for report opinions:

Opinion Level	HOIA Opinion Definition
High (Strong)	High assurance can be given that there is a strong system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are being applied consistently in all areas reviewed.
Significant (Good)	Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.
Limited (Improvement Required)	Limited assurance can be given as there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and internal control that could result in failure to achieve the organisation's objectives.

Opinion Level	HOIA Opinion Definition
Low (Weak)	Low assurance can be given as there is a weak system of internal control and/or significant weaknesses in the application of controls that will result in failure to achieve the organisation's objectives.

Where limited or low assurance is given the management of the Clinical Commissioning Group must consider the impact of this upon their overall Governing Body Assurance Framework and their Annual Governance Statement.

4. 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>

A combined audit of the Governance Framework and associated Risk Management processes was undertaken in 2020/21, for which a high assurance opinion was given.

The audit confirmed that CCG identified and maintained oversight of Covid-19 related risks and existing risks, and sound governance arrangements remained in place during 2020/21. Audit testing found that the composition of the Governing Body is in line with the CCG's Constitution, with good attendance recorded at the Governing Body meetings. Policy amendments required due to Covid-19 were ratified by the Governing Body on a timely basis; Terms of Reference and updates to the Scheme of Delegation were also presented and approved. Chair reports from each sub-committee were discussed by the Governing Body as were regular Covid-19 updates and action logs.

For the period April 2020 to November 2020, the CCG agreed an interim governance position, which suspended the use of the Risk Policy and Strategy and made changes to the conduct of meetings to free capacity. This was reported to the Governing Body. The interim governance arrangements did not require that formal updates to the Corporate Risk Register be carried out during this period. During the pandemic the Governing Body received assurance through a Covid-19 Board Assurance Framework (BAF)/Risk Register and through risk reports from the Quality & Patient Experience Committee and the Finance & Performance Committee. These sub-committees were found to have up-to-date Terms of Reference in place. The CCG also established red and blue Core Covid teams, each with a responsible Director and Deputy. The teams met at least weekly to discuss Covid-19 related issues and maintained a Covid-19 specific action log.

The CCG returned to the use of its Risk Policy and Strategy from 5 November 2020. In the lead up to its return, the CCG carried out a comprehensive review and refresh of the risk registers and its strategic objectives, and took good practice from the Covid-19 BAF/Risk Register and applied it to the BAF going forward.

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

Core & Risk Based Reviews Issued

We issued:

3 **high** assurance opinions:	Budgetary Control and Reporting & Key Financial Controls Safeguarding Children (Hosted by NY CCG) Risk Management and Governance Arrangements
7 **significant** assurance opinions:	Special Educational Needs & Disability Conflicts of Interest Section 117 Aftercare Primary Care Commissioning & Contracting: Contract Oversight and Management Functions Children's Continuing Care (Hosted by NY CCG) Restructure Planning and Implementation Safeguarding Adults (Hosted by NY CCG)
0 **limited** assurance opinions:	N/A
0 **low** assurance opinions:	N/A
0 reviews without an assurance rating	N/A

* In addition, fieldwork is ongoing to complete the mandated Data Security & Protection Toolkit, which will be finalised in time to achieve the submission dates per the national timetable. To date, no major areas of concern have been identified.

Follow Up

A total of 73 Internal Audit recommendations have been live during 2020/21 (this includes recommendations from previous years' reports that were still live in April 2020).

During the course of the year we have undertaken work to track the implementation of Internal Audit Recommendations. The Recommendation clear up summary 2020/21 was as follows:

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
0	10	8	55	73	0%

We can conclude that the organisation has made good progress with regards to the implementation of recommendations. The vast majority of recommendations are implemented on a timely basis. We can confirm that have received appropriate support from the Executive Directors in relation to these and recommendations have been regularly reviewed by the Audit Committee throughout the year.

5. Consideration for your Annual Governance Statement

The Head of Internal Audit Opinion is one source of assurance that the organisation has in providing its Annual Governance Statement and other third-party assurances should also be considered. In addition, the organisation should take account of other independent assurances that are considered relevant. We recommend that the Executive Summary above is used in your Annual Governance Statement.

A significant overall opinion has been provided.

6. Looking Ahead

This opinion is provided in the context that NHS Vale of York Clinical Commissioning Group like other organisations across the NHS continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and COVID-19 recovery. The COVID-19 pandemic led to changes to the NHS financial framework, the establishment of the control and command structures both regionally and within individual organisations and an ongoing focus on the emergency response. This has required NHS organisations to operate in a different way to previous 'business as usual' practice. Guidance was clear that financial constraints must not stand in the way of taking immediate and necessary action but that there was no relaxation in fiduciary duties.

Bold decision making will continue to be needed as organisations recover from COVID-19 whilst at the same time maintaining due focus on governance, probity and internal control. The maintenance of robust financial and organisational control is at the heart of the Head of Internal Audit Opinion and we will continue to work with the organisations we serve to provide timely advice and insight throughout 2021/22.

During the COVID-19 response, there has been an increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This focus on collaboration will continue as the NHS progresses on its journey towards integrated care systems.

Audit Yorkshire has refreshed its planning approach for 2021/22 to take account of the impact of COVID-19 and the moves towards integrating care. Our plans for 2021/22 therefore focus on post-COVID recovery, on how our work can make a real difference on Patient Care and on maximising opportunities for sharing knowledge and learning. In particular, the strategy we have adopted has ring fenced provision in plans to carry out co-ordinated audits across all Audit Yorkshire Members and clients, or at Place, ICS or Sector level. Our plans for 2021/22 leave us very well placed to support organisations in their delivery of the six key priority areas listed in the NHS Operational Planning Guidance issued on 25 March 2021.

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
May 2021

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
- Other explicit review-assurance mechanisms.

The outcome of the review has been to give assurance that the CCG has the necessary control mechanisms in place and that there are no significant control issues.

Conclusion

No significant control issues have been discovered.

2.11 Remuneration Report

2.11.1 Remuneration Committee

Membership and details of the Remuneration Committee's work can be found in the Members Report on page 62.

2.11.2 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.

2.11.3 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.

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

The tables on pages 103 – 106 show the CCG's Senior Manager Remuneration, including salary and pension benefits for 2019-20 and 2020-21.

2.11.4.1 Senior Manager Remuneration 2020-21 (including salary and pension benefits)

2020-21						
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)	150-155	0			95-97.5	245-250
P Mettam - Accountable Officer - see (c)	105-110	0			12.5-15	115-120
S Bell - Chief Finance Officer	120-125	0			35-37.5	155-160
M Carrington - Executive Director of Quality and Nursing	90-95	0			27.5-30	120-125
D Nightingale - Executive Director of Transformation, Complex Care and Mental Health	80-85	100			10-12.5	95-100
Dr A Lee - Executive Director of Primary Care and Population Health (to 31 Oct 2020)	45-50	0			12.5-15	55-60
S Porter - Interim Executive Director Primary Care and Population Health (from 1 Nov 2020)	35-40	0			12.5-15	45-50
D Booker - Lay Member	10-15	0			0	10-15
P Goatley - Lay Member	10-15	0			0	10-15
J Hastings - Lay Member	10-15	0			0	10-15
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 - 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 for their Governing Body roles. 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), his role as Named GP for Safeguarding in Primary Care (banded remuneration £35-40k) and his role as Clinical Chair of Humber Coast and Vale Integrated Care System (banded remuneration £130-135k).

(c) P Mettam is seconded to Humber, Coast and Vale Integrated Care System for 1 day per week. The remuneration disclosed above relates to his CCG role of Accountable Officer only. Total remuneration in 2020-21 across both organisations was £145-150k.

(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.

(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.

Table 11 - Senior Manager Remuneration 2020-21

2.11.4.2 Senior Manager Remuneration 2019-20 (including salary and pension benefits)

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			37.5-40	105-110
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 have been restated following provision of amended figures from NHS Pensions relating to values at 31 March 2020.

(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.

Table 12 - Senior Manager Remuneration 2019-20

1.11.4.3 Senior Manager pension benefits as at 31 March 2021

Table 13 - Senior Manager pension benefits as at 31 March 2021

2.11.4.4 Senior Manager pension benefits as at 31 March 2020

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	18	1,042	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)	0-2.5	0-2.5	25-30	55-60	373	27	424	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 have been restated following provision of amended figures from NHS Pensions relating to values at 31 March 2020.
(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 14 - Senior Manager pension benefits as at 31 March 2020

2.11.5 Cash equivalent transfer values

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

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

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

2.11.6 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).

2.11.7 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 2020-21.

2.11.8 Payments to past directors (subject to audit)

There have been no payments to past directors in 2020-21.

2.11.9 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 2020-21 was £175k - £180k (2019-20: £175k – 180k). This was 5.25 times (2019-20: 4.76) the median remuneration of the workforce, which was £33,779 (2019-20: £38,267).

The movement in the median remuneration for 2020-21 was due to minor changes in structure when vacancies arose throughout the year.

In 2020-21, no employees (2019-20, no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £15k - £20k to £135k - £140k (2019-20: £15k - £20k to £120k - £125k).

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.

2.12 Staff Report

2.12.1 Number of senior managers (subject to audit)

Pay band	Total
Band 8a	7
Band 8b	5
Band 8c	5
Band 8d	6
Band 9	0
VSM	5
Governing body	7
Any other Spot Salary	3

Table 15 - Senior managers by band

2.12.2 Staff numbers and costs (subject to audit)

2.12.2.1 Average number of people employed

	2020-21			2019-20
	Permanently employed Number	Other Number	Total Number	Total Number
Total	**112**	**3**	**115**	**116**
Of the above: Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

Table 16 - Average number of people employed

2.12.2.2 Salaries and Wages

	2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Salaries and wages	4,958	155	5,113
Social security costs	475	0	475
Employer contributions to NHS Pension scheme	886	0	886
Apprenticeship Levy	9	0	9
Less: recoveries in respect of employee benefits	(9)	0	(9)
Total employee benefits expenditure	**6,319**	**155**	**6,473**

Table 17 - Salaries and wages

2.12.3 Staff composition

Gender	Female	Male
Band 8a	4	3
Band 8b	4	1
Band 8c	4	1
Band 8d	3	3
Band 9	0	0
VSM	3	2
Governing body	3	4
Any other Spot Salary	1	2
All other employees (including apprentices)	75	17
Total	**97**	**33**

Table 18 - Staff composition

2.12.4 Staff sickness average

The staff sickness average for 2020-21 was 1.7%.

2.12.5 Staff turnover percentages

Staff turnover percentage for 2020-21 was 1.1%.

2.12.6 Staff engagement percentages

The CCG has an active staff engagement group which carries out its own methods of staff “temperature checks” rather than participate in the national staff survey, on

the basis that local surveys can provide more frequent assurance that is tailored to local needs.

2.12.7 Staff policies

The past year saw unprecedented changes, with all CCG staff working from home due to the COVID pandemic. This presented a variety of challenges in relation to the technical arrangements for home working and also ensuring health and wellbeing support for our staff. A comprehensive programme of health and wellbeing initiatives was set up. These included undertaking individual risk assessment for all our staff, which a particular focus on at risk categories such as ethnic minority staff, pregnant workers and those with underlying health conditions and were followed up with 1-1 health and wellbeing conversations. Throughout the year further individual support was provided along with regular staff briefings and innovative on-line support sessions.

The CCG started implementing actions within the NHS People Plan including developing further the role of Freedom to Speak Up Guardians and a Health and Wellbeing Guardian. The CCG has recorded no FTSU incidents during the 2020/21 financial year.

As a Disability Confident employer, the CCG actively encourages people with disabilities to apply for positions in the organisation. Applicants applying for roles within the CCG, who declare a disability, will be eligible for a guaranteed interview, providing they meet the minimum criteria within the person specification for the particular vacancy. The CCG is also signed up to the Mindful Employer Charter, documenting our commitment to show a positive and enabling attitude to employees and job applicants with mental health issues.

2.12.8 Social Partnership Forum

Recognising the benefits of partnership working, the CCG is a member of the Yorkshire and Humber Social Partnership Forum.

The aim of the Social Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Unions to discuss and debate issues in an environment of mutual trust and respect. In particular it:

- Engages employers and trade union representatives in meaningful discussion on the development and implications of future policy;
- Provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce;

- Promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

2.12.9 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:

2.12.9.1 Relevant union officials

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

Table 19- Relevant union officials

2.12.9.2 Percentage of time spent on facility time

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

Table 20 - Percentage of time spent on facility time

2.12.9.3 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 21 - Percentage of pay bill spent on facility time

2.12.9.4 Paid trade union activities

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

Table 22 - Paid trade union activities

2.12.10 Other employee matters

2.12.10.1 Expenditure on consultancy

The CCG incurred expenditure of £151k on consultancy during 2020-21. The consultancy services purchased in 2020-21 were to support the establishment of the Hospital Discharge Programme (HDP), and as such this HDP funding was allocated to the CCG to cover this expenditure in full.

2.12.10.2 Off-payroll engagements

There were no payments made relating to exit packages in 2020-21.

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

There were no payments made relating to exit packages in 2020-21.

2.13 Parliamentary Accountability and Audit Report

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

Annual Accounts

2020-21

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

Report on the audit of 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 2021, 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 accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, 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 2021 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; 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

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

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 2020/21 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.

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the CCG, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the CCG which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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.

Report on 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 2021.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

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

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

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 under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; 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.

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 satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.


Mark Kirkham (Jun 11, 2021 11:09 GMT+1)

Mark Kirkham, Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

11th June 2021

Audit Completion Certificate issued to the Governing Body of NHS Vale of York CCG for the year ended 31 March 2021

In our auditor's report dated 11 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 11 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

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

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 2021.

We have nothing to report in this respect.

Certificate

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

Mark Kirkham (Jul 30, 2021 13:08 GMT+1)

Mark Kirkham

Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

30 July 2021

NHS Vale of York CCG - Annual Accounts 2020-21

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The Primary Statements

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from services	2	(734)	(677)
Other operating income	2	(949)	(1,455)
Total operating income		**(1,683)**	**(2,132)**
Staff costs	4	6,483	6,752
Purchase of goods and services	5	534,998	507,369
Depreciation	5	9	0
Provision expense	5	25	126
Other operating expenditure	5	144	206
Total operating expenditure		**541,659**	**514,453**
Net operating expenditure		**539,976**	**512,321**
Finance expense	7	0	302
Net expenditure for the year		**539,976**	**512,623**
Comprehensive net expenditure for the year		**539,976**	**512,623**

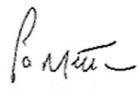
The notes on pages 5 to 29 form part of this statement.

Statement of Financial Position as at 31 March 2021

	Note	31 March 2021 £'000	31 March 2020 £'000
Non-current assets			
Property, plant and equipment	9	9	18
Total non-current assets		**9**	**18**
Current assets			
Trade and other receivables	10	4,357	2,795
Cash	11	167	92
Total current assets		**4,524**	**2,887**
Total assets		**4,533**	**2,905**
Current liabilities			
Trade and other payables	12	(37,694)	(26,467)
Provisions	13	(147)	(139)
Total current liabilities		**(37,841)**	**(26,606)**
Assets less liabilities		**(33,308)**	**(23,701)**
Financed by taxpayers' equity			
General fund		(33,308)	(23,701)
Total taxpayers' equity		**(33,308)**	**(23,701)**

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 28th May 2021 and signed on its behalf by:



Phil Mettam
Accountable Officer
10th June 2021

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 1 April 2020	**(23,701)**	**(23,701)**
Changes in taxpayers' equity for 2020-21		
Net operating expenditure for the financial year	(539,976)	(539,976)
Net funding	530,369	530,369
Balance at 31 March 2021	**(33,308)**	**(33,308)**

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

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

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(539,976)	(512,623)
Depreciation	5	9	0
Other gains and losses	7	0	302
(Increase)/decrease in trade and other receivables	10	(1,562)	2,501
Increase/(decrease) in trade and other payables	12	11,227	(1,927)
Provisions utilised	13	(17)	(9)
Increase in provisions	13	25	126
Net cash outflow from operating activities		**(530,294)**	**(511,630)**
Cash flows from investing activities			
(Payments) for property, plant and equipment	9	0	(18)
Net cash outflow from investing activities		**0**	(18)
Net cash outflow before financing		**(530,294)**	**(511,648)**
Cash flows from financing activities			
Grant in aid funding received		530,369	511,610
Net cash inflow from financing activities		**530,369**	**511,610**
Net increase/(decrease) in cash	11	**75**	**(38)**
Cash at the beginning of the financial year		**92**	**130**
Cash at the end of the financial year		**167**	**92**

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 Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2020-21, 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 the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The Clinical Commissioning Group's accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.2 Accounting Convention

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

1.3 Joint Arrangements - Interests in Joint Operations

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

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

The Clinical Commissioning Group has entered into three 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).

Whilst the section 75 agreements constitute joint operations under IFRS 11, the substance of the commissioning transactions related to the Funds' spending plans indicates that neither the CCG nor the councils are either a joint operator or lead commissioner. Therefore, each organisation accounts for its own transactions without recognising its interest in its share of total assets, liabilities, revenue and expenditure that related to the whole Funds. The income and expenditure relating to these arrangements are detailed in Note 17 - Joint Arrangements - Interests in Joint Operations.

Notes to the Financial Statements

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 Bradford District and Craven CCG
NHS East Riding of Yorkshire CCG
NHS North Yorkshire 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.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Clinical Commissioning Group has not entered into any joint ventures.

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 will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in 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 International Accounting Standard (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 non-consolidated performance pay earned but not yet paid.

Notes to the Financial Statements

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

1.5.2 **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 assets and liabilities. Therefore, the schemes are accounted for as if they were defined contribution schemes; the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

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

1.6 **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 Cinical 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.

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 that is held for operational use is 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.

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

1.8.4 **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.

1.9 **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.

1.9.1 **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.

1.10 **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.

1.11 **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.

Notes to the Financial Statements

1.12 **Clinical Negligence Costs**

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

1.13 **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.

1.14 **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.

1.15 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the contractual provision of the financial instrument 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 when the asset has been transferred and the Clinical Commissioning Group has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

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

1.15.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect 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.

Notes to the Financial Statements

1.15.2 **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.

1.16 **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.

The Clinical Commissioning Group's financial liabilities are classified as other financial liabilities.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.17 **Value Added Tax**

Most of the activities of the Clinical Commissioning Group are outside the scope of value added tax (VAT). 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.

1.18 **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).

1.19 **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.

Notes to the Financial Statements

1.19.1 **Critical Accounting Judgements in Applying Accounting Policies**

No critical judgements, apart from those involving estimations (see below), have been made in the process of applying the Clinical Commissioning Group's accounting policies that have a significant effect on the amounts recognised in the financial statements.

1.19.2 **Sources of Estimation Uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amount of assets and liabilities within the next financial year:

• Accruals:

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

Prescribing - the full year figure is estimated on the spend for the first 10 months of the year based upon historic prescribing patterns. Within the total reported prescribing expenditure for 2020-21, 16.04% is based on estimated figures with a value of £8,775k. Due to the value of this, a review of the accuracy level for prescribing estimates throughout 2020-21 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) of £4,744k is estimated based on GP practice achievement in 2019-20. Payment for 2020-21 will be reconciled and paid to GP practices in June 2021.

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

The GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

The application of IFRS 16 Leases in 2022-23 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 2020-21 right-of-use assets of approximately £816,000 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 2020-21 if it were applied in year.

2. Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Income from services		
Non-patient care services to other bodies	276	425
Prescription fees and charges	449	234
Other contract income	0	18
Recoveries in respect of employee benefits	9	0
Total income from services	**734**	**677**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	65	84
Non cash apprenticeship training grants revenue	6	3
Other non-contract revenue	878	1,368
Total other operating income	**949**	**1,455**
Total operating income	**1,683**	**2,132**

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

	2020-21				2019-20
	Non-patient care services to other bodies	Prescription fees and charges	Recoveries in respect of employee benefits	Total contract income	Total contract income
	£'000	£'000	£'000	£'000	£'000
Source of income					
NHS	0	0	0	0	0
Non NHS	276	449	9	734	677
Total	**276**	**449**	**9**	**734**	**677**

	2020-21				2019-20
	Non-patient care services to other bodies	Prescription fees and charges	Recoveries in respect of employee benefits	Total contract income	Total contract income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	0	0	9	9	18
Over time	276	449	0	725	659
Total	**276**	**449**	**9**	**734**	**677**

4. Employee Benefits and Staff Numbers

4.1 Employee Benefits

	2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	4,958	155	5,113
Social security costs	475	0	475
Employer contributions to NHS Pension Scheme	886	0	886
Apprenticeship Levy	9	0	9
Gross employee benefits expenditure	**6,328**	**155**	**6,483**
Less recoveries in respect of employee benefits (note 4.1.1)	(9)	0	(9)
Total net employee benefits	**6,319**	**155**	**6,474**

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

	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
Gross employee benefits expenditure	**6,483**	**269**	**6,752**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total net employee benefits	**6,483**	**269**	**6,752**

4.1.1 Recoveries in Respect of Employee Benefits

	2020-21		2019-20
	Permanent Employees £'000	Total £'000	Total £'000
Employee benefits - revenue			
Salaries and wages	(7)	(7)	0
Social security costs	(1)	(1)	0
Employer contributions to the NHS Pension Scheme	(1)	(1)	0
Total recoveries in respect of employee benefits	**(9)**	**(9)**	**0**

4.2 Average Number of People Employed

	2020-21			2019-20
	Permanently employed Number	Other Number	Total Number	Total Number
Total	**112**	**3**	**115**	**116**

4. Employee Benefits and Staff Numbers (continued)

4.3 Exit Packages Agreed in the Financial Year

There were no exit packages agreed in 2020-21 (2019-20: £282,029).

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

There were no payments for other agreed departures made in 2020-21 (2019-20: nil).

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

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

4.4.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020 updated to 31 March 2021 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.

4.4.1 Accounting Valuation (continued)
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 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. In 2020-21, NHS Clinical Commissioning Groups continued to pay over contributions at the former rate with the additional amount being paid by NHS England on Clinical Commissioning Groups' behalf. The full cost and related funding has been recognised in these accounts.

For 2020-21, the Clinical Commissioning Group paid £634,206 of employers' contributions directly to the NHS Pensions Scheme (2019-20: £603,638) at the rate of 14.38% of pensionable pay. The Clinical Commissioning Group has expenditure of £609,570 in total for employers' contributions in 2020-21 (2019-20: £584,419). This figure differs from the direct payment to the NHS Pensions Scheme because it includes contributions made by other organisations and recharged to the Clinical Commissioning Group, and is net of contributions paid by the Clinical Commissioning Group and recharged to other organisations. NHS England paid an additional 6.3%, £276,239, on behalf of the Clinical Commissioning Group, which is accounted for within the Clinical Commissioning Group accounts (2019-20 £274,907). These costs are included in the NHS Pension line of note 4.1.

5. Operating Expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,390	1,315
Services from foundation trusts	308,922	296,941
Services from other NHS trusts	31,732	30,979
Purchase of healthcare from non-NHS bodies	67,498	63,400
Prescribing costs	53,425	50,561
General ophthalmic services	90	140
GPMS, PMS and APMS	52,144	47,590
Rentals under operating leases	153	201
Supplies and services – clinical	274	248
Supplies and services – general	13,128	10,930
Consultancy services	151	167
Establishment	758	1,534
Transport	2,097	2,186
Premises	1,026	933
Audit fees	56	52
Other non statutory audit expenditure	9	1
Internal audit services	39	39
Other professional fees	6	8
Legal fees	67	56
Education, training and conferences	28	85
Non cash apprenticeship training grants	5	3
Total purchase of goods and services	**534,998**	**507,369**
Depreciation charges		
Depreciation	9	0
Total depreciation charges	**9**	0
Provision expense		
Provisions	25	126
Total provision expense	**25**	**126**
Other operating expenditure		
Chair and Non-Executive Members	119	130
Research and development (excluding staff costs)	20	33
Expected credit loss on receivables	5	35
Other expenditure	0	8
Total other operating expenditure	**144**	**206**
Total operating expenditure	**535,176**	**507,701**

The Audit fees included above are inclusive of VAT payable on external audit fees.

Non statutory 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 higher rate than their overall published programme funding.

6. Better Payment Practice Code

6.1 Measure of Compliance	2020-21 Number	2020-21 £'000	2019-20 Number	2019-20 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	10,483	129,812	10,349	131,769
Total non-NHS trade invoices paid within target	10,200	127,131	10,034	130,861
Percentage of non-NHS trade invoices paid within target	**97.30%**	**97.93%**	**96.96%**	**99.31%**
NHS payables				
Total NHS trade invoices paid in the year	1,091	351,286	3,338	333,955
Total NHS trade invoices paid within target	1,061	351,008	3,277	333,306
Percentage of NHS trade invoices paid within target	**97.25%**	**99.92%**	**98.17%**	**99.81%**

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 (2019-20: nil).

7. Other Gains and Losses

	2020-21 £'000	2019-20 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	0	(302)
Total	**0**	**(302)**

8. Operating Leases

8.1 As Lessee

In 2020-21, 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.

The Clinical Commissioning Group leases additional office space for Continuing Healthcare staff from York and Scarborough Teaching Hospitals NHS Foundation Trust. 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 2020-21, charges for void and subsidy costs of £697,700 have been included within premises expenditure (2019-20: £614,839).

8.1.1 Payments Recognised as an Expense

	2020-21			2019-20		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	152	1	**153**	201	0	**201**
Total	**152**	**1**	**153**	**201**	**0**	**201**

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.

8.1.2 Future Minimum Lease Payments

	2020-21		2019-20
	Other £'000	Total £'000	Total £'000
Payable:			
No later than one year	2	**2**	0
Between one and five years	8	**8**	0
After five years	0	**0**	0
Total	**10**	**10**	**0**

9. Property, Plant and Equipment

	31 March 2021			31 March 2020	
	Information technology £'000	Total £'000	Plant and machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April	18	18	756	0	756
Additions purchased	0	0	0	18	18
Disposals other than by sale	0	0	(756)	0	(756)
Cost or valuation at 31 March	**18**	**18**	**0**	**18**	**18**
Depreciation 01 April	0	0	454	0	454
Disposals other than by sale	0	0	(454)	0	(454)
Charged during the year	9	9	0	0	0
Depreciation at 31 March	**9**	**9**	**0**	**0**	**0**
Net book value at 31 March	**9**	**9**	**0**	**18**	**18**
Purchased	9	9	0	18	18
Total at 31 March	**9**	**9**	**0**	**18**	**18**
Asset financing:					
Owned	9	9	0	18	18
Total at 31 March	**9**	**9**	**0**	**18**	**18**

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 31 March 2021 £'000	Current 31 March 2020 £'000
NHS receivables: revenue	3,130	515
NHS prepayments	64	954
NHS accrued income	465	509
Non-NHS and other WGA* receivables: revenue	64	92
Non-NHS and other WGA prepayments	320	445
Non-NHS and other WGA accrued income	11	37
Non-NHS and ther WGA contract receivable not yet invoiced/non-	245	216
Expected credit loss allowance - receivables	(1)	(3)
VAT	58	30
Other receivables and accruals	1	0
Total trade and other receivables	**4,357**	**2,795**

* 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

	31 March 2021		31 March 2020	
	DHSC group bodies £'000	Non DHSC group bodies £'000	DHSC group bodies £'000	Non DHSC group bodies £'000
By up to three months	690	32	0	8
By three to six months	0	0	0	21
By more than six months	0	0	18	7
Total	**690**	**32**	**18**	**36**

11. Cash

	31 March 2021 £'000	31 March 2020 £' 00
Balance at 01 April	92	130
Net change in year	75	(38)
Balance at 31 March	**167**	**92**
Made up of:		
Cash with the Government Banking Service	167	92
Cash in statement of financial position	**167**	**92**
Balance at 31 March 2021	**167**	**92**

12. Trade and Other Payables

	Current 31 March 2021 £'000	Current 31 March 2020 £'000
NHS payables: revenue	1,232	1,060
NHS accruals	6	2,127
NHS deferred income	0	56
Non-NHS and other WGA payables: revenue	11,994	2,852
Non-NHS and Other WGA accruals	23,228	18,988
Social security costs	69	67
Tax	58	54
Other payables and accruals	1,107	1,263
Total trade and other payables	**37,694**	**26,467**

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

Other payables include £91,739 outstanding pension contributions at 31 March 2021 (31 March 2020: £86,830).

13. Provisions

	Current 31 March 2021 £'000	Current 31 March 2020 £'000
Restructuring	103	98
Continuing care	44	41
Total	**147**	**139**

The Clinical Commissioning Group has no non-current provisions.

	Restructuring £'000	Continuing Care £'000	Total £'000
Balance at 1 April 2020	**98**	**41**	**139**
Arising during the year	5	44	**49**
Utilised during the year	0	(17)	**(17)**
Reversed unused	0	(24)	**(24)**
Balance at 31 March 2021	**103**	**44**	**147**
Expected timing of cash flows:			
Within one year	103	44	**147**
Balance at 31 March 2021	**103**	**44**	**147**

The Clinical Commissioning Group 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 and has remained seconded with them in 2020-21. 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

There are no contingent liabilities in 2020-21.

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 and currency 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. The majority of these receivables are with NHS organisations and are therefore deemed to be low risk.

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.

15.1.4 Financial Instruments

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

15. Financial Instruments (continued)

15.2 Financial Assets

	Financial assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	2,286	**2,286**	779
Trade and other receivables with other DHSC group bodies	1,310	**1,310**	257
Trade and other receivables with external bodies	321	**321**	334
Cash	167	**167**	92
Total at 31 March	**4,084**	**4,084**	**1,462**

15.3 Financial Liabilities

	Financial liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000	Total 2019-20 £'000
Trade and other payables with NHSE bodies	949	**949**	814
Trade and other payables with other DHSC group bodies	394	**394**	2,594
Trade and other payables with external bodies	35,117	**35,117**	21,619
Other financial liabilities	581	**581**	677
Total at 31 March	**37,041**	**37,041**	**25,704**

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 2020-21 Expenditure £'000	Amounts recognised in CCG accounts 2019-20 Expenditure £'000
Better Care Fund - City of York Health and Wellbeing Board	NHS Vale of York CCG City of York Council	Health and Social Care pooled commissioning budget	12,728	12,1[illegible]4
Better Care Fund - North Yorkshire Health and Wellbeing Board	NHS Vale of York CCG NHS Bradford District and Craven CCG NHS North Yorkshire CCG NHS Morecambe Bay CCG North Yorkshire County Council	Health and Social Care pooled commissioning budget	8,256	7,8[illegible]6
Better Care Fund - East Riding Health and Wellbeing Board	NHS Vale of York CCG NHS East Riding of Yorkshire CCG East Riding of Yorkshire County Council	Health and Social Care pooled commissioning budget	1,439	1,3[illegible]4

18. Related Party Transactions

Details of related party transactions in 2020-21 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	5,562	4	19	0
Sharon Stolz - Governing Body attendance - Director of Public Health, City of York Council	22,770	383	5,380	45
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Surgery	3,030	0	0	0
Dr Helena Ebbs - Governing Body GP - GP Partner Pickering Medical Practice	2,024	0	11	0
Dr Ruth Walker - Governing Body GP - GP Partner Scott Road Medical Practice	1,242	1	7	0
Dr Christopher Stanley - Governing Body GP - Haxby Group Practice	4,777	1	11	0
Dr Christopher Stanley - Governing Body GP - Nimbuscare Limited	1,954	0	4	0
Beech Tree Surgery	3,030	0	0	0
Dalton Terrace Surgery	960	0	0	0
East Parade	73	1	0	0
Elvington Medical Practice	1,934	0	0	0
Escrick Surgery	1,463	0	0	0
Front Street Surgery	963	0	1	0
Haxby Group Practice	4,777	1	11	0
Helmsley Medical Centre	569	0	0	0
Jorvik Gillygate Practice	3,091	1	1	0
Kirkbymoorside Surgery	1,275	6	0	1
Millfield Surgery	1,277	0	0	0
MyHealth	3,147	1	0	0
The Old School Medical Practice	882	0	0	0
Pickering Medical Practice	2,024	0	11	0
Pocklington Group Practice	3,070	0	4	0
Posterngate Surgery	2,708	1	1	0
Priory Medical Group	7,608	4	106	0
Scott Road Medical Centre	1,242	1	7	0
Sherburn Group Practice	1,568	0	0	0
South Milford Surgery	2,396	0	10	0
Stillington Surgery	1,007	0	0	0
Tadcaster Medical Centre	1,529	0	0	0
Terrington Surgery	380	0	0	0
Tollerton Surgery	895	0	0	0
Unity Health	1,769	0	7	0
York Medical Group	5,562	4	19	0

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

The Department of Health and Social Care is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are listed below:

- NHS England
- NHS North Yorkshire CCG
- York and Scarborough Teaching Hospitals 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

Other material transactions have been with City of York Council and North Yorkshire County Council.

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
Simon Bell - Chief Finance Officer -partner worked as 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	281	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
Helmsley Medical Centre	504	0	0	0
Jorvik Gillygate Practice	2,377	0	1	0

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Kirkbymoorside Surgery	904	7	0	0
Millfield Surgery	1,186	0	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
Pocklington Group Practice	2,934	0	0	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
Stillington Surgery	906	0	0	0
Tadcaster Medical Centre	1,352	0	0	0
Terrington Surgery	347	0	0	0
Tollerton Surgery	921	0	16	0
Unity Health	1,749	6	0	0
York Medical Group	4,966	11	2	2

The Department of Health and Social Care is regarded as a related party. During 2019-20 the Clinical Commissioning Group 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

Other material transactions were 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:

	2020-21		2019-20	
	Target	Performance	Target	Performance
Expenditure not to exceed income	548,187	548,184	518,386	518,385
Capital resource use does not exceed the amount specified in Directions	0	0	19	18
Revenue resource use does not exceed the amount specified in Directions	539,979	539,976	512,624	512,623
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	6,935	6,343	7,825	7,405

21. Losses and Special Payments

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

21.1 Losses

	2020-21		2019-20	
	Total number of cases Number	Total value of cases £'000	Total number of cases Number	Total value of cases £'000
Administrative write-offs	4	7	55	35
Total	**4**	**7**	**55**	**35**

The administrative write-offs are 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 and Scarborough Teaching Hospitals NHS Foundation Trust whereby the Clinical Commissioning Group recognises 50% of any unrecoverable overseas visitors charges.These amounts are reported on an accruals basis but excluding provisions for future losses.

21.2 Special Payments

	2020-21		2019-20	
	Total Number of Cases Number	Total Value of Cases £'000	Total Number of Cases Number	Total Value of Cases £'000
Ex-gratia payments	0	0	1	2
Total	**0**	**0**	**1**	**2**