NHS
Vale of York
Clinical Commissioning Group

Annual Report and Accounts

2014-15

The best health and wellbeing for everyone.

Annual Report and Accounts 2014-15

Issue date: 29-05-2015

Document number: ARA14-15_FINAL

Prepared by: NHS Vale of York Clinical Commissioning Group Governing Body

Section A: Annual Report 2014-15

Welcome to the Annual Report and Accounts of NHS Vale of York Clinical Commissioning Group (CCG) for 2014-15. All NHS organisations are required to publish an annual report and financial accounts at the end of each financial year.

This report provides an overview of the CCG's work between 1 April 2014 and 31 March 2015. The report is made up of two parts. The first part is a summary of the CCG's business, performance and projects over the past year, as well as commentary on wider events which have shaped its work and priorities as an organisation. The second is the financial accounts for the year 2014-15.

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

The CCG held six board meetings and a series of Public and Patient Engagement (PPE) events in 2014-15. These events were open to the public. The dates, times and venues of these and future events can be found on the CCG's website: http://www.valeofyorkccg.nhs.uk/

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

You can contact the CCG in the following ways:

Write to NHS Vale of York Clinical Commissioning Group
West Offices
Station Rise
York
Y01 6GA

Phone 01904 555 870
E-mail valeofyork.contactus@nhs.net
Tweet @Valeofyorkccg

Section A

Table of tables

Table of figures

1. Welcome from the Chair and Chief Clinical Officer

Dr Mark Hayes
Chief Clinical Officer

Professor Alan Maynard
Lay Chair

Welcome to the CCG's report on the results of its second year. 2014-2015 was challenging on a number of fronts but ultimately it was a successful one for the CCG.

How is success defined in the context of an organisation working in such a complex environment? Ultimately success is based upon how the CCG demonstrates progress towards the aim of achieving the best health and well-being for everyone in the community. In the last year the CCG has taken a number of significant steps that will result in improved services for the people who live in the Vale of York.

Mental health and learning disability services

The CCG undertook a consultation exercise in the summer of 2014 to establish the local opinion of 'what good looks like' in the delivery of mental health and learning disability services. From this work a new service specification was created and the service procured with a commencement date of October 2015.

Alongside this the CCG worked with its partners to provide an interim enhancement of the wards of Bootham Park Hospital and with the award of the new contract, the CCG will be rapidly moving towards the creation of a new hospital in York for patients with mental health needs.

Urgent care services

The CCG contracted a new Out of hours GP service provider for the Vale of York. This unified service replaced the historic arrangement that was provided by three different organisations. The service specification was also the result of a detailed consultation process that involved the public and other stakeholders.

Elective orthopaedic services

To enhance the provision of orthopaedic services in the city, an independent sector treatment centre was built in York ten years ago. The contract to deliver these services ended in 2014 and following a procurement process, the contract was awarded to the existing provider.

The integration of health and social care

The CCG has gained national recognition for its work with partners in pursuing the goal of creating a seamless integration of health and social care. In October 2014 the CCG was one of only six CCG's in the country to be part of the 'New models of care' programme and in January 2015 it was one of only 11 CCGs to be given Pioneer Wave 2 status.

This is recognition of the progress that the CCG has made with its partners at City of York Council, North Yorkshire County Council, East Riding of Yorkshire Council, York Teaching Hospital Foundation Trust, the voluntary sector and its member practices.

Primary care

Like most commissioners in the NHS, the CCG views primary care as the core component of any future health service. That is why the CCG has worked closely with its member practices to enhance their ability to deal with rising demands.

The CCG created a 'general practice improvement programme' which is being rolled out across the Vale of York. This programme is tailored to the individual needs of the practices and draws on established theories of improvement science. Recognising the importance of continuous improvement and training, the CCG has also introduced a programme of training sessions for colleagues in primary care.

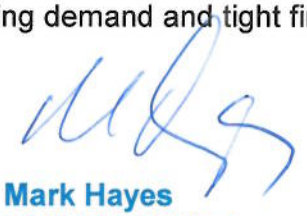
Financial Performance

The CCG successfully met all of the NHS business rules. This is the first time that the local commissioner has achieved this, including the delivery of a 1% surplus. This strong financial performance underpins the CCG's ability to pursue and deliver improvement whilst providing increased funding to mental health and learning disability services and recommencing the provision of In-Vitro Fertilisation (IVF) services in the Vale of York.

The future

The CCG has had two very successful years and has developed a national reputation for innovation. Maintaining this success into a third year and beyond will be very challenging. The NHS is under unprecedented financial strain and nationally both providers and commissioners are preparing deficit financial plans. There has been recognition of an £8 billion annual gap in funding by 2020. The reality is that there remains to be a problem now.

The CCG is working on initiatives for 2015-16 that will seek to address the issues of rising demand and tight financial funding.



Dr Mark Hayes
Chief Clinical Officer

Professor Alan Maynard
Lay Chair

2. Member practices introduction

Dr Tim Hughes
Chair - Council of Representatives (Member practices)

Planning for the future

One of the strongest features of the CCG is the strength of its primary care membership. GPs and practice staff bring their knowledge and understanding of patient experiences, local services and the health needs of the community to help to shape services in the Vale of York.

This expertise is a key enabler to help deliver the CCG's commissioning plans. The plans were set out in the CCG's five year strategy – an Integrated Operational Plan for 2014-19 and working closely with member practices and Health and Wellbeing Boards in North Yorkshire, York and East Riding of Yorkshire, the CCG has focussed upon the areas of greatest need by improving service quality, performance and efficiency whilst embedding its plans for the integration of health and social care.

Achieving financial balance

Whilst planning for the future, throughout 2014-15 the CCG delivered its financial plan, generating a surplus of £3.85m (1%). The CCG is to be commended for this, especially as this was achieved for the second year running whilst it dealt with the challenges of the on-going financial environment that the NHS is faced with.

Engaging and involving the community

Throughout its improvement planning and delivery, the CCG has proactively delivered a wide range of quality engagement and involvement approaches with patients, service users and other stakeholders. The feedback gathered from these events and other conversations have helped to shape commissioning decisions, service specifications and improvement programmes in 2014-15.

In a novel approach to gaining stakeholder views, the CCG hosted an event that handed the commissioning reins over to the public. The 'Be the commissioner' event was a simplified version of the process and the outcomes provided the CCG with an insight into what the local community viewed as important.

Pioneering through partnerships

In January 2015, the CCG was awarded Integrated Care Pioneer status for its work around partner collaboration to provide a truly seamless health and social care system that embraced innovation to deliver high quality care.

Throughout 2014-15 the views of stakeholders were a founding principle in the CCG's work to integrate health and social care. Patient opinions such as 'I want to tell my story only once' and 'better co-ordination of care' led the way to three pilot projects that were delivered by the CCG and partners in primary care, acute care and the voluntary sector. The schemes; testing approaches to deliver proactive, community-centred care, were the first steps to look at alternative ways of combining and integrating the resources of the public sector, independent sector and assets in the community to deliver joined-up care and improved outcomes for patients whilst developing approaches to share data and care plans.

Initially focusing upon the frail elderly and those with long term conditions, the pilots focussed upon ways to assess, diagnose and deliver care to enable individuals to remain at home or return there as early and safely as possible following ill-health or a crisis. The CCG incorporated the core themes of prevent, reduce, delay, that are enshrined in the Care Act. In order to achieve this vision the CCG worked to deliver a significant shift in the provision of care and support and to achieve this within tighter budgets through its drive to deliver more care and support in a more effective and efficient way.

The integration of health and social care through the Better Care Fund

The collaboration of the CCG and its partners at City of York Council, North Yorkshire County Council, East Riding of Yorkshire Council, North Yorkshire Police, acute trusts, member practices and other care providers has led to the provision of better support at home and earlier treatment in the community so people can remain healthy and independent in their own home without the need for urgent hospital care.

The Better Care Fund has been the conduit for the CCG and its partners to work in partnership and jointly produce schemes and seamless care that:

- wraps around the individual;
- where possible, provides care outside of hospital settings to deliver reduced hospital admissions and rapid discharge after admission to hospital;
- supports better end of life care and;
- increases collaboration across organisations to deliver seamless care.

Annual evaluation of Membership Body effectiveness

The Membership Body is pleased to report that the CCG has continued with its robust evaluation and governance measures throughout 2014-15.

In addition to the on-going evaluation of effectiveness from external sources, internal governance functions drive the delivery of the CCG's Five Year Integrated Operational Plan 2014-19, monitoring its delivery, reporting on progress and providing assurance. The CCG's internal governance and assurance measures include:

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

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

NHS England Area Team - NHS England's Yorkshire and Humber Area Team review the CCG on a quarterly basis. The 2014-15 quality and assurance reviews have been very positive and have strengthened the joint co-commissioning relationship with NHS England.

The membership congratulates the CCG on its ability once again to confront the financial challenges and achieve financial balance, whilst delivering innovative healthcare projects.

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

3. Strategic Report

3.1 About us and our community

NHS Vale of York Clinical Commissioning Group (CCG) is an NHS organisation which is led by clinicians that see patients every day and understands the needs of the community and the impact that local services have on patients' health.

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

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

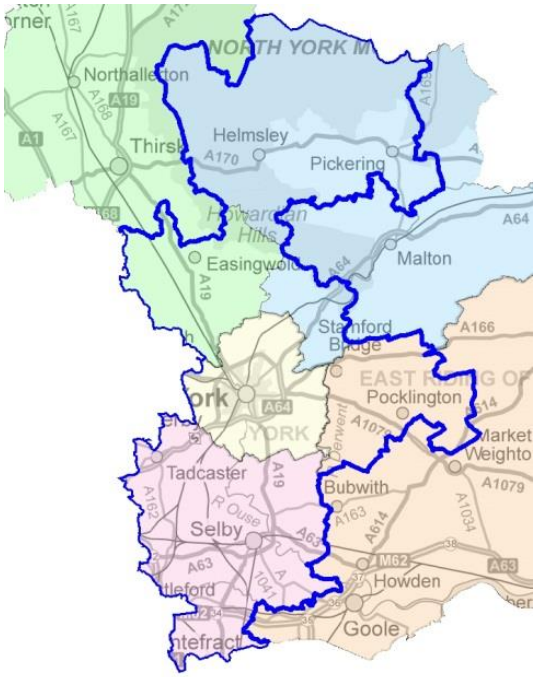


Fig 1 The NHS Vale of York CCG operating area.

3.1.1 CCG footprint

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

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

In 2014-15, the CCG had 31 member GP practices in its operating area and an annual commissioning budget is £376.4m. The budget is set by central government and based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

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

3.1.2 CCG accountability

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

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

3.1.3 Location of the CCG

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

3.1.4 The CCG's vision

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

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

3.1.5 The CCG's mission

The CCG's mission is to:

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

3.1.6 The CCG's values

- Communication – Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
- Courage – We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.
- Empathy – We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.
- Equality – We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.

- Innovation – We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
- Integrity – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.

3.2 The CCG's achievements in 2014-15

The CCG's work in 2014-15 realised the following achievements:

- Financial balance achieved after inheriting debt from North Yorkshire and York Primary Care Trust which carried forward a deficit for many years.
- One of six New Models of Care national pilot sites for integrated working.
- Awarded Wave 2 Pioneer status to develop the integrated care system with the NHS England New Models of Care team.
- Recommencement of In Vitro fertilisation (IVF) services.
- Commencement of the following new services: Bone protection service, Hospice at Home, Urgent Care Practitioners, Psychiatric Liaison service, improvements to prescribing pathways for a number of chronic and acute conditions, new acute Back Pain Pathway.
- Extensive redesign of community diabetes and neurology services to provide more care closer to home.
- £245,000 of additional funding for delivering Improved Access to Psychological Therapies (IAPT) and an associated increase in IAPT uptake.
- 24/7 psychiatric liaison service in the Emergency Department at York Hospital to safely and effectively manage patients presenting with psychiatric requirements.
- Improvement in dementia diagnosis rates supported by a new Directed Enhanced Service with the support of Strategic Clinical Networks and NHS England.
- Establishment of local System Resilience Groups (SRG) with all local provider, local authority and CCG partners and the development of over 38 schemes of work to deliver additional capacity and improve resilience in the system to manage urgent and emergency care activity and planned care.
- National recognition of Quality Assurance Framework for care homes (Compassion in Practice).
- Delivery of Quality Premium for 2013-14 and associated additional CCG income of £313,000.

- Approval of the CCG & all three Local Authorities joint Better Care Fund schemes which aim to reduce unnecessary non-elective admissions.
- Intensive programme in reducing falls and identifying at risk patients.
- Development of on-line Referral Support Service (RSS) for all GPs that encompasses review of some specialty referrals from GPs and a comprehensive website providing guidance and support to optimise the quality of referrals and enhance Choice.
- Establishment of a published local formulary managed by a new joint Medicines Commissioning Committee with Scarborough and Ryedale CCG, York Hospitals Foundation Trust and both local mental health providers.
- Presenting the work of the CCG at national conferences, including Commissioning Live, The Future of Primary Medical Care in the North, Pulse Live and the National Neurological Society conference.

3.3 Legislative requirements

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

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

- Cooperated in relation to the preparation of local Joint Strategic Needs Assessments.

The CCG's constitution makes explicit reference to the legislative duties of the CCG and sets out the CCG's approach to meeting our statutory duties. The document is available at http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/governance/nhs-vale-of-york-ccg-constitution-version-3-approved-26-03-15.pdf. The CCG holds providers to account for meeting requirements within the NHS Constitution and includes this in induction information for staff.

The CCG's 2014-19 Integrated Operational Plan is available at http://www.valeofyorkccg.nhs.uk/data/uploads/publications/5-year-plan/nhs_vale_of_york_ccg__integrated_operational_plan_2014_to_2019-final-30th-june-with-signatories.pdf

A summary document of the 2014-19 Integrated Operational Plan can be found at http://www.valeofyorkccg.nhs.uk/data/uploads/publications/strategic-plan/integrated-operational-plan-2014-19-summary-document.pdf

The 2014-19 'Plan on a Page' document is available at http://www.valeofyorkccg.nhs.uk/data/uploads/publications/5-year-plan/nhs_vale_of_york_ccg_five_year_plan_on_a_page1.pdf

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

3.4 The risks we face

Significant risks identified during the financial year 2014-15 were monitored through the Quality and Finance Committee, (risk is a standing item on the Quality and Performance Committee agenda and a significant risk report is presented at each meeting), reported to the Audit Committee and escalated to Governing Body as appropriate.

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

The CCG's current significant risks can be found at: http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/2-april-2015/item-6-assurance-framework.pdf

3.5 Our performance

The CCG continues to lead on a collaborative approach to service improvement and it has strong clinical engagement in all areas of work and has seen significant process in areas such as mental health, during 2014-15. The CCG uses local Joint Strategic Needs Assessments; a range of performance information, quality outcomes, financial

data and feedback from the local population to understand the health needs and specific issues in the Vale of York. These are compared to other similar areas in the UK to help prioritise work and to drive improvements in health across the local area. The following section provides the detail on our 2014-15 performance.

3.5.1 York health profile 2014

The health of people in York is generally better than the England average. Deprivation is lower than average, however about 13.1% (4,000) children live in poverty. Life expectancy for both men and women is similar to the England average.

3.5.1.1 Living longer

- Life expectancy is 7.2 years lower for men and 5.9 years lower for women in the most deprived areas of York than in the least deprived areas.

3.5.1.2 Child health

- In Year 6, 16.4% (270) of children are classified as obese, better than the average for England.
- The rate of alcohol-specific hospital stays among those under 18 was 28.9, better than the average for England. This represents 10 stays per year.
- Levels of GCSE attainment are better than the England average.

3.5.1.3 Adult health

- In 2012, 20.7% of adults are classified as obese.
- The rate of alcohol related harm hospital stays was 594, better than the average for England.
- This represents 1,123 stays per year. The rate of self-harm hospital stays was
- 196.8. This represents 432 stays per year.
- The rate of smoking related deaths was 297. This represents 323 deaths per year.
- Estimated levels of adult excess weight and physical activity are better than the England average.
- Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.
- Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular diseases are better than average.

3.5.2 North Yorkshire health profile 2014

The health of people in North Yorkshire is generally better than the England average. Deprivation is lower than average, however about 11.9% (11,900) children live in poverty. Life expectancy for both men and women is higher than the England average.

3.5.2.1 Living longer

- Life expectancy is 6.7 years lower for men and 5.4 years lower for women in the most deprived areas of North Yorkshire than in the least deprived areas.

3.5.2.2 Child health

- In Year 6, 15.3% (801) of children are classified as obese, better than the average for England.
- The rate of alcohol specific hospital stays among those under 18 was 48.5. This represents 58 stays per year.
- Levels of smoking at time of delivery are worse than the England average.
- Levels of teenage pregnancy and GCSE attainment are better than the England average.

3.5.2.3 Adult health

- In 2012, 23.2% of adults are classified as obese.
- The rate of alcohol related harm hospital stays was 577, better than the average for England. This represents 3,570 stays per year.
- The rate of self-harm hospital stays was 164.3, better than the average for England. This represents 936 stays per year.
- The rate of smoking related deaths was 266, better than the average for England. This represents 1,037 deaths per year.
- Estimated levels of adult excess weight are worse than the England average.
- Estimated levels of adult physical activity are better than the England average.
- The rate of people killed and seriously injured on roads is worse than average.
- Rates of sexually transmitted infections and TB are better than average.
- Rates of statutory homelessness, violent crime, long term unemployment, drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

3.5.3 East Riding of Yorkshire health profile 2014

The health of people in East Riding of Yorkshire is varied compared with the England average. Deprivation is lower than average, however about 12.9% (7,100) children live in poverty. Life expectancy for both men and women is similar to the England average.

3.5.3.1 Living longer

- Life expectancy is 6.6 years lower for men and 4.7 years lower for women in the most deprived areas of East Riding of Yorkshire than in the least deprived areas.

3.5.3.2 Child health

- In Year 6, 17.7% (583) of children are classified as obese.
- The rate of alcohol-specific hospital stays among those under 18 was 44.2. This represents 28 stays per year.
- Levels of breastfeeding and smoking at time of delivery are worse than the England average.
- Levels of teenage pregnancy are better than the England average.

3.5.3.4 Adult health

- In 2012, 21.1% of adults are classified as obese. The rate of alcohol related harm hospital stays was 567, better than the average for England. This represents 1,999 stays per year.
- The rate of self-harm hospital stays was 152.8, better than the average for England. This represents 474 stays per year.
- The rate of smoking related deaths was 290. This represents 647 deaths per year.
- The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average.
- The rate of new cases of malignant melanoma is worse than average.
- Rates of violent crime, long term unemployment, drug misuse and early deaths from cancer are better than average.

3.6. Achieving operational resilience

Ensuring there is sufficient capacity and resilience in the local system to deliver core NHS Constitution standards and waiting time targets across emergency, unplanned and planned care is one of the greatest challenges the CCG is addressing with its partners.

The NHS has experienced unprecedented levels of demand during 2014-15 with an 8% increase in A&E activity between October and December 2014 and 7% increase in elective planned care activity. Yorkshire Ambulance Service experienced a year on year increase of 15% for Red 1 and Red 2 calls in Vale of York.

Significant local and regional issues with staffing recruitment and retention have stretched our providers capacity even further, resulting in the failure to meet national waiting times for 3 successive quarters. The CCG, like many others nationally, has worked closely in 2014-15 with its providers, commissioner partners in acute care, community care, ambulance services and social care and its voluntary sector partners as part of its local System Resilience Group (SRG) to build capacity and resilience and deliver recovery plans.

A number of SRG and Better Care Fund (BCF) schemes in delivery have begun to make a positive impact on recovery plans to meet NHS Constitution targets. The CCG will be allocating full year funding for a number of the SRG schemes that can demonstrate impact to continue throughout 2015-16.

The CCG will continue to work closely with its provider, local authority and voluntary sector partners in the SRG to drive recovery. This is an area of significant challenge and focus for 2015-16 to ensure delivery of the NHS constitutional standards for the Vale of York. This is reflected in the CCG's actions across unplanned care and planned care strategic initiatives in the short term and through integration and prevention (self-care) strategic initiatives in the medium to longer term.

3.7 Achieving CCG outcome measures

There are five outcomes which NHS England has prioritised for improvement. These are:

- Preventing people from dying prematurely;
- Ensuring that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life;
- Ensuring patients are able to recover quickly and successfully from episodes of ill-health or following an injury;
- Ensuring patients have a great experience of all their care;
- Ensuring that patients in our care are kept safe and protected from all avoidable harm.

The CCG is committed to deliver the NHS Outcomes Framework. Within the past 12 months it has worked closely with partners in three Health and Wellbeing Boards to address key health issues in the Vale of York and target interventions that provide the greatest impact. Aligned with the CCG's strategic initiatives, the intervention and improvement work that has taken place in 2014-15 are provided below.

3.7.1 Preventing people from dying prematurely

Planned Care	diabetes; neurology; asthma pathway improvements; cardio vascular disease, hypertension and prevention
Mental health	services review and re-procurement; psychiatric liaison
Primary care	GP care planning; risk stratification; neurology, GP training
Prevention	binge drinking; crisis care / early psychosis intervention (suicide)
Cancer	alcohol / smoking cessation
Children	challenge campaign and health promotion / self-care

3.7.2 Ensuring that those people with long-term conditions, including those with mental illnesses, get the best possible quality of life

Integrated Care	Integration pilots for long term conditions and end of life care
Urgent Care	Urgent Care Practitioners and crisis management reducing admissions avoidance; out of hours services (now procured)
Planned Care	New integrated neurology care pathway and carers strategy
Primary Care	Referral Support Service (RSS); risk stratification
Mental Health	Crisis care and early psychosis intervention; Improving Access to

	Psychological Therapies; mental health service review and re-procurement; transforming care for people with learning disabilities (self-care and improvements in physical health)
Prevention	Self-care; early crisis intervention; falls; bone protection

3.7.3 Ensuring patients are able to recover quickly and successfully from episodes of ill-health or following an injury

Urgent Care	All system resilience schemes – including ambulatory care, Urgent Care Practitioners and 'see and treat' (impact on falls); out of hours services with key performance indicators for the management of emergency demand; psychiatric liaison; street triage; paediatric zero length of stay
Integrated Care	Hospice at home; cellulitis, bronchiectasis and community intravenous (IV) treatment
Planned Care	**Diabetes** - October 2014 onwards 10% reduction in admissions where diabetes is secondary diagnosis and a primary diagnosis of: (i.) urinary tract infection with a length of stay 2+ days; (ii.) syncope and collapse; (iii.) patients 70 years+ with a mental health primary diagnosis **Neurology** - new integrated care pathways developed for Parkinson's disease / epilepsy / multiple sclerosis / motor neurone disease; asthma

3.7.4 Ensuring patients have a great experience of all their care

Planned Care	Diabetes; neurology
Primary Care	Referral Support Service
Quality improvement programmes	Recruitment of a Patient Experience Lead Soft intelligence analysis

3.7.5 Ensuring that patients in our care are kept safe and protected from all avoidable harm

Urgent Care	Re-procurement of Out of hours GP services contract (service commenced 1 April 2015) with new key performance indicators and outcomes included
Integrated Care	Community intravenous treatment
Planned Care	New integrated community pathways for diabetes and neurology
Primary Care	Referral Support Service - primary care web tool GP care planning GP education and training
Quality improvement programmes	Patient Experience Lead Soft intelligence analysis A focus on new primary care outcomes measures and indicators (included in the performance planning submission)

3.8 Achieving the NHS Constitution targets

Against the outcome measures, the CCG has compared its performance against England and peer CCGs.

Ambition over the next five years	2012-13	2013-14	Level of ambition 2018-19
Reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 21%	1950.6	1911	1658
Improve the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions to equal the best amongst our peers	76.7	76	77.95
Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.	1989	1981.4	1712.9
Increase the number of people with mental and physical health conditions having a positive experience of hospital care by 12%. Please note - units shown are not %. England results for 2013 range from 72.3 to 174.9.	96.9	95.5	84.7
Increase the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community by 12%	5.1	5.2	4.76

Table 1 CCG ambitions for the next five years

3.8.1 Potential years of life lost (PYLL) from causes amenable to healthcare

- For all persons 2013 has seen a 2.1% drop in PYLL which slightly exceeds the projected ambition.
- PYLL for Males has actually risen from 2,125 to 2,262 whereas PYLL for Females has decreased from 1,783 to 1,569.
- Relative position against comparators remains unchanged against comparator group in comparison with 2012. The CCG remains 7th in group.
- Current performance improvement is slightly above target (assuming 3.2% reduction each year).

3.8.2 Health-related quality of life for people with long-term conditions

- The total EQ-5D score (quality of life measure) has reduced since the baseline performance from 76.7 to 76 but the CCG remains in the upper quintile, and third in the peer group.
- Relative position against comparators remains unchanged from 2012-13 baseline. The maximum score for any CCG in 2013-14 is 79 which happens to be one of the CCG's peer group. As shown in the chart above,

ambition for 2014-15 is on the same trajectory; however performance for 2014-15 must be improved significantly if the CCG is to remain on target.

3.8.3 Reducing the amount of time people unnecessarily spend in hospital - combined emergency admissions

- There was an increase in emergency admissions between 2012-13 and 2013-14, but performance has improved slightly, from 1,989 in to 1,981.4. This is slightly above the England average of 1,963.0.
- The CCG has moved from 10th in the comparator group to 9th overall.

3.8.4 Patient experience of inpatient care

- The CCG performs very well on this indicator which is based largely on scores from the YTHFT inpatient patient survey. There is little headroom for improvement against the current national best scores.
- Patient experience of hospital care has improved since the baseline performance and exceeded the projected ambition.
- Current performance is excellent compared to other CCGs. The CCG achieved the best performance in the comparator group.

3.8.5 Patient experience composite indicator, comprising GP services and GP out of hours services

- The CCG's performance decreased from 5.1 in 2012-13 to 5.2 in 2013-14, although the CCG has moved from 9th to joint 5th within the comparator group.
- CCG performance remains below the England average at 7.0.

3.9 Our year-end financial position

3.9.1 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).

3.9.2 Accounting Policies

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

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

3.9.3 Financing Transactions

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

3.9.4 Cash

The CCG delivered against all of its cash targets in 2014-15 and plans to do so again in 2015-16.

3.9.5 Summary of expenditure

The CCG has two funding streams:

Programme costs – A funding allocation based on a weighted capitation formula that takes into account population and demographics, deprivation levels and health needs and profile. This covers direct payments for the provision of healthcare or healthcare-related services.

Running costs - Payment allocated to CCGs based on £24.73 per head of ONS population to pay for non-clinical management and administrative support, including commissioning support services.

3.9.5.1 Analysis of the programme costs expenditure

Allocation (£'000s) - £376,413 **Spend** (£'000s) - £374,143

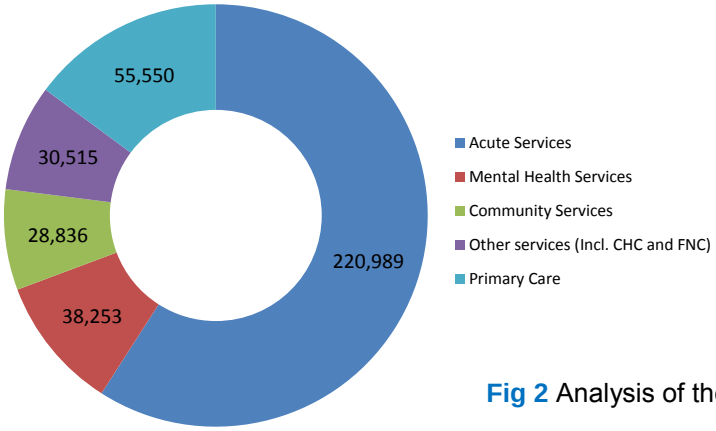


Fig 2 Analysis of the CCG's programme costs 2014-15

3.9.5.2 Analysis of the Running Costs expenditure

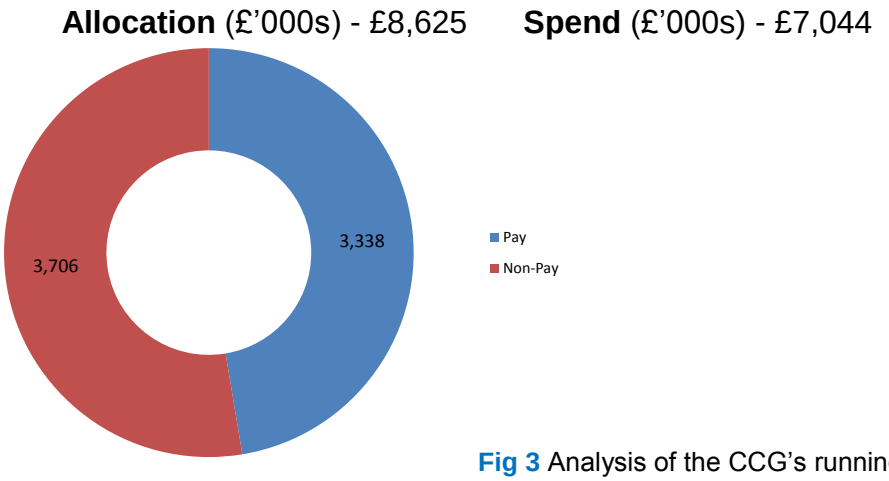


Fig 3 Analysis of the CCG's running costs 2014-15

3.9.6 Underlying recurrent position

Excluding the effect of all non-recurrent elements in this year's position, the CCG has a significantly poorer financial position and one that is worse than at the end of 2013-14 with an underlying recurrent surplus of £1.4m moving into the 2015-16.

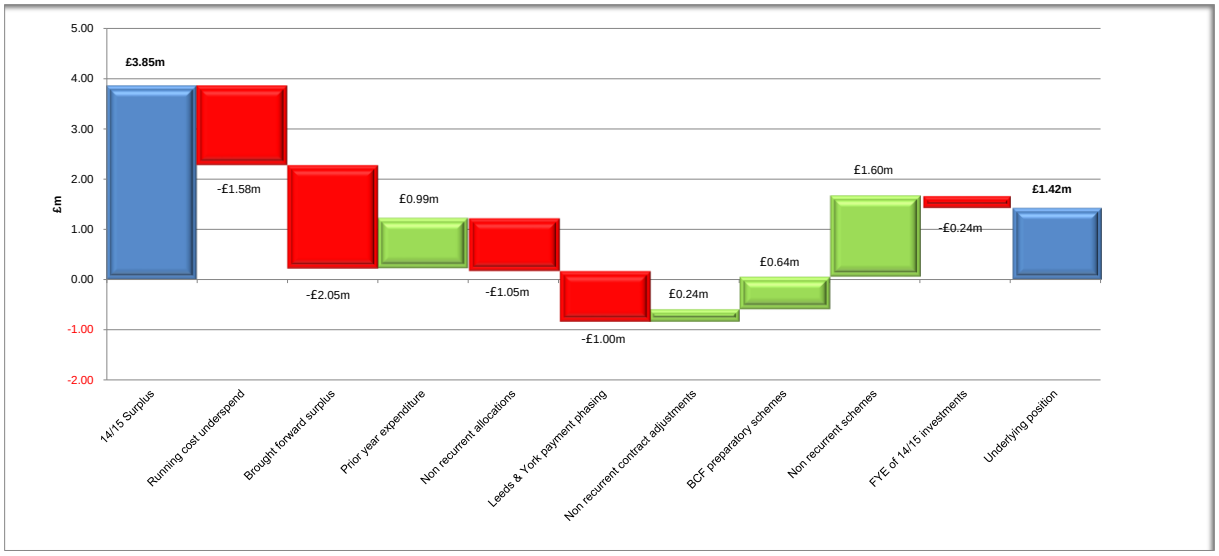


Fig 4 2014-15 Underlying recurrent position

However, there are a number of factors that are likely to affect the financial position going forward.

3.9.6.1 Acute services - specialised commissioning

Issues relating to the correct distribution of resource relating to specialised services have continued through 2014-15. Although the majority of these have been finalised it is unclear as to whether there will be a further recurrent allocation adjustment from the CCG.

3.9.6.2 Acute services - contract overtrade

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

3.9.6.3 Prescribing - prescribing overspend

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

3.9.6.4 Quality, Improvement, Performance and Productivity – under delivery

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

3.9.6.5 Continuing care - retrospective cases payments greater than risk pool

A risk pool was created nationally in 2014-15 through a top-slice of funding included in CCG allocations which was greater than the actual amount required in year. The CCG, through the Partnership Commissioning Unit, agreed a contract to undertake the assessment and payment of these cases during 2014-15 to accelerate the process for patients, families and carers. The CCG is again contributing the national risk pool in 2015-16 and has been notified of the amount to provide for. There is a risk that if the risk pool nationally is insufficient that CCGs will be asked to contribute further.

3.9.6.6 Mental health - costs in 2015-16 and beyond

The current contract with the main provider of mental health services runs to September 2015 so there remains a degree of uncertainty as to the costs of the service after that point depending on the preferred bidder selected following the procurement process.

3.9.6.7 Better Care Fund - savings and outcomes not delivered as planned

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

3.10 Our strategy

The CCG is led by a number of local GPs and other health professionals and it works with the community and its partners to understand the needs of patients. It is dedicated in its work to ensure local people have access to the right services, in the best place, at the right time through:

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

3.11 Our business model

3.11.1 Commissioning Support

The CCG currently commissions a range of support services from Yorkshire and Humber Commissioning Support and these include:

- Workforce management
- Information management and technology support
- Business intelligence and data management
- Procurement
- Service delivery and transformation
- Communications and engagement
- Corporate services
- Quality and clinical support
- Medicines management

The CCG is working alongside colleagues in other local CCGs to review the support services provided by Yorkshire and Humber Commissioning Support with a view to bringing a number of services in house and to commission other services from the recently procured Lead Provider Framework for commissioning support services. The CCG continues to work closely with NHS England and CCGs across Yorkshire and the Humber to ensure a smooth transition of commissioning support services.

3.11.2 Better Care Fund

The Better Care Fund (BCF) is a joint initiative between health and local authority services, to integrate health and social care systems and pooling funds to facilitate this. The emergence of the BCF has strengthened the already effective partnerships the CCG enjoys across the health and social care landscape across the three local authority boundaries the CCG covers in the City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council.

In 2014-15 a number of major initiatives identified for the BCF were commenced in shadow form (to be fully funded from the BCF in 2015-16). Such initiatives included:

- Integrated care pilots in York, Selby and Pocklington;
- Mental health street triage service;
- Urgent Care Practitioners;
- The expansion of the Hospice at Home service with St Leonards Hospice for palliative care.

In 2014-15 the total spent on these schemes across all three BCFs was £2m. From 2015-16 £19.4 million of CCG resources will support the BCF in collaboration with the three local authorities and, where relevant, other local CCGs, with a total pooled fund of £77.7m. This is broken down as follows:

- City of York - £11.2m CCG (Total pooled budget - £12.1m)
- North Yorkshire County Council - £6.9m CCG (Total pooled budget - £43.2m)
- East Riding of Yorkshire County Council - £1.3m CCG (Total pooled budget - £22.4m)

The implementation of the Better Care Fund in 2015-16 sees the setting up of a significant pooled budget arrangement, a financial mechanism designed to drive integration and the most efficient use of resources for commissioning of services. The continued development of the BCF during 2015-16 and beyond will see greater sophistication in commissioning arrangements and will support the CCG in shifting care closer to patients own homes, where this is the most appropriate place for care, and a reduced reliance on hospital based care. There are significant contractual and monitoring implications for the CCG and its partners in the Better Care Fund to ensure that the transformation of services is achieved in the required timescales.

3.11.3 Primary care co-commissioning

NHS England recently announced details of the CCGs approval to take on greater delegated responsibility to commission GP services from 1 April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services. The CCG has been approved under delegated commissioning arrangements, which means that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2015 with a total budget of £40.2m.

This will enable the CCG to work in much closer partnership with primary care in achieving better health care services for patients as it will have influence over services, finances and contracts in a way that was not possible previously. This will drive much closer working between primary and hospital care as the CCG can ensure the vision for health services in the Vale of York is disseminated across all parts of the system and now has the influence to drive the necessary changes.

3.11.4 CCG's senior management team and clinical lead GPs

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

3.11.4.1 Clinical lead GPs

Planned Care and Prescribing
Primary Care
Women's health
Mental Health and Learning Disabilities
Urgent / Unplanned Care

3.11.4.2 Senior management team

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

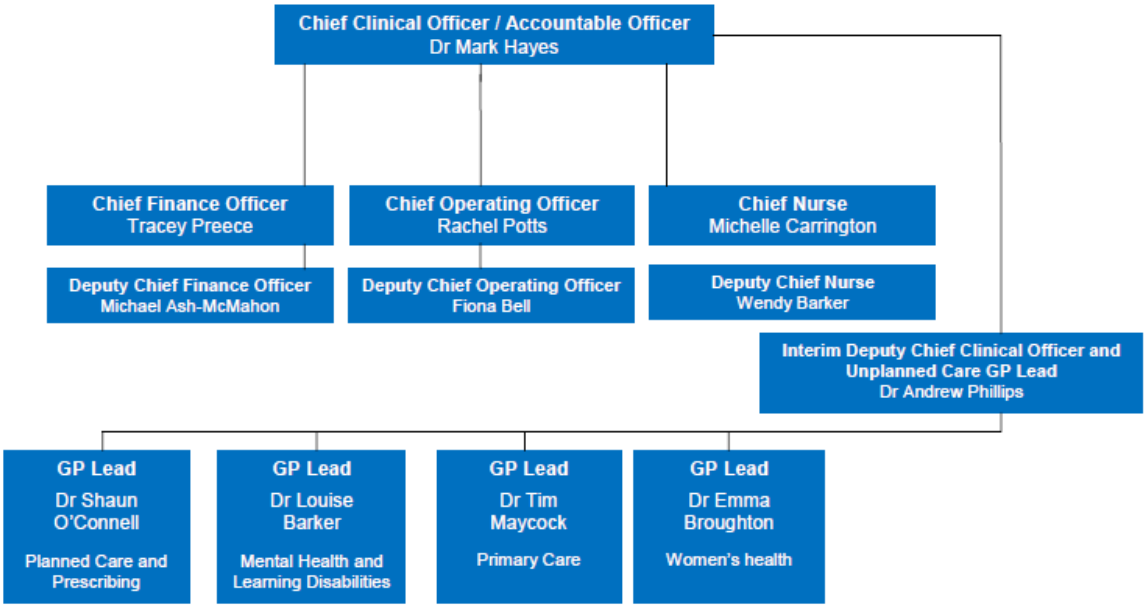


Fig 5 The CCG's Senior Management Team and GP Lead structure

The CCG has a robust governance structure to support its decision making, planning and commissioning processes. The following governance structure describes the CCG's immediate operating environment and the framework of the organisation's business environment that includes policy setting and agreement, standard operating procedures, rules and guidelines. For information about the CCG's committee structure, membership, performance and highlights please see the Annual Government Statement in section 7 of this report.

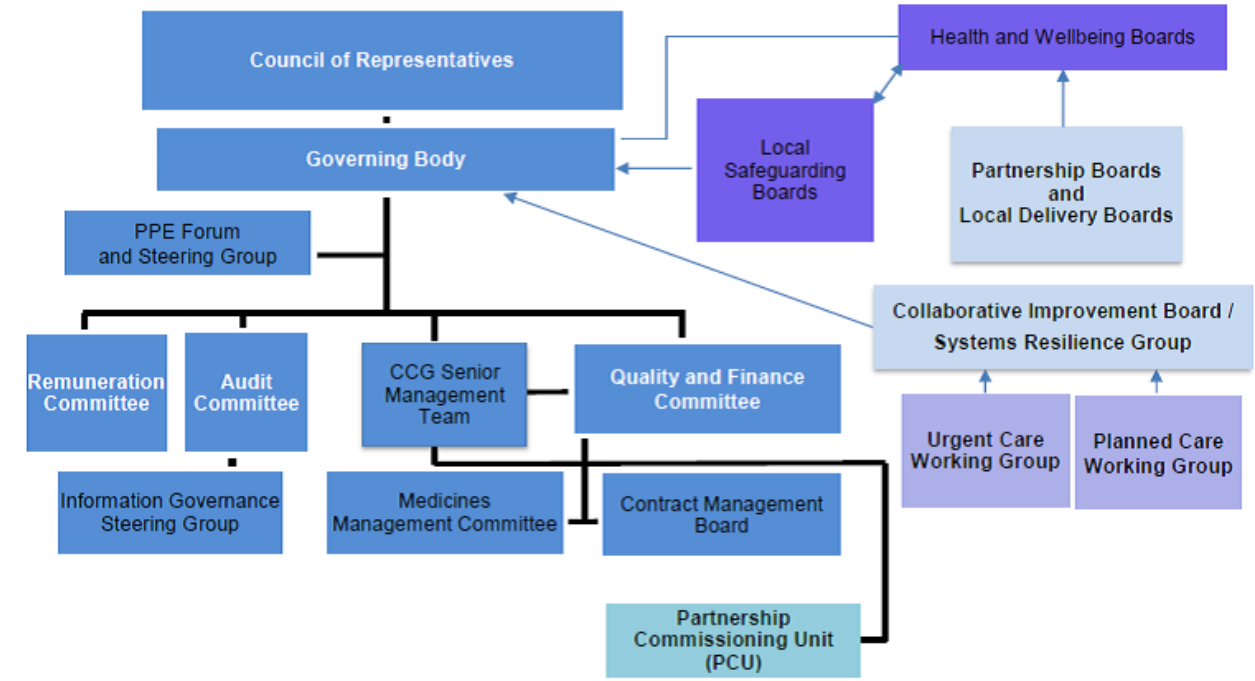


Fig 6 The CCG's Governance Structure

3.11.5 Health and wellbeing boards

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

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

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

The CCG's Integrated Operational Five Year Plan for 2014-19 reflected these local priorities through its work programmes and specific programmes of work and projects were developed to take them forward. These included:

- Projects to Improve Access to Psychological Therapies (IAPT);
- System Resilience Schemes;
- The Urgent Care Working Group;
- Delivering projects with partners through Better Care Fund monies;
- Integration pilots;

- Services that deliver and will sustain the integration of health and social care;
- Projects to increase dementia diagnosis.

The CCG's Five Year Plan has ensured that local priorities will continue to be placed at the centre of the planning cycle and that its objectives and improvement interventions are targeted to support our Health and Wellbeing Boards' priorities.

3.11.6 Mental Health and Learning Disabilities Partnership Board

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

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

Involving those who use services is a priority objective for the Board as is appreciating public and patient views that can influence the work of the Board and its sub-groups.

Understanding these views ensure that members of the local community that use services can inform the planning, commissioning, design and service delivery.

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

These boards involve health and social care partners and oversee the development of integrated care and support across the Vale of York footprint. They lead the delivery of an implementation plan for whole system change across all appropriate care and support services in the Vale of York and ensure that strategies and plans are deeply rooted in patient/carer experience as well as feedback on the needs and views of local residents. It works on the principles of co-production and co-design.

3.11.8 Collaborative Improvement Board

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

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

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

3.11.9 Strategic collaborative commissioning groups

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

3.11.10 Urgent Care Working Group

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

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

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

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

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

3.12 Going concern

The CCG's accounts have been prepared on a going concern basis.

Management and those charged with governance are required to form a view as to the going concern status of the CCG as it governs the basis on which accounts are prepared for 2014-15 and services are commissioned in 2015-16. In May the Audit Committee and Governing Body will consider a number of criteria and are expected to ratify the decision and formally recommend that the Annual Accounts for 2014-15 are prepared on a going concern basis.

3.13 Assurance framework

The NHS England CCG Assurance Framework requires clinical commissioning groups to report on their delivery of the duties laid down in the National Health Service Act 2006

(as amended). The report for how we have delivered on the duties in the Act can be found in the Annual Governance Statement which can be found at section 2 to Statements from the Accountable Officer.

The Risk Register and Assurance Framework are the Clinical Commissioning Group's tools for managing risks to the organisation and our objectives. More detail on the Risk Register and Assurance Framework can be found in the Annual Governance Statement.

3.13.1 Managing risk

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

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

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

3.14 Sustainability report

The CCG is firmly committed to shaping and commissioning services that:

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

To support its ambitions, the CCG has developed and implemented a Sustainability Development Management Plan. The plan addresses nine key objectives, these are:

- Governance;
- Travel;
- Procurement;
- Facilities management;
- Workforce;
- Community engagement;
- Buildings;

- Adaptation;
- Models of care.

This report is in accordance with the Government Financial Reporting Manual and includes an overview commentary covering our performance in the reported year along with an overview of our forward plans.

3.14.1 Achievements to date

Over the past 12 months, the CCG's programme to integrate care has gathered pace with sustainability at the core of the three integration pilots, which aim to test whole system approaches with increased community based support. This is reflected in the objectives and KPIs used to develop and monitor progress for the pilots, which include a model with a patient at the centre, multidisciplinary working and a workforce fit for the future, fewer visits to emergency departments, more self-care and self-management. Implementing the Shared Care record is fundamental to the success of integrated working.

Through the System Resilience Group, the CCG is working on a number of projects with all local stakeholder organisations to ensure the local health and care system will be sustainable and fit for the future. This includes investing in Urgent Care Practitioners, who respond to 999 calls for life threatening emergency care but they are also able to assess and treat patients in their own home, where it is appropriate to do so; making referrals to the most appropriate agencies as required.

The CCG's Referral Support System (RSS) enables GPs to manage referrals with increased efficiency, streamlining appointments and ensuring appropriate referrals to secondary care. Additionally, the general practice improvement programme includes a focus on the most frequent attendees and how the organisation can work to reduce the need for so many appointments and follow-ups.

3.14.2 Commissioning intentions for 2015-16

In 2015-16 the CCG will continue to provide the right service at the right place at the right time and to reduce avoidable emergency hospital admissions wherever possible. This will be supported by:

- The delivery of Better Care Fund schemes with the CCGs three local authorities, in order to meet the 11.7% in reduction in non-elective admissions identified during 2014-15;
- Risk profiling and stratification in our general practices to effectively target resources where they are most needed;
- Expansion of community services including community pharmacy;
- Working with the voluntary and community sector to provide more community support;
- Working with providers to confirm the level of activity the local system needs to commission in 2015-16, to ensure resilience in the systems to meet demand in a safe and sustainable way;

- Working with NHS England to develop and sustain maternity services for the future as well as delivering the right level of choice for women;
- Working with NHS England to consolidate where appropriate specialised services including stroke, trauma and some general surgery;
- Further expansion of the Referral Support System.

3.14.3 Policies supporting sustainability

Main providers are required to update the CCG annually on how they are delivering against the business continuity policy and the Emergency Preparedness Framework, which has now been approved. All departments in the CCG have an action plan with protocols in place to deal with a range of emergencies, from flooding to infectious disease outbreaks

A Surge and Escalation Plan is in place that enables stakeholder organisations in the local system to manage the winter period including periods of pressure on emergency care services. We will continue to embed the sustainability Impact Assessment Framework in all programmes of work and project management processes.

3.14.4 Working with our commissioned services

Our main providers produce annual updates on sustainability progress. For example, York Hospital presented its sustainability report to the CCG Performance and Quality meeting in February 2015.

3.14.5 Working with health and wellbeing boards

There is widespread agreement across the Vale of York geography that current models of health and social care are not sustainable. Over the past twelve months the CCG and local authorities have been leading on the Better Care Fund to accelerate progress towards integrating health and social care. During 2015-16 our pilot sites will have tested different approaches leading to an improved understanding of the different care models required to meet the needs of the population well into the future.

3.14.6 York Health and Wellbeing Strategy

Through the Health and Wellbeing Board, the partners have committed to being a living wage employer. A number of key organisations within the local health and care system have also committed to this, including York Hospital. Achieving a sustainable local health and care system is one of five priorities in the Health and Wellbeing strategy; this is further supported by the Collaborative Transformation Board.

3.14.7 North Yorkshire Health and Wellbeing Strategy

Silo approaches to commissioning are no longer sustainable. Creating and developing healthy and sustainable places and communities is one of six policy objectives.

3.14.8 East Riding Health and Wellbeing Strategy

This strategy supports a partnership approach to increasing resilience of children, young people and adults, and includes the reduction of risk taking behaviours.

3.14.9 Travel

The CCG plays an active role in encouraging the use of remote communication in place of face to face meetings. The CCG has access to a range of unified communications such as teleconferencing. The following graphs illustrate our business miles and carbon footprint using the Sustainability Development Unit's model and Treasury Scopes.

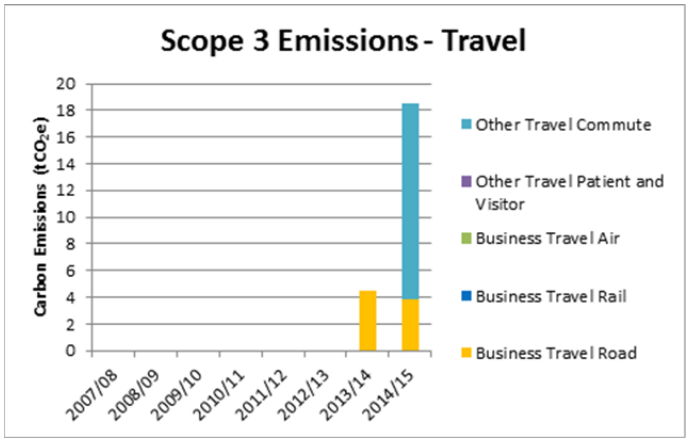


Fig 7 The CCG's business kilometres - a reduction of 2,360km in 2014-15 in comparison to 2013-14

3.14.10 Procurement

Through its contract management arrangements the CCG monitors key providers for sustainability compliance and improvements. During 2015-16 the CCG will embed yearly reporting requirements of sustainability of key providers to ensure commissioned services are delivering continuous improvement in this area.

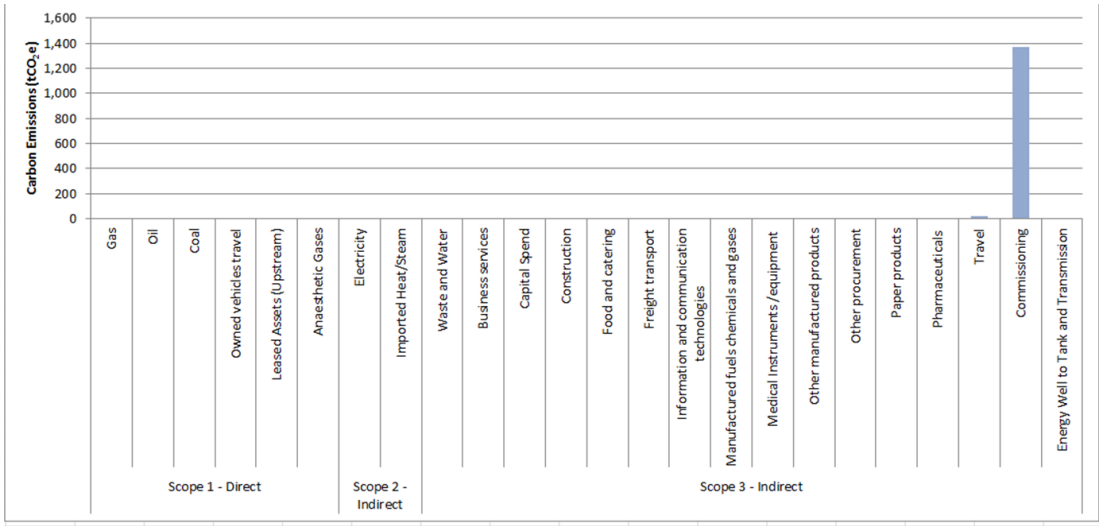


Fig 8 Calculation of the CCG's carbon footprint using the Sustainability Development Unit model and Treasury Scopes

3.15 Equality and diversity report

Underpinned by our vision, mission and values; this strategy highlights and supports our guarantee to promote equality throughout the planning and development of service commissioning; whilst appreciating and respecting the diversity of our local community and staff.

This strategy will support our commitment to give everyone in the community the opportunity to be heard and give their opinions about local healthcare services. It will also allow us to continue to have open, honest and two-way conversations – at times and in ways that are appropriate for our stakeholders.

The CCG's equality objectives are:

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

3.15.1 Objective 1 – achievements

- The CCG's Communications strategy specifically addresses accessible communications and the range of different needs that must be considered by commissioners when communicating with the public and commissioning services. All public documents include the following accessibility statement, in 14point font:

  This document contains information about [subject title / information]. If you need this information in another format or language, please phone: 01904 555870 or email valeofyork.contactus@nhs.net.

- The CCG has supported NHS England in a piece of work they have undertaken to make information about health and social care services more accessible.
- The requirement for providers to ensure that information for patients is made accessible and that interpretation services are provided as needed is now a requirement of the standard contract. Funding for this is provided in funding tariff.

3.15.1.1 Objective 1 – areas for development

- More analysis should be done on previous surveys about how people would like to receive information. All future surveys should routinely include a question on how accessible people find the information and what improvements they can suggest.

- Transcribe the Equalities Strategy and a number of other important documents into Easy Read format, working in partnership with local authorities and the voluntary sector.

- From April 2016, health and social care organisations will have to implement the Accessible Information Standard, a formal guidance for health and social care organisations on how they ensure that disabled

patients / service users and, where appropriate, carers, receive information in formats that they can understand, and that they receive appropriate support to help them to communicate. The CCG will review our public-facing information to ensure it meets the new guidance and work with our providers to ensure they too are working to this guidance and are making reasonable adjustments to meet communication needs and preferences.

3.15.2 Objective 2 - achievements

- The new Joint Strategic Needs Assessment (JSNA) has just been published and gives population and health needs data across many of the protected characteristics – the Innovation and Improvement Team and Clinical Leads are encouraged to use this data to inform equality analysis.

- The CCG's Equality Lead is a member of the York JSNA Steering Group which means that insight can be shared more widely with the CCG about health needs and population data, networks can be developed and CCG specific issues and challenges with data can be shared.

- An equality analysis tool has been developed to support commissioners with equality analysis across the commissioning cycle.

- Three training sessions were delivered in autumn 2014 to CCG staff. These sessions aimed to increase the awareness, understanding and use of the equalities analysis tool and provide further information and advice how we pay 'due regard' to protected groups as a public sector organisation.

- Data reporting on how providers have made their services more accessible to people with different needs is monitored through routine contract monitoring.

- Equalities and engagement have been embedded within the CCG's systems and processes, e.g. within Initial Viability Assessments, Business Cases and on Covalent (the CCG's risk management and performance system).

3.15.2.1 Objectives 2 - areas for development

- Collecting equality data from providers is still a challenge. The national data set does not include protected characteristics apart from age and gender. Current IT systems do not have the capacity to record characteristics and anecdotal evidence suggest that staff often feel uncomfortable asking for this data, and patients do not see why this data is needed. Therefore, even where systems do have the capacity to record

and report on this data, the data fields are often incomplete or set as 'unknown' or 'undefined'.

- Build on the relationships with the Equality and Diversity officers of the main provider organisations to work together to make progress on this objective. The aim is to have sufficiently robust data to meaningfully inform the equality analysis.
- Work with York University who are developing the NHS Equity Dashboard, which shows how people in the most deprived neighbourhoods compare with those from the least deprived against a number of health measures.

3.15.3 Objective 3 - achievements

- The Equality Lead has worked collaboratively with equality and diversity leads from York Hospitals NHS Foundation Trust and from Leeds and York Partnership Foundation Trust to implement the Equality Delivery System 2 (EDS2). A range of stakeholders participated in the assessment and grading of each organisation, including representatives across most of the protected characteristics. Through the EDS2 process four joint objectives for all three organisations have been identified, one of which is 'To improve the collection and analysis of patient/service user data for people with protected characteristics'.

- Health Watch is part of the CCG's public and patient engagement group and there is regular communication between the CCG and all three of its local Health Watch organisations. The CCG also receives and responds to Health Watch reports which deal with health service access issues.

- As noted in Objective 2, the CCG's Equality Lead is on the JSNA Steering Group which strengthens partnership working with public health.

- The Equality Lead is also working with the City of York Council's equality lead to strengthen engagement and understanding of equality and inequality across the Vale of York.

3.15.3.1 Objective 3 - areas for development

- Further follow up is needed to link into North Yorkshire County Council and East Riding Council's work on equalities.

- Further development is needed to establish joint objectives with the NHS England's Local Area Team, particularly where issues have been raised regarding GP services.

3.15.4 Objective 4 – achievements

- Following the Appreciative Inquiry work in October 2013, the CCG has now adopted this approach in all public and staff engagement.

- In June 2014 all CCG staff were asked to take part in a survey and we currently have an Organisational Development programme of work which is due to report back to Senior Management Team. Priorities include work/life balance for staff and coaching support.

3.15.4.1 Objective 4 - areas for development

- The Workforce Race Equality Standard (WRES) is now mandated in the NHS Standard Contract for 2015-16. The Equality Lead will work alongside our contracting team and with our major providers to ensure they have plans in place to meet this new standard, aiming for the workforce (including provider Board level) to be more representative of the population it serves.
- The CCG will carry out an initial comparison of its workforce and local population to identify whether the current workforce is representative.

3.15.5 Objective 5 - achievements

- The Equality Strategy has been fully endorsed by the Governing Body after a detailed presentation.

- The Governing Body has participated in a development session which included clarifying their role with respect to paying due regard to equality.

- In January 2015 the Governing Body received a presentation about the role of a CCG in addressing health inequalities, in terms of duties, local evidence and evidenced-based interventions. York's Acting Director of Public Health also attended this workshop to facilitate the discussion. It was agreed that a joint health inequality work plan would be developed across Public Health and the CCG for 2015-16.

- Equality and diversity has been embedded into the systems and processes of the CCG. For example the environmental impact assessment (EIA) tool is used for all policy development and Governing Body decision papers. Addressing equalities is also embedded within the business case process and within Covalent (risk management system) and is a strong theme in the CCG's five year strategy, which includes a robust EIA.

3.15.5.1 Objective 5 - areas for development

- The CCG's 5 year strategic plan sets clear outcomes and trajectories for improvement in health indicators. There is potential to look at health outcomes by protected characteristic, where this data is available.
- Using available data, including engagement findings, establishing whether there are any particular groups that experience inequalities particularly relating to their protected characteristic.
- The Equality Lead to work closely with equality and diversity leads in main provider organisations to gain assurance that equalities duties within the contract are being met and to identify further opportunities for collaboration.

3.15.6 Conclusion

A great deal of work was done in 2014-15 to develop an equality strategy that was meaningful, collaborative and enabled the embedding of equalities across the full range of commissioning activities undertaken by the CCG. Stakeholders and staff were effectively engaged and involved throughout the process of developing the strategy.

There has been much progress against the Implementation Plan, but there is still work to do in Year 3, particularly in meeting new requirements such as the Workforce Race Equality Standard and the Accessible Information Standard. The CCG will continue to focus on coaching staff to ensure that equality analysis is an integral part of service improvement and contract management.

Collaboration with local authorities and our major providers is critical and focus will be on continuing to strengthen links and improve the collection of and analysis of equality data whilst working towards joint objectives that will make the most effective use of resources.

3.15.7 Composition of the governing body

Governing Body Member	Governing Body Role	Attendance (public meetings)
Professor Alan Maynard	CCG Chair	5/6
Mr Michael Ash-McMahon *from 17 October 2014*	Interim Chief Finance Officer	2/2
Dr Louise Barker	GP Member	2/6
Mr David Booker *from 1 August 2014*	Lay Member	4/4
Miss Lucy Botting *to 4 December 2014*	Chief Nurse	4/4
Dr Emma Broughton	GP Member	4/6
Dr Chris Burgin *to 31 July 2014*	GP Member	0/2
Mrs Michelle Carrington	Head of Quality Assurance/Deputy Chief	2/2

from 4 December 2014	Nurse from 4 December 2014 *Chief Nurse from 6 March 2015*	
Dr Paula Evans *from 19 September 2014*	GP, Council of Representatives Member	3/3
Dr Mark Hayes	Chief Clinical Officer	6/6
Dr Tim Hughes	GP, Council of Representatives Member	5/6
Dr Jonathan Lloyd *to 31 July 2014*	GP, Council of Representatives Member	2/2
Dr Tim Maycock	GP Member	6/6
Mr John McEvoy *to 4 December 2014*	Practice Manager Member	5/5
Dr Shaun O'Connell	GP Member	5/6
Dr Andrew Phillips	GP Member	4/6
Dr Guy Porter	Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member	6/6
Mrs Rachel Potts	Chief Operating Officer	5/6
Mrs Tracey Preece *to 17 October 2014*	Chief Finance Officer	4/4
Mr Keith Ramsay	Lay Member and Audit Committee Chair	5/6
Attendees		
Name	**Governing Body Role**	**Attendance (public meetings)**
Miss Siân Balsom *from 1 August 2014*	Manager, Healthwatch York	4/4
Dr Paul Edmondson-Jones *to 30 September 2014*	Director of Public Health and Well-being, City of York Council	1/3 (representative attended October meeting)
Guy Van Dichele	Interim Director of Adult Social Care	from 4 December 2014
Dr John Lethem	Local Medical Committee Liaison Officer, Selby and York	5/6
Mr Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire County Council	4/6 (Representative attended the 2 meetings)

3.15.8 Gender breakdown of the Governing Body

Gender	Male	Female	Transgender
	11 (55%)	9 (45%)	0

3.15.9 Gender breakdown of our senior managers

Gender	Male	Female	Transgender
	3 (37.5%)	5 (62.5%)	0

3.15.10 Gender breakdown of all of our staff

Gender	Male	Female	Transgender
	25 (39%)	39 (61%)	0

3.16 Key performance indicators

3.16.1 Financial

The CCG must deliver against a number of measures to assess financial performance during the year in order to demonstrate it has operated within its legal framework.

As the following table shows the CCG delivered all of the statutory financial targets.

Target	Duty achieved?	Plan	Actual
Expenditure not to exceed income (£'000s)	Yes	£376,412	£374,143
Revenue administration resource use does not exceed the amount specified in Directions (£'000s)	Yes	£8,625	£7,051
Revenue - 1% planned Surplus is achieved	Yes	0.57%	1%
Cash - Must be less than Maximum Cash Drawdown (£'000s)	Yes	£380,737	£378,388
Cash - 95% of NHS Invoices by Value are Paid within 30 Days	Yes	95%	99.9%
Cash - 95% of NHS Invoices by Number are Paid within 30 Days	Yes	95%	98.6%
Cash - 95% of Non NHS Invoices by Value are Paid within 30 Days	Yes	95%	99.2%
Cash - 95% of Non NHS Invoices by Number are Paid within 30 Days	Yes	95%	98.1%
Cash - Period End Cash Balances are within 0.125% of Drawdown	Yes	0.125%	0.047%

Table 2 Progress against agreed targets

The CCG aims to build on this position and is putting plans in place for 2015-16 to continue to deliver these targets in full together with the following business rules as published in the planning guidance:

- Reinstate 0.5% Contingency
- Non Elective Threshold available for investment
- Re-admissions available for investment
- Better Care Fund contribution

3.16.2 Better Payment Practice Code

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

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements and are summarised below for 2014-15.

NON-NHS						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-14	261	258	98.85	3,129,909.86	3,128,645.52	99.96
May-14	270	266	98.52	3,037,758.87	3,015,439.38	99.27
Jun-14	230	225	97.83	2,180,383.98	2,177,480.78	99.87
Jul-14	332	319	96.08	2,193,770.62	2,123,978.14	96.82
Aug-14	259	254	98.07	2,059,629.22	2,038,327.51	98.97
Sep-14	300	300	100.00	2,160,108.06	2,160,108.06	100.00
Oct-14	374	371	99.20	1,952,348.43	1,950,962.31	99.93
Nov-14	291	290	99.66	2,540,961.03	2,539,711.03	99.95
Dec-14	267	265	99.25	2,924,084.34	2,902,338.69	99.26
Jan-15	333	318	95.50	2,165,844.27	2,100,966.81	97.00
Feb-15	291	284	97.59	2,970,990.67	2,950,569.45	99.31
Mar-15	374	365	97.59	3,427,089.40	3,407,752.83	99.44
	3,582	**3,515**	**98.13**	**30,742,878.75**	**30,496,280.51**	**99.20**

NHS						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-14	307	287	93.49	26,547,405.60	26,471,917.88	99.72
May-14	276	274	99.28	24,439,312.01	24,415,009.51	99.90
Jun-14	245	241	98.37	25,029,327.17	25,011,129.52	99.93
Jul-14	210	205	97.62	26,300,796.25	26,255,451.07	99.83
Aug-14	298	297	99.66	25,077,771.29	25,076,409.94	99.99
Sep-14	246	245	99.59	24,758,714.22	24,752,464.22	99.97
Oct-14	321	320	99.69	24,941,240.96	24,928,016.14	99.95
Nov-14	296	294	99.32	25,420,057.51	25,413,504.45	99.97
Dec-14	201	200	99.50	25,443,673.87	25,439,611.87	99.98
Jan-15	204	203	99.51	27,711,562.16	27,711,489.75	100.00
Feb-15	325	319	98.15	25,002,869.82	24,835,485.96	99.33
Mar-15	334	331	99.10	26,539,173.26	26,536,870.40	99.99
	3,263	**3,216**	**98.56**	**307,211,904.12**	**306,847,360.71**	**99.88**

Table 3 Better Payment Practice Code summary statements 2014-15

This compares with the following performance in 2013-14.

NON-NHS						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-13	51	51	100.00	985,004.11	985,004.11	100.00
May-13	134	130	97.01	1,070,938.59	1,059,594.12	98.94
Jun-13	183	161	87.98	2,068,827.98	2,014,689.84	97.38
Jul-13	199	175	87.94	2,184,748.40	2,099,333.95	96.09
Aug-13	353	297	84.14	2,339,380.37	2,172,621.20	92.87
Sep-13	182	161	88.46	1,099,704.39	1,004,410.15	91.33

Oct-13	360	323	89.72	2,664,110.57	2,622,927.86	98.45
Nov-13	298	265	88.93	2,447,241.22	2,382,550.48	97.36
Dec-13	281	258	91.81	2,097,461.00	2,016,198.00	96.13
Jan-14	311	299	96.14	2,092,479.85	2,062,408.10	98.56
Feb-14	246	238	96.75	1,891,508.68	1,887,069.21	99.77
Mar-14	296	284	95.95	2,942,043.85	2,903,535.02	98.69
	2,894	**2,642**	**91.29**	**23,883,449.01**	**23,210,342.04**	**97.18**
NHS						
Month	Total paid	Invoices paid on time	% paid within target	£ total paid	£ value paid on time	% paid within target
Apr-13	12	12	100.00	20,107,496.76	20,107,496.76	100.00
May-13	18	14	77.78	21,107,430.42	20,993,947.42	99.46
Jun-13	35	29	82.86	22,007,191.82	21,940,574.82	99.70
Jul-13	182	175	96.15	23,120,732.40	23,069,669.97	99.78
Aug-13	326	312	95.71	16,010,782.13	15,877,054.77	99.16
Sep-13	249	232	93.17	25,393,252.27	25,291,675.87	99.60
Oct-13	204	188	92.16	21,798,549.36	21,734,826.74	99.71
Nov-13	165	158	95.76	24,686,327.80	24,640,927.87	99.82
Dec-13	307	283	92.18	26,999,227.00	26,552,973.00	98.35
Jan-14	296	277	93.58	26,000,534.15	25,951,795.67	99.81
Feb-14	278	273	98.20	25,523,662.10	25,504,894.59	99.93
Mar-14	274	267	97.45	28,560,185.02	28,514,005.91	99.84
	2,346	**2,220**	**94.63**	**281,315,371.23**	**280,179,843.39**	**99.60**

Table 4 Better Payment Practice Code summary statements 2013-14

3.16.3 Prompt Payment Code (PPC)

The CCG signed up to and complied with the Code of Practice with effect from 1st April 2014. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

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

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

3.17 The wider context in which we operate

3.17.1 Local population demographics

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

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

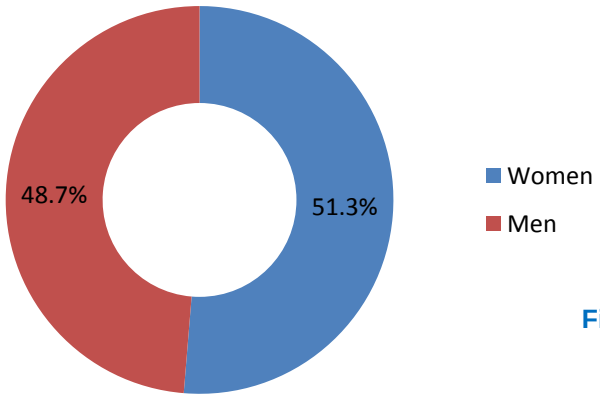


Fig 9 Population split in the Vale of York

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

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

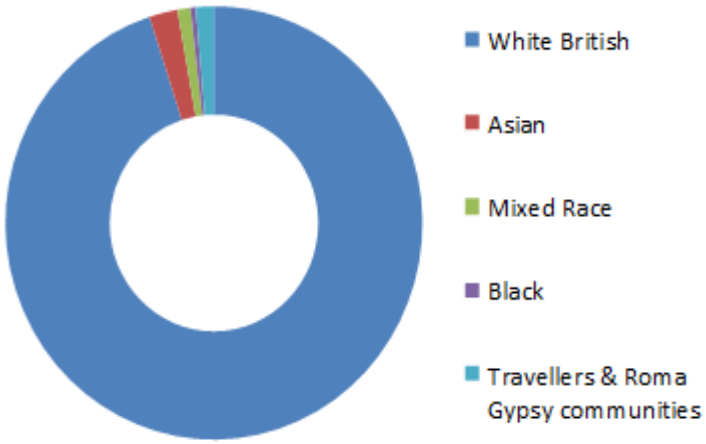


Fig 10 Demographic split of the Vale of York population

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

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

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

3.18 The CCG's external business environment

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

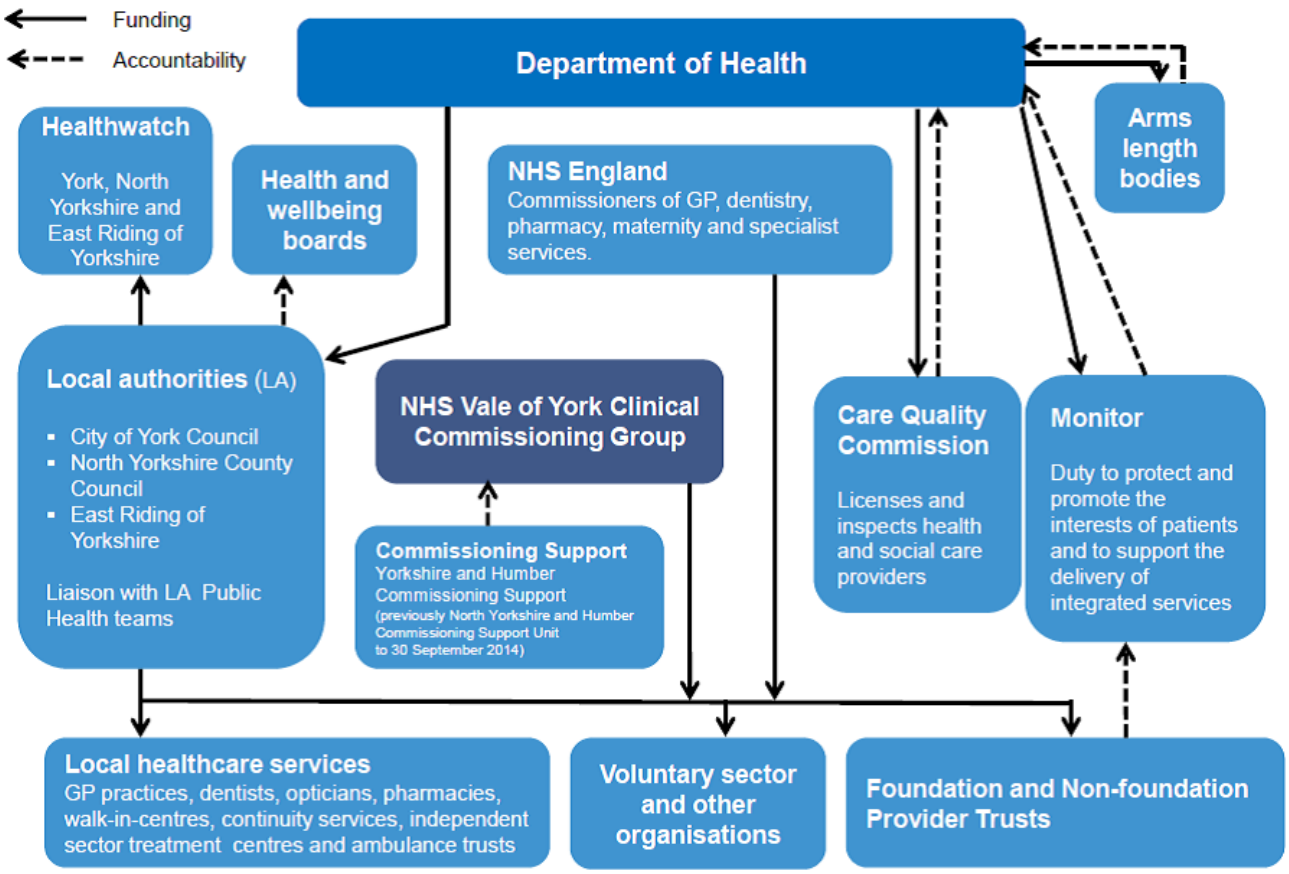


Fig 11 The CCG's external business environment

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

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

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

As a public body the CCG will adhere to the legislation that governs the award of contracts which requires commissioners to ensure that they adhere to good practice in relation to procurement, to not engage in anti-competitive behaviour and protect and promote the right of patients to make choices about their healthcare.

3.18.1 Structure of the business: organisations that the CCG commissions services from

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

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

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

Table 5 Services that the CCG commissions

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

3.18.2 Commissioning support

During 2014-15; until 30 September 2014, the CCG was supported by NHS North Yorkshire and Humber Commissioning Support Unit that provided a range of back office functions and clinical policy support to the CCG.

On the 1 October 2014, NHS North Yorkshire and Humber Commissioning Support Unit merged with NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit and became Yorkshire and Humber Commissioning Support. Yorkshire and Humber Commissioning Support provided the CCG with a range of back office functions and clinical policy support from 1 October 2014 to 31 March 2015.

The CCG collaborates with neighbouring North Yorkshire CCGs and is supported by the Partnership Commissioning Unit in the commissioning of Continuing Health Care, Mental Health and Learning Disabilities, Children's and Adult Safeguarding Services.

3.19 Social and community issues, human rights issues and policies

Underpinned by our vision, mission and values; this strategy highlights and supports our guarantee to promote equality throughout the planning and development of service commissioning; whilst appreciating and respecting the diversity of our local community and staff.

The strategy also set out the legal duties that the CCG, as a public authority, must comply with:

- Equality Act 2010;
- Public Sector Equality Duty;
- Human Rights Act 1998;
- Health and Social Care Act 2012;
- NHS Constitution.

Equality, diversity and human rights are inextricably linked. For example, within the NHS Constitution:

As an NHS patient

"You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age."

As a member of staff

You have a duty "Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation."

You have the right "To a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of race, gender, sexual orientation, disability, age or religion or belief."

The strategy and the following supporting documents are available on the CCG's website at http://www.valeofyorkccg.nhs.uk/about-us/equality/.

- Legal Equality Duties.
- Population and Health Inequalities Data.
- Equality Delivery System Assessment.
- Human Rights Act 1998 and Health.
- Equality Analysis Template.

This Equality, Diversity and Human Rights Strategy & Implementation Plan 2013 – 2017 supports our commitment to give everyone in the community the opportunity to be heard and give their opinions about local healthcare services. It will also allow us to continue to have open, honest and two-way conversations – at times and in ways that are appropriate for our stakeholders.

The CCG's equality objectives are:

To provide accessible and appropriate information to meet a wide range of communication styles and needs.

To improve the reporting and use of equality data to inform equality analyses.

To strengthen stakeholder engagement and partnership working.

To be a great employer with a diverse, engaged and well supported workforce.

Ensure our leadership is inclusive and effective at promoting equality.

3.20 Our future plans, performance and objectives

Looking to the future, the CCG will continue with its work, plans and priorities as set out in its 5 Year Integrated Operational Plan 2014-19. The plan details the strategic planning behind its work to improve and innovate to deliver the integration health and social care services, bringing services closer to home, helping patients to remain independent for longer whilst keeping patients at the centre of everything that it does.

3.20.1 The CCG's objectives

The Governing Body holds the CCG to account for delivery of its objectives which are monitored on a regular basis by the Quality and Finance Committee.

The CCG's objectives are:

People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life.

People will have more opportunities to influence and choose the healthcare they receive and shape future services.

People will continue to have good access to safe and high quality healthcare services.

When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.

Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life.

When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.

A move to integrated care pilots, providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.

High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.

A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.

Access to world class highly complex and specialist care provided through specialist centres across the country.

Opportunities for accessing and leading research to improve healthcare systems for all.

3.20.2 Strategic initiatives

The CCG has eight main strategic initiatives to transform services and deliver its Five Year Plan and its associated ambitions for improving the health and wellbeing of the Vale of York community.

At the core of the CCG's strategic vision is the 'Care Hub' approach involving a whole system change to achieve the best and most futureproof model of care.

The CCG's eight strategic initiatives are:

- Integrated care;
- Self-care, prevention and well-being;
- Primary care reform;
- Urgent care reform;
- Planned care;
- Transforming mental health and learning disability services;
- Women's and children's services;
- Cancer, palliative and end of life care.

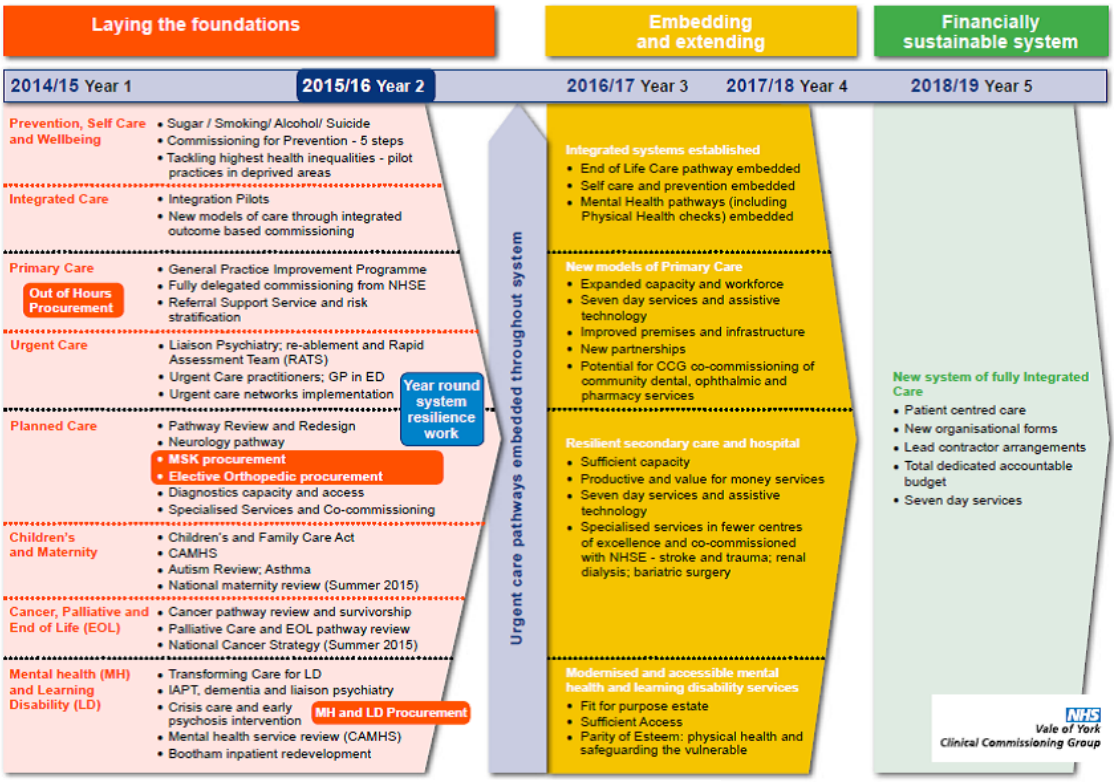
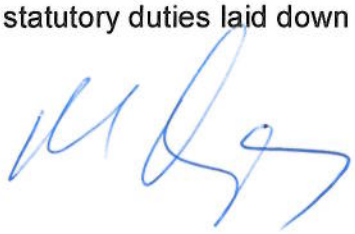


Fig 12 – the CCG's Five Year Plan on a page 2014-19

I, as Accountable Officer, certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).



Dr Mark Hayes
Accountable Officer
27 May 2015

4 Members' Report

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

4.1 Our Membership Body and Governing Body

4.1.1 Composition of the Membership Body (Council of Representatives)

The Council of Representatives met on five occasions in 2014-15. The membership during this time is provided below along with the attendances per member.

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

Practice	15 May	18 September	20 November	22 January	19 March
Beech Grove Medical Practice	Y (m)	Y (m)	Y (f)	Y (f)	Y (f)
Beech Tree Surgery	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Clifton Medical Practice	Y (f)	Y (f)	Y (f)	A	Y (f)
The Surgery at 32 Clifton (merged with York Medical Group 1 Oct 2014)	Y (m)	Y (m)			
Dalton Terrace Surgery	Y (m)	Y (f)	A	Y (m)	Y (m)
East Parade Medical Practice	N	N	N	N	N
Elvington Medical Practice	Y (f)	Y (m)	Y (m)	Y (f)	Y (m)
Escrick Surgery	N	Y (f)	N	Y (f)	Y (f)
Front Street Surgery	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Gale Farm Surgery	Y (f)	Y (f)	Y (f)	Y (f)	Y (f)
Gillygate Surgery (merged with Jorvik 1 Oct 2014)	Y (m)	Y (m)			
Haxby Group Practice	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Helmsley and Terrington Surgeries	N	Y (m)	N	Y (m)	N
Jorvik Medical Practice Jorvik Gillygate Practice (from 1 October 2014)	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Kirbymoorside Surgery	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Millfield Surgery	Y (f)	Y (f)	Y (f)	Y (m)	Y (f)
MyHealth	Y (m) and PM (f)	Y (m)	Y (m) and PM (f)	PM(f)	Y (m) and PM (f)
Old School Medical Practice	PM (m)	Y (m)	Y (m)	Y (m)	Y (m)
Petergate Surgery	Y (f)	Y (f)	A	Y (m)	A
Pickering Medical Practice	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Pocklington Group Practice	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Posterngate Surgery	PM (f)	Y (m)	Y (f)	Y (m)	Y (m)
Priory Medical Group	A	Y (f)	Y (f)	Y (f)	Y (f)
Scott Road Medical Centre	Y (f)	Y (f)	Y (f)	Y (f)	Y (f)
Sherburn Practice	Y (m)	Y (f)	Y (m)	Y (f)	Y (f)
South Milford Surgery	Y (f)	A	Y (f)	A	N
Stillington Surgery	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Tadcaster Medical Centre	Y (m)	Y (m)	Y (m)	Y (m)	Y (m)
Tollerton Surgery	N	Y (f)	A	Y (f)	Y (f)
Unity Health	Y (m)	PM (f)	Y (m) and PM (f)	Y (m)	Y (m) and PM (f)
York Medical Group	Y (m)	Y (f)	Y (f)	Y (f)	Y (f)

Table 6 Composition of the Council of Representatives (2014-15) and attendances

4.1.2 Composition of the CCG's Governing Body

The Governing Body met six times in public and was quorate on each occasion. Additionally eight workshop sessions were held when discussion included the CCG's strategic and financial planning, community services and integrated care pilots, risk management and conflicts of interest, and a review of committees.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Professor Alan Maynard	CCG Chair	5/6
Mr Michael Ash-McMahon *from 17 October 2014*	Interim Chief Finance Officer	2/2
Dr Louise Barker	GP Member	2/6
Mr David Booker *from 1 August 2014*	Lay Member	4/4
Miss Lucy Botting *to 4 December 2014*	Chief Nurse	4/4
Dr Emma Broughton	GP Member	4/6
Dr Chris Burgin *to 31 July 2014*	GP Member	0/2
Mrs Michelle Carrington *from 4 December 2014*	Head of Quality Assurance/Deputy Chief Nurse from 4 December 2014 *Chief Nurse from 6 March 2015*	2/2
Dr Paula Evans *from 19 September 2014*	GP, Council of Representatives Member	3/3
Dr Mark Hayes	Chief Clinical Officer	6/6
Dr Tim Hughes	GP, Council of Representatives Member	5/6
Dr Jonathan Lloyd *to 31 July 2014*	GP, Council of Representatives Member	2/2
Dr Tim Maycock	GP Member	6/6
Mr John McEvoy *to 4 December 2014*	Practice Manager Member	5/5
Dr Shaun O'Connell	GP Member	5/6
Dr Andrew Phillips	GP Member	4/6
Dr Guy Porter	Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member	6/6
Mrs Rachel Potts	Chief Operating Officer	5/6
Mrs Tracey Preece *to 17 October 2014*	Chief Finance Officer	4/4
Mr Keith Ramsay	Lay Member and Audit Committee Chair	5/6
Attendees		
Name	**Role**	**Attendance (public meetings)**
Miss Siân Balsom *from 1 August 2014*	Manager, Healthwatch York	4/4
Dr Paul Edmondson-Jones *to 30 September 2014*	Director of Public Health and Well-being, City of York Council	1/3 (representative attended October meeting)

Guy Van Dichele	Interim Director of Adult Social Care	from 4 December 2014
Dr John Lethem	Local Medical Committee Liaison Officer, Selby and York	5/6
Mr Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire County Council	4/6 (Representative attended the 2 meetings)

4.2 The CCG's member practices

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

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

Table 7 The CCG's member practices

4.3 Audit Committee

4.3.1 Names of the members of the CCG's Audit Committee

The Audit Committee was chaired by Keith Ramsay, a Lay Member of the CCG's Governing Body with a lead role in governance. The other members include Dr Guy Porter, Consultant Radiologist from Airedale Hospital NHS Foundation Trust who is the Secondary Care Doctor Member of the Governing Body along with David Booker, a CCG Governing Body Lay Member who joined the Audit Committee in August 2014.

Dr Guy Porter held a position on the Audit Committee throughout 2014-15 and up until and including the date of signing the Annual Report and Accounts.

John McEvoy, Practice Manager Governing Body Member, stepped down from his roles on Governing Body and Audit Committee in November 2014.

On the 31 March 2015, Keith Ramsay stepped down from his role of Audit Committee Chair to take up a new role on the CCG's Governing Body as Lay Chair from 1 April 2015.

4.4 Details of company directorships or other significant interests held by directors / members

Declarations of interest for Governing Body members are published on the CCG's website at http://www.valeofyorkccg.nhs.uk/about-us/our-governing-body/

Declarations of interest for Council of Representatives members are published on the CCG's website at http://www.valeofyorkccg.nhs.uk/about-us/council-of-representatives/

Declarations of interest for individual members of staff are available on request: http://www.valeofyorkccg.nhs.uk/contact-us/

4.5 Political or charitable donations

The CCG has not made any political or charitable donations during the 2014-15 financial year.

4.6 Key events since the end of the financial year

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

4.7 Future developments

Aside from the information provided in section 3.15, the CCG is not aware of any other developments.

4.8 Pension liabilities

For Pension Liability information please refer to note 4.5 to the accounts.

4.9 Fraud

Information about the CCG's policies and procedures that relate to countering fraud and corruption is available on the CCG's website at:
http://www.valeofyorkccg.nhs.uk/publications/policies/

4.10 Health and safety

The Health and Safety Assessment and action plan for 2014-15 includes actions to manage stress and reduce ill-health. Performance management arrangements, including objective setting, appraisal and personal development processes and staff team meetings are in place and staffing issues are a standing item on the senior management team's agenda.

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

The CCG is also setting up a Staff Engagement Group to increase the involvement of staff in the CCG's organisational development and policies, including equalities, health and safety and other ways to improve the wellbeing of staff.

Through sharing premises with the local authority, the CCG also has access to an extensive range of facilities and access to staff wellbeing days held in West Offices.

4.11 Sickness absence data

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

The CCG's 2014-15 sickness absence level for directly employed staff is 2.65%. Details of the total staff days lost due to sickness are included within the Financial Statements.

4.12 External audit

The CCG's external auditor is Mazars. It was appointed by the Audit Commission. Auditors' and remuneration to Mazars for April 2014 to March 2015 totalled £97,000 (including VAT). This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and work to examine the CCG's use of resources and financial aspects of corporate governance).

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

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

4.13 Disclosure of serious incidents

The CCG has implemented systems to ensure that corporate records and data are appropriately and adequately protected. The CCG as a commissioner of healthcare services is not authorised to hold patient data. Small amounts of personal data are held to enable the organisation to respond to enquiries and complaints and to manage its own staff.

An Information Governance Serious Incident (SI) is any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and / or the Common Law of Confidentiality. This includes unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy.

The CCG is supported by Yorkshire and Humber Commissioning Support for the purposes of Information Governance and management of incident reporting.

Incidents are logged through the CCG's incident reporting system and investigated by the Commissioning Support Information Governance Team in conjunction with the CCG's Information Governance Lead. Serious incidents are notified to the CCG's Senior Information Risk Owner (SIRO) and Caldicott Guardian where applicable and reported to the Audit Committee. Risks arising through the investigation are logged in the CCG's risk registers, along with a note of actions to be taken to minimise the chances of occurrence and reduce impact.

The CCG is pleased to report that there has been no information governance breach during the 2014-15. This is reflected in the table below. More information can be found in the governance statement.

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

[5]

Table 8 Summary personal data related incidents

4.13.1 Serious incidents and never events

Serious Incidents in health care are:

'adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified'.

The CCG has robust systems in place to manage, monitor and scrutinise serious incidents and never events from providers. The process lies with the Quality and Performance Team that reports to the Governing Body via the Quality and Finance Committee. Meetings of the Serious Incident Review Group are held with providers to ensure reports are of high quality, that root cause analysis is robust and learning is captured and disseminated appropriately.

4.14 Cost allocation and setting of charges for information

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

4.15 Principles for remedy

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

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

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

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

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

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

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

4.16 Employee consultation

The CCG's internal communications and consultation strategy provides:

- clear, open, honest and two-way conversations;
- accurate, regular and timely information to and from staff;
- consistent messages across the whole organisation;
- a mechanism for formal consultation and negotiation with accredited Trade Union organisations.

As a people-centred organisation that has pledged to meet its promise to value all of its stakeholder groups, the CCG is committed to maintain and continually improve its conversations with staff. To ensure the CCG can fulfil its vision it needs to communicate effectively and openly with its staff and everyone in the organisation is part of that process.

In its second year the CCG built upon its clear vision that recognised staff as key to the CCG's success. The expertise and skills of staff helped to deliver the organisation's objectives by creating and delivering positive outcomes for stakeholders. The CCG places a high value on the work and commitment of all staff members – whatever their role.

To ensure staff received feedback and important information about the organisation, the CCG's internal communications strategy sets out clear objectives that:

- highlight responsibilities of staff in the communications process;
- provides new and novel ways to share ideas and opinions;
- ensures staff have the right information to do their job well and effectively and are clear on the priorities, goals and objectives of the organisation;
- gives opportunities for staff to feedback to the Senior Management Team and to each other;
- provide ways for staff to suggest improvements and offer good ideas.

The Joint Trade Union Partnership Forum (JTUPF) organised by Yorkshire and Humber Commissioning Support provides the formal mechanism for consultation and negotiation with accredited recognised Trade Union representatives.

All new and replacement Human Resources policies are consulted upon. A two week consultation period is provided for staff to respond to proposed new polices and amendments. After this formal consultation is undertaken with Trade Union representatives via the JTUPF sub group, before the final version of each policy is taken to JTUPF for ratification.

4.16.1 Good quality, regular staff communication and involvement

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

4.16.1.1 Staff survey

Consultation and engagement has proved to be a vital tool to enable and support the staff participation. The second staff survey took place throughout June and July 2014 and the results were provided in October 2014. The comments and feedback received have proved to be extremely useful to the Senior Management Team, providing it with suggestions and recommendations that staff have said that they want or need. The results will provide a basis for benchmarking when subsequent surveys are conducted.

4.16.1.2 Staff e-update

A fortnightly staff e-update continues to provide a communication to all staff that includes updates about project development, CCG performance, important deadlines as well as information about individual team members. The e-update received a re-branding in November 2014, to give it a new name and an opportunity to refresh the content.

4.16.1.3 Weekly staff 'huddle'

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

4.16.1.4 Intranet site

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

4.17 Disabled employees

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

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

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

The policies and processes in place to support this include:

- Managing performance;
- Disciplinary / conduct;
- Grievance;
- Staff induction;
- Bullying and harassment;
- Flexible working;
- NHS Code of conduct for managers;
- Job descriptions (with equality and diversity statements);
- Health policies;
- Annual appraisals with staff;
- Employment equality monitoring forms.

An updated Equality and Diversity policy will be published early 2015-16.

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

4.18 Emergency preparedness, resilience and response

Under the Health and Social Care Act 2012, the Civil Contingencies Act 2004 (CCA 2004) and NHS England Core Standards for Emergency Preparedness, Resilience and Response (2014) the CCG is required to develop sufficient plans that ensure the organisation and all commissioned services are well prepared to respond effectively to major incidents / emergencies so that they can mitigate the risk to public and patients and maintain a functioning health service.

The CCG is a designated Category 2 responder under the CCA 2004 and its main role, in the event of a declared incident, will be in support of Category 1 responders, under the direction of Public Health England (PHE) and NHS England (Area Team) and dependent on the nature of the major incident/ emergency. During 20114/15, the CCG refreshed the Emergency and Preparedness Policy and supporting procedures and staff in responder roles have undertaken appropriate training.

The CCG has also completed and submitted an EPRR self-assessment against NHS England Core Standards for Emergency Preparedness, Resilience and Response and has maintained an action plan.

NHS England's Area Team has incident response plans in place that are compliant with statutory responsibilities and core standards. The CCG is assured that the Area Team regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan locally.

As a Category 2 Responder the CCG is required to have an up-to-date Business Continuity Plan. Business Continuity plans and supporting action cards have been reviewed and refreshed within year. These documents provide assurance that the CCG has robust processes in place to meet its statutory duties.

Regular reviews and improvements to the major incident plan are undertaken and the CCG has participated in testing of the plan in conjunction with business partners.

I certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. NHS Vale of York Clinical Commissioning Group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

4.18.1 The CCG's certification of emergency preparedness

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

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

4.19 Statement as to disclosure to auditors

The Governing Body confirms that:

- it is not aware of any relevant audit information of which NHS Vale of York Clinical Commissioning Group's external auditor is unaware;
- it has taken all of the necessary steps to make its members aware of any relevant audit information;
- where necessary it has ensured that the CCG's auditor is aware of any relevant audit information.

Dr Mark Hayes
Accountable Officer
27 May 2015

5 Remuneration Report

5.1 Remuneration Committee report summary

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

The Committee met five times in 2014-15, with an additional virtual meeting, and was quorate on each occasion except for a specific item - CCG Lay Chair Appointment - at the March meeting when the Chair was not present and the Vice Chair was required to withdraw due to a conflict of interest. Subsequent approval by the Chair was sought and received in respect of this item.

6.1.1 Remuneration Committee performance / highlights

- Ratification of appointment of Interim Chief Finance Officer for maternity leave cover
- Ratification of appointment of Chief Nurse
- Review of performance objectives for Very Senior Managers
- Agreement of arrangements for Chief Clinical Officer's election leave

6.1.2 Details of membership of Remuneration Committee

Name	Role	Membership from	Attendance
Professor Alan Maynard	CCG and Remuneration Committee Chair	April 2014	4/5
David Booker	Lay Member	November 2014	3/3
John McEvoy	Practice Manager Governing Body Member	April to December 2014	3/4
Keith Ramsay	Lay Member with a lead role in governance and Audit Committee Chair	April 2014	5/5

Note: The virtual meeting held on 19 December is not included in the attendance. John McEvoy had left the CCG prior to this; all other members responded to the email circulation.

5.1.3 Non Remuneration Committee member attendances

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

Amanda Wilcock, Director of Human Resources, Yorkshire and Humber Commissioning Support attended each meeting (on one occasion by phone) of the Remuneration Committee in the capacity of external advisor.

Sheila Duckett, HR Business Partner for Yorkshire and Humber Commissioning Support to December 2014, attended two meetings in addition to Amanda Wilcock (in the capacity of external advisor).

Miss Kerry Ryan, HR Business Partner for Yorkshire and Humber Commissioning Support, attended one meeting in addition to Amanda Wilcock (in the capacity of external advisor).

Mrs Wilcock, Mrs Duckett and Miss Ryan also provided a range of general HR advice to the CCG during the 2014-15 financial year. They are employed by Yorkshire and Humber Commissioning Support who are contracted to provide an HR service to the CCG. The Committee is satisfied that the advice received was objective and independent. There was no additional fee paid other than the contracted commitment to Yorkshire and Humber Commissioning Support through the Service Level Agreement (SLA).

Dr Mark Hayes attended one meeting for a specific item.

5.2 Policy on remuneration of senior managers

5.2.1 2014-15 Policy on remuneration of senior managers

Very senior managers pay rates are set taking into account guidance on the Pay Framework for Very Senior Managers in CCGs received from NHS England.

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

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

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

5.2.2 2015-16 Policy on remuneration of senior managers

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

Performance of Very Senior Managers will be monitored in line with the organisation's objective setting and appraisals processes. The Committee will continue to receive regular performance objective reports on all of the CCG's senior team.

5.3 Senior managers' performance related pay

There were no Performance Related Pay (PRP) payments made during 2014-15.

5.4 Policy on senior managers' contracts

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

5.5 Senior managers' service contracts

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

5.6 Payments to senior managers

There were no payments made to senior managers over and above that contained within section 5.7 Salaries and Allowances.

5.7 Salaries and allowances

5.7.1 Salaries and allowances 2014-15

2014-15						
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £00	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
Professor A Maynard - Chair	10-15				0	10-15
Mrs R Potts - Chief Operating Officer	95-100				37.5-40	130-135
Dr M Hayes - Chief Clinical Officer	155-160				37.5-40	195-200
Mrs T Preece - Chief Finance Officer - see (a)	85-90				80-82.5	165-170
Mr M Ash-McMahon - Interim Chief Finance Officer (from 20 October 2014) - see (a)	35-40				17.5-20	55-60
Ms L Botting - Chief Nurse (to 5 March 2015)	80-85				30-32.5	115-120
Mrs M Carrington - Deputy Chief Nurse (from 4 December 2014 to 5 March 2015) and Chief Nurse (from 6 March 2015) - see (c)	20-25				-	20-25
Dr S O'Connell - GP Governing Body Member	110-115				20-22.5	130-135
Dr T Maycock - GP Governing Body Member	40-45				0-2.5	40-45
Dr E Broughton - GP Governing Body Member	45-50				15-17.5	65-70
Dr A Phillips - GP Governing Body Member	110-115				17.5-20	125-130
Dr L Barker - GP Governing Body Member	65-70				90-92.5	155-160
Dr C Burgin - GP Governing Body Member (to 31 July 2014)	10-15				0-2.5	10-15
Mr D Booker - Lay Member (from 1 August 2014)	5-10				0	5-10
Mr K Ramsay - Lay Member and Audit Committee Chair	5-10				0	5-10
Dr P Evans - Council of Representatives Member (from 19 September 2014)	0-5				0	0-5
Dr T Hughes - Coucil of Representatives Member	5-10				0	5-10
Dr J Lloyd - Council of Representatives Member (to 31 July 2014)	0-5				0	0-5
Dr G Porter - Secondary Care Doctor - see (b)	15-20				0	15-20
Mr J McEvoy - Practice Manager Representative (to 4 December 2014)	10-15				0	10-15
Miss S Balsom - Manager, Healthwatch York (Co-opted) - see (d)	0				0	0
Dr P Edmondson-Jones - Local Authority Director of Public Health and Wellbeing (Co-opted) (to 30 September 2014) - see (d)	0				0	0
Mr G VanDichele - Interim Director of Adult Services (Co-Opted) (from 6th November 2014) - see (d)	0				0	0
Dr J Lethem - Local Medical Committee Representative (Co-opted) - see (d)	0				0	0
Mr R Webb - Local Authority Corporate Director Health and Adult Services (Co-opted) - see (d)	0				0	0

NB all senior managers are continuing except where stated.
(a) Mrs T Preece was on maternity leave from 20th October and the Chief Finance Officer role was covered by Mr M Ash-McMahon.
(b) Dr G Porter is employed by Airedale NHS Foundation Trust and the CCG is invoiced directly by them for his time.
(c) Mrs M Carrington was on secondment from York Teaching Hospital NHS Foundation Trust as Deputy Chief Nurse, and was the Chief Nurse representative on Governing Body until her permanent appointment to the role of Chief Nurse with effect from 6th March 2015.
(d) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.
(e) Dr P Evans, Dr T Hughes and Dr J Lloyd invoice the CCG for their time. Dr Evans and Dr Hughes invoice through their practices (York Medical Group and Kirkbymoorside Surgery respectively).

Table 9 Salaries and allowances 2014-15

5.7.2 Salaries and allowances 2013-14

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

NB all senior managers are continuing except where stated:
(a) Mr K Howells was employed through an agency. The salary & fees represents the overall cost to the CCG and not the amount paid to Mr K Howells by the agency.
(b) Dr G Porter is employed by Airedale NHS Foundation Trust and the CCG is invoiced by them directly for his time.
(c) Mr J McEvoy invoices the CCG as John McEvoy Ltd.
(d) Dr T Hughes remuneration relates to his role as a GP Governing Body member only.
(e) Mr A Snarr (Total salary band £000 = 107.5-110) and Ms C Wollerton (Total salary band £000 = 80-82.5) held shared posts between the CCG and Scarborough & Ryedale CCG hence their costs only represent the portion of their time attributable to the CCG, 0.6 Whole Time Equivalent (WTE).
(f) Co-opted members of the Governing Body do not receive remuneration direct from the CCG for their role.
"Taxable Benefits" relate to lease cars (the lease for the lease car of Mrs R Potts expired on 5 June 2013).

Table 10 Salaries and allowances 2013-14

5.8 Payments for loss of office

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

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

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

There were two payments made as a result of restructuring that occurred within the Partnership Commissioning Unit (PCU). Under the International Accounting Standard 18 (IAS 18), net accounting principles apply to the reporting of PCU expenditure. The CCG has therefore reflected its share, £149,777, of the total PCU restructuring costs; which included payments totalling £329,574. Both payments were early retirement options under the compulsory redundancy scheme.

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000	2	£149,777						
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Totals	2	£149,777						

Table 11 Payments for loss of office 2014-15

5.9 Payments to past senior managers

There were no payments to past senior managers.

5.10 Pension benefits

Name and title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 1 April 2014	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015	Employers Contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
Mrs R Potts - Chief Operating Officer	0-2.5	5-7.5	35-40	115-120	647	60	724	0
Dr M Hayes - Chief Clinical Officer	0-2.5	0-2.5	15-20	55-60	296	20	324	0
Mrs T Preece - Chief Finance Officer	2.5-5	10-12.5	15-20	55-60	197	60	263	0
Mr M Ash-McMahon - Interim Chief Finance Officer (from 17 October 2014)	0-2.5	2.5-5	10-15	35-40	119	14	155	0
Ms L Botting - Chief Nurse (to 5 March 2015)	0-2.5	5-7.5	20-25	60-65	274	46	331	0
Mrs M Carrington - Deputy Chief Nurse (from 4 December 2014 to 5 March 2015) and Chief Nurse (from 6 March 2015)	0-2.5	0-2.5	15-20	45-50	235	3	249	0
Dr S O'Connell - GP Governing Body Member	0-2.5	2.5-5	10-15	40-45	196	32	233	0
Dr T Maycock - GP Governing Body Member	0-2.5	0-2.5	5-10	25-30	130	9	142	0
Dr E Broughton - GP Governing Body Member	0-2.5	2.5-5	15-20	45-50	180	17	202	0
Dr A Phillips - GP Governing Body Member	0-2.5	2.5-5	5-10	25-30	149	32	185	0
Dr L Barker - GP Governing Body Member	0-2.5	0-2.5	5-10	20-25	77	11	90	0
Dr C Burgin - GP Governing Body Member (to 31 July 2014)	0-2.5	0	5-10	0	51	1	56	0

Table 12 Pension Benefits 2014-15

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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

5.11 Pay multiples

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

The banded full time equivalent remuneration of the highest paid member of the Governing Body of the Clinical Commissioning Group in the financial year 2014-15 was £185k - £190k (2013-14, £185k - £190k). This was 4.70 times (2013-14, 4.35) the median remuneration of the workforce, which was £39,899 (2013-14 £43,133).

The movement in median salary 2014-15 was due to recruitment to posts below the median.

In 2014-15, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £0k - £5k to £155k – £160k (bands of £5,000). In 2013-14 remuneration ranged from £0k - £5k to £185 – £190k (bands of £5,000).

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

5.12 Off-payroll engagement

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

5.13 2014-15 Governing Body profiles

Professor Alan Maynard, Lay Chair of the Governing Body

Alan is a Professor of Health Economics in the Department of Health Sciences and Hull York Medical School. He has worked in the NHS for 30 years; and from 1997-2010 was Chair of York Hospitals NHS Foundation Trust. Alan's tenure as Lay Chair of the Governing Body ended on 31 March 2015.

Dr Mark Hayes, Chief Clinical Officer / Accountable Officer

Dr Hayes has been Chief Clinical Officer of the CCG since its launch in April 2013. Since then he has overseen the strong financial performance of the organisation and he has fostered a culture of continuous improvement and innovation. Under his leadership the CCG has achieved national recognition in the area of integration of health and social care services. Before moving to the CCG in December 2013, Dr Hayes had been a GP in Tadcaster for 26 years.

Michael Ash-McMahon, Interim Chief Finance Officer (from 17 October 2014)

Michael joined the NHS in 2001 through the NHS Financial Management Training Scheme, graduating in 2004. He spent two years working within Ernst & Young's healthcare consultancy team, working on large scale NHS projects with a range of organisations across the country. Michael has built up nearly 14 years of NHS finance experience and has held several positions in acute provider organisations in the North West. Most recently Michael has been the CCG's Deputy Chief Finance Officer. He is a member of the Chartered Institute of Public and Finance and Accountancy.

Dr Louise Barker, GP Member

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

David Booker, Lay Member and Deputy Chair of the Audit Committee (from 1 August 2014)

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 Barnardos. 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.

Lucy Botting, Chief Nurse (to 4 December 2014)

Lucy joined the CCG as Chief Nurse in January 2014. She has worked in Northern Ireland and England in both provider and commissioning organisations. She has held senior positions including Director of Clinical Commissioning, Director of Quality and Governance and Executive Nurse and has worked in the Department of Health and Royal College of Nursing.

Dr Emma Broughton, GP Member

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

Dr Chris Burgin, GP Member (to 31 July 2014)

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

Michelle Carrington,
Deputy Chief Nurse (from 4 December 2014)
Chief Nurse (from 6 March 2015)

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

Dr Paula Evans - CCG Council of Representatives member (from 19 September 2014)

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

Dr Tim Hughes, CCG Council of Representatives member

Tim is a Principal GP at Kirkbymoorside Surgery with a specialist interest in musculoskeletal medicine and pain management as well as an interest in older person's medicine. His commissioning interest is in the delivery of community services. As well as his roles in practice and the Governing Body, Tim is also a GP trainer for the York GP Training Programme and until March 2015 was Chair of the CCG's Council of Representatives.

Dr Jonathan Lloyd, CCG Council of Representatives member (to 31 July 2014)

Jonathan graduated from Edinburgh University in 1978 and has been a GP Partner in the Priory Medical Group in York since 1983. From 1984 – 2003 Jonathan worked as a Forensic Medical Examiner for North Yorkshire Police and since 1997 has worked as one of the Training Programme Directors of the York GP Vocational Training Scheme. Jonathan is Director of Clinical Studies and Associate Clinical Dean for Students at Hull York Medical School.

Dr Tim Maycock, GP Member

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

John McEvoy, Practice Manager Member and Chair of the Quality and Finance Committee (to 4 December 2014)

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

Dr Shaun O'Connell, GP Member

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

Dr Andrew Phillips, GP Member and Interim Deputy Chief Clinical Officer

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

Dr Guy Porter, **Secondary Care Doctor Member**

Consultant Radiologist, Airedale Hospital NHS Foundation Trust.

Rachel Potts, Chief Operating Officer

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

Tracey Preece, Chief Finance Officer (to 17 October 2014)

Tracey joined the CCG as Chief Finance Officer in November 2013. She has almost 16 years of NHS finance experience after graduating from the NHS Financial Management Training Scheme in 2002 and has held a number of senior finance positions across Yorkshire and the North East. Tracey is a graduate of York University and an Associate Member of the Chartered Institute of Management Accountants.

Keith Ramsay, Lay Member and Chair of the Audit Committee

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

5.13.1 Co-opted member profiles (as of 31 March 2015)

Siân Balsom, Lay Member Healthwatch York (from 1 August 2014)

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

Dr Paul Edmondson-Jones, City of York Council
(to 30 September 2014)

Dr Edmondson-Jones trained in Scotland and then spent 23 years as an Army Doctor. He joined the NHS in 2000 and has worked in a range of roles including Director of Public Health, Director of Adult Social Services and Deputy Chief Executive. As well as his co-opted member role on the CCG's Governing Body he is a member of the Home Office's Partnership Advisory Group on Community Safety, Member of the Advisory Board for the Centre for Reviews and Dissemination and Secretary of the Association of Directors of Public Health.

Dr John Letham, Local Medical Committee Liaison Officer

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

Guy Van Dichele, City of York Council
(from 4 December 2014)

Guy is the Interim Director of Adult Social Services. He is a qualified social worker and has 26 years of experience of working in local authorities across the country. Guy works closely with CCG and partners at York Teaching Hospital NHS Foundation Trust, NHS England, the Partnership Commissioning Unit, the police and fire service.

Richard Webb, North Yorkshire County Council

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

Dr Mark Hayes
Accountable Officer
27 May 2015

6 NHS Vale of York Clinical Commissioning Group Annual Governance Statement

6.1 Introduction and context

As a fully authorised CCG during 2014-15, the CCG has been assessed through the CCG Assurance Framework as Assured with Support by NHS England. This recognises the achievements and improvements in a number of the assurance domains whilst acknowledging further work required.

2014-15 has seen the continuous improvement in systems and processes to ensure delivery of our key strategic objectives and provides the foundations for commissioning further improved outcomes through new models of care.

6.2 Scope of responsibility

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

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

6.3 Compliance with the UK corporate governance code

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

For the financial year ended 31 March 2015, and up to the date of signing this statement, the CCG complied with the provisions set out in the Code, and applied the principles of the Code except in areas where the CCG is committed to working towards the UK Corporate Governance Code, as outlined below.

Leadership	The NHS Vale of York CCG is a membership organisation and is led by the Council of Representatives. This includes a representative from each member practice. The strategic and operational management of the CCG is led by the Governing Body. The Governing Body met formally 6 times during the past 12 months with regular attendance from Governing Body members. The Governing Body included an independent Chairman and Lay Member for governance, additional Lay member, as well as the Executive team, Chief Nurse, Secondary Care doctor, six clinical leads, two Council of Representative members, directors from local

	authorities and Healthwatch, a Practice Manager and a Local Medical Committee representative.
Effectiveness	The Governing Body had a broad skill mix, supported by officers within the CCG. This supporting capacity was expanded in 2014-15 with the recruitment of an additional Lay Member. The tenure for the Chair ended at the end of 2014-15 and recruitment for a new Governing Body Chair was successful, with the appointment of the former Audit Committee Chair as the new Chairman for 2015-16. The CCG is in the process of recruiting a replacement Lay member and Chair of the Audit Committee. The tenure of the Chair is three years, and for the Lay Member three years. The Governing Body was supported by an Executive Assistant. The Governing Body members undertook statutory and mandatory training and induction as required with the Executive Team. Performance management arrangements were in place for the Chair, clinical leads and lay members and Chief Officer members. The Constitution provided clear roles and responsibilities and procedures for replacing key roles. The CCG's supporting Organisational Development Plan embraced the 'Appreciative Inquiry' approach to organisational working.
Accountability	The CCG's Audit Committee was chaired by the Lay Member lead for finance and governance. The CCG has a series of financial controls in place and these were reviewed during 2015-16 to include provisions for the Partnership Commissioning Unit arrangements and the move to delegated authority for primary [medical] care com-commissioning. The CCG has reviewed its Constitution to ensure it appropriately reflects the full delegation of primary medical services commissioning with effect from 1 April 2015. The Risk Management Framework was also in place, with risk, performance and financial issues being reported weekly to the Senior Management Team monthly to the Quality and Finance Committee and to each Governing Body meeting, via the minutes of the Quality and Finance Committee. A supporting software system (Covalent) has been implemented during 2014-15 to standardize reporting in line with the CCG's strategic priorities and assurance framework. The CCG had policies in place regarding conflicts of interest and business conduct, and published the declarations of interest for Governing Body members. During 2014-15 the CCG approved a revised Conflicts of Interest policy in line with the national guidance for delegated authority of primary [medical] care co-commissioning. The CCG's Information Governance Steering Group, reporting into the Audit Committee, has overseen the improvements required to ensure the CCG achieves its governance goals. The CCG instructed internal audits (NYAS) and External Auditors (Mazars) to report to Audit Committee.
Remuneration	The CCG worked within the guidance for Agenda for Change and NHS Commissioning Board guidance: '*Remuneration guidance for Chief Officers (where the senior*

	manager also undertakes the accountable officer role) and Chief Finance Officers' The Remuneration Committee was in place and set the policies for pay and expenses based upon the guidance above.
Relations with Stakeholders	The Chairman of the Governing Body was the lead for engagement within the CCG. There were robust arrangements for engaging with stakeholders and the public. The CCG has been actively engaged with three Health and Wellbeing Boards (North Yorkshire, York and East Riding) and had Governing Body representation at each one. The Health and Wellbeing Boards were underpinned by key strategic partnerships, including children's trusts, joint commissioning boards (leading on the integration of health and social care including the Better Care Fund). The CCG has been working collaboratively with Scarborough and Ryedale and East Riding CCGs through Systems Resilience Groups, reporting to the Collaborative Improvement Board. Significant partnership work across the provider and commissioning landscape has been taken forward through the Planned Care and Urgent Care working groups. The CCG worked closely with neighbouring CCGs to help plan across the health system and manage collaborative commissioning arrangements. This was managed through the North Yorkshire Strategic Collaborative Commissioning Committee and the North Yorkshire and Humber CCG Collaborative. This work has more recently involved a co-ordinated approach to the transition of commissioning support services as a result of the outcome of the Lead Provider Framework arrangement for the provision of commissioning support to CCGs. The CCG continued its commitment to public engagement through the work of its Public and Patient Engagement (PPE) Steering Group, with strong links to Healthwatch and community groups. A number of engagement events were held during 2013-14 to inform commissioning decisions and strategic planning. One major engagement exercise included the Discover work which involved patients, carers, professionals and others providing feedback and views on local mental health services. This feedback was used to inform the specifications developed as part of the CCG's procurement of mental health services. The CCG had a quarterly programme of practice manager meetings and developed Board to Board arrangements with key providers. The CCG is scheduling an AGM and annual meeting of the Council of Representatives to be held later in the year (Late summer 2015)

6.4 The CCG's governance framework

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

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

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

6.4.1 The Constitution

The NHS Vale of York CCG has set its vision of 'achieving the best health and wellbeing for everyone in our community'. To deliver this vision it is committed to developing a strong, transparent and effective organisation to deliver excellent local commissioning. The CCG's constitution provides the framework for the organisation. It is signed up to by all member practices and is embedded across the organisation.
The constitution is available on the CCG's website at:
http://www.valeofyorkccg.nhs.uk/data/uploads/publications/nhs-vale-of-york-ccg-draft-constitution-version-3-approved-26-03-15.pdf

The constitution covers:

- the CCG's geographic area;
- membership;
- vision, mission and values;
- functions and general duties;
- the governing structure (decision-making);
- roles and responsibilities;
- standards of business conduct and managing conflicts of interest;
- the CCG as an employer;
- transparency, ways of working and standing orders.

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

The constitution sets the framework for decision making through the scheme of delegation, which sets out the split of responsibilities and decision making between the membership body (Council of Representatives), the Governing Body and the committees of the CCG. This was in place for authorisation and has been implemented throughout 2014-15. In November 2013, the Governing Body approved to delegate approval of Human Resources policies to the Senior Management Team.

The constitution is a living document and was updated during 2014-15 to take account of the requirements for delegated authority for primary [medical] care co-commissioning, in line

with nationally produced guidance. This enhanced the conflicts of interest arrangements and revised the Terms of Reference for the Quality and Finance Committee, as well as amending the Membership details in line with mergers during 2014-15. The Constitution will be further revised in 2015-16, and consultation on the revised version is underway. The process is on-going with an annual review of the constitution embedded in the planning cycle.

During 2014-15 the Council of Representatives has continued to develop, with increased meetings, held 5 times a year. The Council of Representatives has two members on the Governing Body.

The constitution is supported by a range of underpinning documents, which were reviewed and where necessary refreshed through 2014-15. These included the detailed financial policies and the detailed scheme of financial and operational delegation (refreshed in April 2014 and March 2015), Equalities Strategy (EDS2 review March 2015) and Sustainability Management Plan (Reviewed March 2015).

6.4.2 Governing body and committee structure

The CCG has continued to operate under the Committee Structure established in 2014-15, with bi-monthly formal Governing Body meetings, alternating formal meetings with Governing Body workshops, monthly Quality and Finance Committee meetings, quarterly Audit Committee meetings and ad-hoc Remuneration Committee meetings. The Senior Management Team continues to meet weekly.

The CCG works in collaboration with the three other 'North Yorkshire' CCGs (NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG) through the Partnership Commissioning Unit. This allowed the four CCGs to combine resources on areas of specialism, namely Continuing Health Care, adult safeguarding, children and maternity and vulnerable adults. The CCG is involved in the Partnership Commissioning Unit Management Board, in line with Partnership Commissioning Unit governance arrangements and the CCG's detailed scheme of delegation. The Partnership Commissioning Unit provide regular feedback to the Governing Body and to the Audit Committee as well as the CCG Senior Management Team.

A post-implementation review of the CCG's Committee structure was carried out during 2014-15 on the arrangements agreed in November 2013.

The CCG works collaboratively across the Health Care system through Planned Care and Urgent Care System Resilience Groups, reporting up to the Collaborative Improvement Board. These forums have agreed the schemes for funding using the ring-fenced Systems Resilience monies, and targeted action to address performance issues on the NHS Constitution requirements.

6.4.3 Committee structure

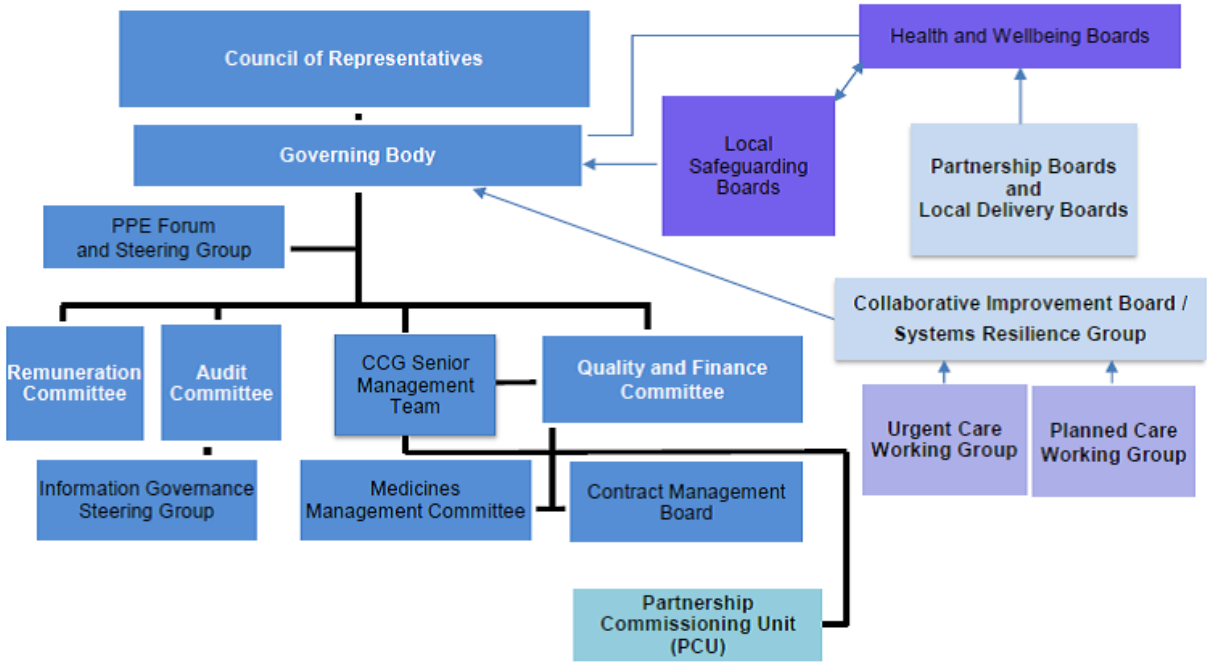


Fig 13 - The CCG's Committee Structure

6.4.4 Governing body meetings

The Governing Body met six times in public and was quorate on each occasion. Additionally eight workshop sessions were held when discussion included the CCG's strategic and financial planning, community services and integrated care pilots, risk management and conflicts of interest, and a review of committees.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Professor Alan Maynard	CCG Chair	5/6
Mr Michael Ash-McMahon *from 17 October 2014*	Interim Chief Finance Officer	2/2
Dr Louise Barker	GP Member	2/6
Mr David Booker *from 1 August 2014*	Lay Member	4/4
Miss Lucy Botting *to 4 December 2014*	Chief Nurse	4/4
Dr Emma Broughton	GP Member	4/6
Dr Chris Burgin *to 31 July 2014*	GP Member	0/2
Mrs Michelle Carrington *from 4 December 2014*	Head of Quality Assurance/Deputy Chief Nurse from 4 December 2014 *Chief Nurse from 6 March 2015*	2/2
Dr Paula Evans	GP, Council of Representatives Member	3/3

from 19 September 2014		
Dr Mark Hayes	Chief Clinical Officer	6/6
Dr Tim Hughes	GP, Council of Representatives Member	5/6
Dr Jonathan Lloyd *to 31 July 2014*	GP, Council of Representatives Member	2/2
Dr Tim Maycock	GP Member	6/6
Mr John McEvoy *to 4 December 2014*	Practice Manager Member	5/5
Dr Shaun O'Connell	GP Member	5/6
Dr Andrew Phillips	GP Member	4/6
Dr Guy Porter	Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member	6/6
Mrs Rachel Potts	Chief Operating Officer	5/6
Mrs Tracey Preece *to 17 October 2014*	Chief Finance Officer	4/4
Mr Keith Ramsay	Lay Member and Audit Committee Chair	5/6
Attendees		
Miss Siân Balsom *from 1 August 2014*	Manager, Healthwatch York	4/4
Dr Paul Edmondson-Jones *to 30 September 2014*	Director of Public Health and Well-being, City of York Council	1/3 (representative attended October meeting)
Guy Van Dichele	Interim Director of Adult Social Care	from 4 December 2014
Dr John Lethem	Local Medical Committee Liaison Officer, Selby and York	5/6
Mr Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire County Council	4/6 (Representative attended the 2 meetings)

Table 13 Composition of the Governing Body (2014-15) and attendances per member at its public meetings.

6.4.5 Committee roles and attendances

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 and highlights for each Committee are also captured in the table below.

Strategic Committees	
Committee	**Role and performance highlights**
Audit Committee	Chaired by the Lay Member with the lead role in governance, the Audit Committee has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other

	significant assurance functions, counter fraud and security management, and financial reporting. The Committee met five times in 2014-15 and was quorate on each occasion. All meetings were preceded by a private meeting of members with internal and external audit. **Members:** Keith Ramsay (Committee Chair), Lay Member with the lead role in governance David Booker, Lay Member, from August 2014 John McEvoy, Practice Manager Governing Body Member, to December 2014 Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member **Performance/Highlights:** ▪ Review of terms of reference and work plan taking account of the new Healthcare Financial Management Association NHS Audit Committee Handbook ▪ Review of Committee effectiveness through Chair's self-assessment and members' and attendees' self-assessment ▪ Regular updates on Detailed Financial Policies and Procedures and Scheme of Delegation ▪ Review of Assurance Framework and Risk Register processes ▪ Regular updates on Counter Fraud ▪ Review of Commissioning Support assurance ▪ Review of Partnership Commissioning Unit assurance
Committee	**Role and performance highlights**
Remuneration Committee	Chaired by the CCG Chairman, the Remuneration Committee has delegated authority from the Governing Body to determine pay and remuneration for employees of NHS Vale of York Clinical Commissioning Group including development pay, the use of Recruitment and Retention Premiums, annual salary awards where applicable, allowances under any pension scheme it might establish as an alternative to the NHS pension scheme, severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money', and receipt and review of new policies and instructions relating to remuneration. The Committee met five times in 2014-15, with an additional virtual meeting, and was quorate on each occasion except for a specific item - CCG Lay Chair Appointment - at the March meeting when the Chair was not present and the Vice Chair was required to withdraw due to a conflict of interest. Subsequent approval by the Chair was sought and received in respect of this item. **Members:** Professor Alan Maynard, CCG and Remuneration Committee Chair

	David Booker, Lay Member, from November 2014 John McEvoy, Practice Manager Governing Body Member, to December 2014 Keith Ramsay, Lay Member with the lead role in governance and Audit Committee Chair **Performance / highlights:** ▪ Ratification of appointment of Interim Chief Finance Officer for maternity leave cover ▪ Ratification of appointment of Chief Nurse ▪ Review of performance objectives for Very Senior Managers ▪ Agreement of arrangements for Chief Clinical Officer's election leave
Committee	**Role and performance highlights**
Quality and Finance Committee	Chaired by the Practice Manager member of the Governing Body for eight meetings, the Lay Member for three meetings and the Secondary Care Doctor for one meeting, the Quality and Finance Committee met each month and was quorate on each occasion. The overall objectives of the Quality and Finance Committee were to ensure that the CCG had strong contractual and quality performance, clinically appropriate and safe services, and to ensure that this is delivered within the financial plan. Where the Committee deemed necessary, matters of concern would be escalated to the Governing Body. The terms of reference were reviewed in January when updates related to the addition of procurement, membership, and an additional paragraph stating links to other committees (Audit and Primary Care), and the establishment of task and finish groups. Following the review deputies were in attendance, not members of the Committee. The members regularly reviewed safeguarding and child protection policies and procedures and these are standing items. **Members:** John McEvoy, Practice Manager Member of the Governing Body (Chair for eight meetings), to December David Booker, Lay Member, from August (Committee Chair from December and Chair for three meetings) Michael Ash-McMahon, Deputy Chief Finance Officer to October, Interim Chief Finance Officer, from October Lucy Botting, Chief Nurse, to February meeting Michelle Carrington, Chief Nurse, for March meeting Dr Mark Hayes, Chief Clinical Officer Dr Tim Maycock, Governing Body GP, Primary Care Lead Dr Shaun O'Connell, Governing Body GP, Clinical Lead for Quality and Performance Dr Andrew Phillips, Governing Body GP, Unplanned Care Lead Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member (Chair for one

	meeting) Rachel Potts, Chief Operating Officer Tracey Preece, Chief Finance Officer, to October Kathryn Shaw-Wright, Interim Deputy Chief Finance Officer, from October **Performance / highlights:** ▪ Monthly detailed consideration of the Integrated Quality and Performance Exception Report (formerly Core Performance Dashboard) and Finance, Activity and Quality, Improvement, Performance and Productivity Report (formerly Financial Dashboard) ▪ Regular Safeguarding reports ▪ Monthly Corporate Risk Register update ▪ Children and Families Act 2014 Part 3 – briefing summary ▪ Yorkshire Ambulance Service Performance and Quality Outcomes presentation ▪ Procurement presentation ▪ Development of Better Care Fund Dashboard ▪ Revised terms of reference following full delegation of primary (medical) care co-commissioning

Table 14 Committee roles and highlights for 2014-15

6.5 The CCG's risk management framework

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

The NHS Vale of York CCG has an agreed Risk Management Strategy, which was refreshed in February 2015 to align the strategy with the new Risk Management software implemented during 2014-15. It sets out our definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management to which we adhere. The Board Assurance Framework developed in 2014-15 was maintained during 2014-15, with a full review scheduled in May 2015 in line with full implementation of the risk management software.

6.5.1 Risk assessment

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

Probability (Likelihood) x Severity (Consequences) = Risk

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

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

Fig 14 Risk Assessment Tool

6.5.2 Probability

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

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

Table 15 - Probability and Severity Scales

6.5.3 Severity

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

Table 16 Consequence score (severity levels) and examples of descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**
Statutory duty / inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern / media interest Damage to an individual's reputation.	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Damage to a team's reputation	Local media coverage – long-term reduction in public confidence Damage to a services reputation	National media coverage with <3 days service well below reasonable public expectation Damage to an organisation's reputation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence (NHS reputation)
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted	Serious potential breach and risk assessed high e.g. unencrypted clinical records. Up to 20 people affected	Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected	Serious breach with potential for ID theft or over 1000 people affected

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

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

The CCG maintains a governance risk register, assessing risk against compliance with CCG licence and statutory duties. This impact assessment is based upon the 'Statutory Duty' section within the risk assessment framework. Each department maintains a risk register with significant risks or those which may impact on the delivery of the critical success factors for the organisation escalated to the Quality and Finance Committee and Governing Body and are reported on the corporate Assurance Framework.

In addition to the ongoing review of risks, of which many are ongoing relating to the financial and performance positions of the CCG, the CCG has implemented a 'horizon scanning' process across the CCG to identify emerging risks and opportunities for the CCG. This is reviewed fortnightly by the Senior Management Team and action taken as appropriate. The Chief Clinical Officer report to the Governing Body provides a forum for future risks to be reported and signalled to the Governing Body. The future risks to the CCG include achievement of the planned efficiencies in the Five Year Forward View, changes to the Commissioning Support Arrangements to the CCG and ensuring the local health economy has an appropriate workforce to meet the health needs of the local population.

6.5.4 Risk reduction

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

The CCG has approved policies on conflicts of interest and business standards, with revised policies approved in January 2015 and whistleblowing to encourage transparency and encourage reporting of incidents. The CCG works with NHS Protect and Internal Audit services (NYAS) to reduce the risks of fraud.

The CCG had 10 counter fraud days in its plan for 2014-15 allocated in accordance with the generic counter fraud areas of action as noted below:

- Strategic governance;
- Promoting an anti-fraud culture;
- Preventing fraud;
- Where it cannot be deterred, detecting fraud;
- Professionally and objectively investigating suspicions of fraud where they arise;
- Consistently applying a range of sanctions where fraud is proven;
- Seeking redress to recover funds obtained through fraud.

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

The Audit Committee recently approved the draft counter fraud plan for 2015-16 which, aligned with, and was in the format required by, the recently issued Standards for Commissioners – fraud, bribery and corruption. The allocation of six days for proactive and strategic work and two days for reactive work was agreed, but would be increased if required.

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

The engagement and involvement of patients, partners and other stakeholders is intrinsic to the commissioning and procurement of services. This work is led by the Deputy Chief Operating Officer who has the Senior Management Team responsibility for engagement and the Lay Chair who is the Governing Body lead for this work. The CCG's Communications Lead is heavily involved in the CCG's engagement programme with support from the Patient Experience Lead and Engagement Support Officer. Alongside this robust structure and responsibility for engagement, the CCG has embedded a culture of stakeholder involvement and engagement in all roles, with every staff member being part of the process.

The CCG is transparent about the risks it faces and publishes the current risks within the Quality and Finance minutes as part of the Governing Body papers.

6.6 The CCG's internal control framework

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

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

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

The CCG has a robust system for internal control including arrangements for internal audit, external audit and counter fraud support. Underpinning the Prime Financial Policies, the CCG has detailed financial policies and a supporting detailed scheme of delegation. The detailed scheme of delegation is aligned to the CCG financial systems to ensure appropriate

level approvals. The CCG has implemented an annual review of the detailed financial policies and the detailed scheme of delegation. In 2014-15 changes were made to these to include provision for Primary Care Co-Commissioning and strengthening arrangements with the Partnership Commissioning Unit. The financial system the CCG operates is kept up to date in line with detailed financial policies and a supporting detailed scheme of delegation. This is then subject to internal audit which as part of its financial governance review the CCG received a high level of assurance.

6.6.1 Assurance framework

The CCG Assurance Framework has been maintained during 2014-15, with the risks assessed against the critical success factors for the organisation:

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

Table 17 Assurance Framework

Each risk on the Assurance Framework is embedded into the relevant departmental risk register. During 2014-15, significant work has been undertaken through the implementation of the risk management software to refresh the team risk-registers and establish project risk registers. The risk registers and overall Assurance Framework are reviewed and updated monthly and reported to each Quality and Finance Committee, with the significant risks reported to Governing Body on an exception basis through the Quality and Finance minutes.

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

The CCG uses risk management software to maintain the risk registers, which are reviewed monthly by each department and reported monthly to the Quality and Finance Committee. The significant risks within each register (score over 15) are also included on the Assurance Framework as appropriate and reported to the Governing Body. Audit Committee receives bi-annual reports on risk management and assurance processes and receives reports of incidents and breaches of standing orders as required.

The process has been enhanced through the implementation of the risk and project management software, and the CCG has brought risk management functions, previously delivered through commissioning support, in house during 2014-15.

Risk management is embedded across the organisation through these processes, but also through assessment of specific risks including information security, business continuity planning and emergency preparedness. There is a clear mechanism for reporting incidents and sharing findings. There have been no reported incidents to the Information Commissioners Office during 2014-15 and low level incidents have been reported to Audit Committee.

6.7 Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

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

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

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

Table 18 Summary of other personal data related incidents

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

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

The CCG has implemented an Information Governance Framework as defined in the CCG's Information Governance Strategy. Supporting this framework is a number of information governance policies as follows:

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

To further enhance data security a number of controls have been employed including: encryption of portable devices, authenticated remote access, access controls via passwords, and physical controls to control access to the hosting data centre. Information

and publicity about the above policies is provided by way of the CCG's website and inclusion of Information Governance matters in the CCG's newsletter and intranet.

All staff working for the CCG are required to undertake training on Information Governance standards. During 2014-15 the CCG was compliant with the requirement to have 95% staff working for the CCG having received Information Governance training. Guidance and reminders and updates on information governance have also been disseminated through the staff bulletin throughout the year.

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

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

6.7.1 Access to information

During the period 1 April 2014 to 31 March 2015, the CCG processed the following requests for information under the Freedom of Information (FOI) Act 2000

	2014-15
Number of FOI requests processed	246
Percentage of requests responded to within 20 working days	100%
Average number of days taken to respond to an FOI request	14.1

Table 19 Freedom of Information Requests 2014-15

In 8 cases, no information was provided and in 26 cases, only part of the information was provided because an exemption was applied. Exemptions applied included information being accessible by other means, intended for future publication, the cost of providing the information exceeded the limits set by the FOI Act, the information requested was commercially sensitive or it was personal information.

Our publication scheme contains documents that are routinely published; this is available on our website: http://www.valeofyorkccg.nhs.uk/freedom-of-information-new/publication-scheme/

6.8 Risk assessment in relation to governance, risk management and internal control

The CCG's current significant risks can be found at:
http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/2-april-2015/item-6-assurance-framework.pdf

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

The CCG has significant and realised risks in relation to performance against NHS Constitution targets, including A&E waiting times, Ambulance Turn-around times, 18 week waits from referral to treatment times and waiting times relating to cancer and diagnostic tests. The CCG has proactively managed these risks through the establishment of the multi-agency Urgent Care and Planned Care system resilience groups. These working groups have focussed on understanding the pressure within the system and developing high impact schemes to improve performance drawing on a range of expertise across the health, social care and voluntary sectors. The impact on some schemes established during 2014-15 is expected to be realised in 2015-16 to improve performance and pressure within the urgent care and planned care systems.

The CCG has increased in-house capacity for information analysis, with a dedicated quality analyst in post during 2015-16. The CCG has refreshed the service specifications with Yorkshire and Humber Commissioning Support during 2015-16, including in relation to business intelligence to help manage the risk relating to access to high quality data, and an internal working group has been established to ensure the CCG is using the information available effectively.

The CCG is working with, NHS Property services, Leeds and York Partnership Foundation Trust, English Heritage and City of York Council to implement improvements to the local mental health estate. Proposals for interim solutions have been approved during 2014-15, with expected completion during 2015-16. The CCG will be working with partners to develop a longer term solution relating to mental health services estate.

The Better Care Fund (BCF) plans were completed during 2014-15 and signed off by the relevant Health and Wellbeing Boards. The North Yorkshire and East Riding Council plans were fully approved by NHS England. The City of York BCF plan was approved with support by NHS England, with a high level of ambition around the reduction of non-elective admissions for the City of York. The CCG is proactively managing the risks associated with BCF. During 2014-15 the CCG established joint programme management arrangements for BCF, developed partnership arrangements, including local delivery boards reporting to the Health and Wellbeing Boards and conducted detailed analysis to set the improvement targets. Progress on implementation and delivery against the BCF plans is reported to the CCG Senior Management Team, Quality and Finance Committee and Governing Body.

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

During 2014-15 the CCG's overall financial performance was monitored and managed on a regular basis by the Senior Management Team and by a formal committee of the Governing

Body at the Quality and Finance Committee. The Governing Body also receives a finance report at each meeting which covers all aspects of financial performance.

The CCG began the year planning to maintain the 2013-14 level of surplus at 0.57%. However, throughout the year it became clear that, despite the challenging financial environment, the CCG had the ability to increase this further. This was a result of two key factors.

Firstly, with regards to the nationally mandated accounting for the underutilisation of the continuing healthcare legacy risk pool of £156m in 2014-15, this was returned to all CCGs in the same proportions as their contribution to the original £250m pool. The impact for the Vale of York was £888k that resulted in an equivalent improvement to the planned surplus.

Secondly, a lower than planned spend against our running costs allocation, primarily as a result of staffing vacancies throughout the year.

The target was subsequently amended and the CCG delivered the full 1% surplus and therefore met this key statutory requirement for the first time.

The CCG has undertaken a detailed refresh of the 2015-16 financial plan, year two of the original five year plan covering 2014-15 to 2018-19, including an assessment of the underlying, recurrent financial position from 2014-15. The Governing Body considered and approved this plan, which maintained the full 1% surplus, based on a number of assumptions around contract negotiations at that point in time. The plan clearly articulated the scale of the financial challenge the CCG will face, the level of savings required from the Better Care Fund and Quality, Improvement, Performance and Productivity (QIPP) and a detailed list of contingencies that would need to be enacted to bridge this. It is clear that there are considerable financial risks in the coming year for the CCG.

The QIPP target in the 2014-15 financial plan was £9.4m. Of this £4.4m had always been unidentified and unallocated and £2.9m was actually delivered in year. As outlined above there remains significant risk in the delivery of recurrent savings in order to meet the CCG's part of the national £20bn funding gap outlined in 'A Call to Action' published in July 2013. The CCG is responding to this challenge by focussing on transformational change and the collaborative working across the primary, secondary, social and voluntary sector care in order to deliver this.

The CCG has further increased the finance and contracting team resource during the year. A new Head of Finance was appointed in October 2014 and an additional Contract Analyst post has been filled with an internal secondment. This has further added to the CCG's ability to deliver the financial position at the end of 2014-15 due to the greater analysis that has been undertaken.

The Audit Committee has developed during 2014-15 and has an annual work plan in place in line with the Audit Committee handbook enhanced by specific local requirements. The committee has requested reports in person from the Commissioning Support Unit and

Partnership Commissioning Unit in order to gain assurance on the operation of those bodies and follow up attendances are scheduled during the early part of 2015-16.

6.9.1 Commissioning support

The CCG currently commissions a range of support services from Yorkshire and Humber Commissioning Support and these include:

- Workforce management
- Information management and technology support
- Business intelligence and data management
- Procurement
- Service delivery and transformation
- Communications and engagement
- Corporate services
- Quality and clinical support
- Medicines management

The CCG is working alongside colleagues in other local CCGs to review the support services provided by Yorkshire and Humber Commissioning Support with a view to bringing a number of services in house and to commission other services from the recently procured Lead Provider Framework for commissioning support services. The CCG continues to work closely with NHS England and CCGs across Yorkshire and the Humber to ensure a smooth transition of commissioning support services.

6.9.2 Better Care Fund

The Better Care Fund (BCF) is a joint initiative between health and local authority services, to integrate health and social care systems, and pooling funds to facilitate this.
The emergence of the BCF has strengthened the already effective partnerships the CCG enjoys across the health and social care landscape across the three local authority boundaries the CCG covers in the City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council.

In 2014-15 a number of major initiatives identified for the BCF were commenced in shadow form (to be fully funded from the BCF in 2015-16). Such initiatives included:

- Integrated care pilots in York, Selby and Pocklington;
- Mental Health Street Triage;
- Urgent Care Practitioners;
- The expansion of the Hospice at Home service with St Leonards Hospice for palliative care.

In 2014-15 the total spent on these schemes across all three BCFs was £2m. From 2015-16 £19.4 million of CCG resources will support the BCF in collaboration with the three local authorities and, where relevant, other local CCGs, with a total pooled fund of £77.7m. This is broken down as follows:

- City of York - £11.2m CCG (Total pooled budget - £12.1m)
- North Yorkshire County Council - £6.9m CCG (Total pooled budget - £43.2m)
- East Riding of Yorkshire County Council - £1.3m CCG (Total pooled budget - £22.4m)

This reports a move towards much greater use of financial mechanisms such as pooled budgets to commission services.

The implementation of the Better Care Fund in 2015-16 sees the setting up of a significant pooled budget arrangement, a financial mechanism designed to drive integration and the most efficient use of resources for commissioning of services. The continued development of the BCF during 2015-16 and beyond will see greater sophistication in commissioning arrangements and will support the CCG in shifting care closer to patients own homes, where this is the most appropriate place for care, and a reduced reliance on hospital based care. There are significant contractual and monitoring implications for the CCG and its partners in the Better Care Fund to ensure that the transformation of services is achieved in the required timescales.

6.9.3 Primary care co-commissioning

NHS England recently announced details of the CCGs approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services. The CCG has been approved under delegated commissioning arrangements, which means that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2015 with a total budget of £40.2m.

This will enable the CCG to work in much closer partnership with primary care in achieving better health care services for patients as it will have influence over services, finances and contracts in a way that was not possible previously. This will drive much closer working between primary and hospital care as the CCG can ensure the vision for health services in the Vale of York is disseminated across all parts of the system and now has the influence to drive the necessary changes.

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

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

6.11 Capacity to handle risk

The CCG's approach to risk management is outlined in its Constitution and documented in the CCG Risk Management Policy and Strategy which was reviewed and updated during 2014-15. The document is published on the CCG's website.

The CCG's capacity to handle risk has been enhanced during the past 12 months through implementation of electronic integrated governance and risk management system, Covalent.

The CCG has undertaken a significant amount of work during the year to review and develop its risk management framework and the risk reporting and escalation process. Risks registers are recorded, reported and escalated from this system and structured as follows:

- Project Risks
- Team Risk
- Corporate Risks

Risks are escalated through this structure with red risks being escalated to the Quality and Performance Committee via the corporate risk register report.

The CCG has implemented clear roles and responsibilities in relation to risk management as detailed in the CCG's Risk Management Policy and Strategy.

The Governing Body was briefed regarding the new approach to risk management and the Assurance Framework. Risk is a standing item on the Quality and Finance Committee agenda with a significant risk report being received at each meeting.

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

6.11.1 Roles and responsibilities

6.11.1.1 NHS Vale of York Clinical Commissioning Group Governing Body

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

- Identifies risks to the achievement of its strategic objectives;
- Monitors these via the Assurance Framework;
- Ensures that there is a structure in place for the effective management of risk throughout the CCG;
- Approves and reviews strategies for risk management on an annual basis;
- Receives regular reports from the Quality and Finance Committee and Audit Committee identifying significant clinical risks;
- Receives regular updates and reports from the Management Team identifying significant risks and progress on mitigating actions;

- Demonstrates leadership, active involvement and support for risk management.

6.11.1.2 The Chief Operating Officer

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

- Continually promoting risk management and demonstrating leadership, involvement and support;
- Ensuring an appropriate committee structure is in place, with regular reports to the Governing Body;
- Ensuring that chief officers and senior managers are appointed with managerial responsibility for risk management;
- Ensuring appropriate Policies, Procedures and Guidelines are in place and operating throughout the CCG;
- Ensuring risk management systems are in place throughout the CCG;
- Ensuring the Assurance Framework is regularly reviewed and updated;
- Ensuring that there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body;
- Overseeing the management of risks as determined by the Executive Team;
- Ensuring risk action plans are put in place, regularly monitored and implemented.

6.11.1.3 Senior managers

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

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

6.11.1.4 Head of Integrated Governance

The Head of Integrated Governance has responsibility for:

- Ensuring that a risk register and Assurance Framework are developed and maintained and reviewed by the Senior Management Team;

- Ensuring that Senior Management Team have the opportunity to review risks jointly;
- Providing advice on the risk management process;
- Ensuring that the CCG Assurance Framework and risk register is up to date for the Governing Body and all of its sub committees;
- Working collaboratively with Internal Audit.

6.11.1.5 All staff

All staff working for the CCG are responsible for:

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

The CCG has implemented Covalent software during 2014-15 to support the consistent assessment, monitoring and management of risk. A programme of training has been implemented across each team, with all departments having a lead officer for risk reporting onto Covalent.

The Policy and Assurance Manager provides a lead on the overall implementation and use of Covalent across the CCG. The format for presenting risk information has been improved to provide clear and consistent risk reporting to Committees and Governing Body during 2014-15.

6.12 Review of effectiveness

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

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

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

The system of internal control has been actively reviewed during 2014-15, with the implementation of Covalent software to standardise risk assessment, reporting and management across the CCG. This has included developing project risk registers in addition to the team and corporate risk registers. Risks have been reported to each Quality and Finance Committee, with escalated risks reported to Governing Body through the agenda items and minutes of the Quality and Finance Committee. The Governing Body has received reports on the overall Assurance Framework for CCG.

The Audit Committee has received reports on the Assurance Framework, risk management process and implementation of the risk management software during 2014-15.

During 2014-15 the CCG has also been subject to a series of quarterly assurance review meetings with NHS England in line with the 2014-15 CCG Assurance Framework and has been Assured with Support, with a focus on the CCG finances and performance against the NHS Constitution.

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.

6.13 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 2015

Roles and responsibilities

On behalf of the Clinical Commissioning Group the Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

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

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;

- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

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

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

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

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

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

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within the internal audit risk-based plan, that

have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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

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

During 2014-2015 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to evolve.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. It has revisited the structure of the Assurance Framework during the year along with the risk register.

The CCG has undertaken a significant amount of work during the year to review and develop its risk management framework and the risk reporting and escalation process. The CCG has procured and implemented a system (Covalent) to facilitate this process. Risks registers are recorded, reported and escalated from this system. Risks are escalated through this structure with red risks being escalated to the Quality and Finance Committee via the corporate risk register report. The Governing Body discussed the new approach to risk management at a workshop in July 2014 and a further workshop in August to discuss the direction of travel in relation to the Assurance Framework.

The Governing Body has approved a Risk Management Strategy. This is to be reviewed to reflect the developments during 2014-2015 and changes to the governance structure. This will include how the identification of risk is embedded throughout the organisation and document the revised arrangements for escalating risk to the Governing Body.

Internal Audit undertook a review of the CCG's governance arrangements during the year. This incorporated its risk management, assurance and reporting processes. An overall opinion of Significant Assurance was awarded to the progress being made by the CCG in further embedding these arrangements. A number of recommendations were made to further strengthen risk management and assurance processes and an action plan is being put in place to address these for 2015-2016.

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

The 2014-15 Internal Audit Operational Plan was approved by the Audit Committee on 19 April 2014. The work of Internal Audit has continued to focus on the progress being made in designing, implementing and embedding core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

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

- Financial Governance
- Information Governance.

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

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

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

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

The outcome of the audit reports presented to the CCG from the 2014-2015 audit plan are summarised below.

Audit	Assurance Level
Governance	Significant
Partnership and Pooled Budgets	Significant
Stakeholder Strategy	Significant
Children's Safeguarding	Significant
Delivering of Commissioning Priorities	Significant
Learning to Improve	Significant

Transfer of Payroll	High
Clinical Procurement	High
Financial Systems	High
Information Governance Toolkit	Significant
Partnership Commissioning Unit* –	
Follow Up of Financial Reporting Processes	Limited
Continuing Healthcare	Limited
Out of Area Placements	Significant
Mental Health Contract Management	Significant
Personal Health Budgets	Significant
Adults Safeguarding	Significant
Information Governance Toolkit	Significant

* Note: The Partnership Commissioning Unit (PCU) is a hosted organisation established by the CCGs in North Yorkshire to undertake commissioning activities on behalf of all four organisations. This includes Continuing Health Care, Children Services Commissioning, Mental Health Commissioning and Adult Safeguarding. As part of each internal audit plan a number of audit days are allocated to the audit of systems and controls at the PCU in order to provide assurance to all four CCGS. A detailed audit plan for the PCU for 2014-2015 was agreed to provide assurance in relation to the commissioning activities undertaken on behalf of the CCGs.

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

- Assurance cannot be currently provided that the National Framework for Continuing Healthcare is being met. In April 2013 responsibility for the administration of Continuing Healthcare (CHC) transferred from NHS North Yorkshire and York to the PCU following the NHS reorganisation. The PCU administers CHC on behalf of the four North Yorkshire and York CCGs. In addition to the management and reporting arrangements that required significant improvements the PCU inherited a backlog of CHC assessments and retrospective CHC assessments. The PCU and CHC team is aware of the risks and issues impacting on performance and delivery against the National Framework. Steps have been taken to address the issues, including; review of the team structure, introduction of System One to facilitate greater monitoring, a sub-contract for assessment of retrospective cases and a contract for provision of equipment have been put in place. Whilst the audit confirmed that the assessment and decision making process is compliant with the National Framework the audit

identified a number of areas where further improvement is required in order to comply with the National Framework requirements, in particular meeting timescales and completing on-going reviews of patients. An action plan has been agreed with the PCU to address these issues. Progress is being made on implementing these recommendations. However, they will take some additional time to embed. Further audit work is planned for 2015-2016 to assess the improvements made.

6.14 Audit reports

During the year Internal Audit issued no audit reports to the CCG with a conclusion of no or limited assurance. This is a significant improvement on the reports issued in 2013-14 when three limited assurance reports were issued.

Internal Audit also issued three reports to the CCG with a conclusion of high assurance. This is a considerable improvement on 2013-14 when no reports received this assurance level.

6.14.1 Third party assurances

At the time of writing this report the full and final Third Party Assurances have not yet been received for 2014-15, although the CCG expects them as follows:

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

A draft report has been received for the following:

- Yorkshire and Humber Commissioning Support - services provided under the SLA.

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

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

Throughout 2014-15 the CCG continued with its ambitious work programme of improvement and transformational schemes with a particular focus on working in partnership to develop new projects and pathways of care. The integration of services across health and social care was a particular priority with a number of new initiatives having been implemented in partnership with the CCG's acute provider colleagues, the voluntary sector and with each of the CCG's local authority partners.

Some of the new schemes to help support people at home included:

Urgent Care Practitioners - who are able to visit and treat a large number of individuals in their own home without the need to go to the Emergency Department.

Home from hospital scheme – working in partnership; with Age UK, this scheme supports the transition from hospital, back safely to an individual's residence.

Street triage schemes - to provide crisis support to individuals with mental health problems.

Link support worker scheme – that has improved links between Arclight York Homeless Shelter and the Emergency department at York hospital.

Integration pilots - three ambitious projects in York, Pocklington and Selby that provide care outside of a hospital setting.

Involving a range of providers including health and social care, primary care, and the voluntary sector, early indications showed that the schemes supported a more co-ordinated care approach to help individuals to stay at home.

Recognition of this work nationally was welcomed as the CCG and its partners were announced as one of 25 Pioneer sites across the country; selected as it was recognised as being at the leading edge of innovation in care delivery. Learning from the best examples of health and social care services from across the world will continue to shape the CCG's work in 2015-16.

Delivering high quality services within the resources available remains a priority and a number of improvements to pathways of care have been delivered including the implementation of a Community Diabetes Service and reviews of the prescribing of gluten free products and wound dressings.

A significant number of member practices also invested time in a new general practice improvement programme which helped to identify ways to deliver even better primary care services for the future. The CCG will continue to work closely with colleagues in primary care and ensure GPs are involved in Vale of York commissioning and service improvement projects.

6.15 Data quality

The quality of data available to the CCG has greatly improved in 2014-15, subsequently removing the risks that previously featured on the CCG's Risk Register and board Assurance Framework.

Through changes in the approach to tasks and internal developments that have enhanced the use of data, the following actions to improve the quality of data took place in 2014-15:

- Linking meeting dates and data publication schedules to ensure the robustness of data and that any lag in its presentation to the Quality and Finance Committee and the Governing Body is minimised wherever possible.

- The creation of a comprehensive guide to data for the CCG that includes clear details on the source and frequency of data, together with the various publication schedules.
- Development of a shared area to store data. Discussions continue around the options available, including a shared network drive or an online data management system.
- An agreement between Yorkshire and Humber Commissioning Support and the CCG on the roles and responsibilities of the data analysts in each organisation.
- Improved access and consistency was achieved by the development of a shared email box for all data relating to the CCG or its providers.

The above and continued work in 2015-16 will ensure that providers of system resilience schemes are provided with clearer data and key performance indicators.

Robust processes that are currently underway will also ensure that data is meaningful and timely to enable coherent measurements of scheme successes. An example of this is an urgent care dashboard which is currently under development. It aims to give a more detailed, real time picture of system pressures and in turn highlight opportunities to direct a more timely action.

Work is also underway to compare the functions of the CCG's existing systems including Covalent, RAIDR, Cerner and the Business Information Zone (BIZ), with an aim of ensuring that data is held in the most appropriate location and form to reduce duplication and encourage accuracy and consistency

The CCG also plans to continue with its close monitoring of the performance of Yorkshire and Humber Commissioning Support, managing potential risks linked to data quality and taking immediate remedial action when required.

6.16 Business critical models

The CCG receives modelling advice and support from Yorkshire and Humber Commissioning Support that includes multi-disciplinary expertise for finance, business intelligence, workforce and service re-design services.

Quality assurance is delivered internally to the CCG through peer reviews and Yorkshire and Humber Commissioning Support's own internal audit programme.

The CCG also gains assurance through the involvement of its own staff in the specification and testing of models, often against real life scenarios e.g. through the involvement of clinicians and hospital managers, and through its own internal audit mechanisms too.

6.17 Data security

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

The CCG has no serious untoward incidents relating to data security breaches, including any that were reported to the Information Commissioner.

6.18 Discharge of statutory functions

To ensure compliance with relevant legislation, the CCG's corporate governance arrangements informed the matters reserved for Membership Body and Governing Body decision and scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to a Chief Officer who confirmed that structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

6.19 Conclusion

During 2014-15 the CCG identified no significant internal control issues. The CCG took remedial action through risk assessment and mitigation on the following as detailed in the Annual Report:

- performance against NHS Constitution targets in relation to urgent care and referral to treatment times (A&E 4 hour, 18 weeks, cancer and diagnostic targets)
- financial risks and the delivery of the Better Care Fund;
- the mental health estate for the CCG's patients.

Dr Mark Hayes
Accountable Officer
27 May 2015

7. Statement of Accountable Officer's responsibilities

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

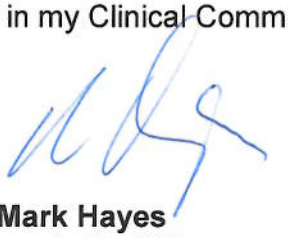
The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction.

The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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



Dr Mark Hayes
Accountable Officer
27 May 2015

Section B

Annual Accounts 2014-15

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

We have audited the financial statements of NHS Vale of York CCG for the year ended 31 March 2015 under the Audit Commission Act 1998[1]. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 72;
- the table of pension benefits of senior managers and related narrative notes on page 75; and
- the pay multiples and related narrative notes on page 76.

This report is made solely to the members of NHS Vale of York CCG in accordance with Part II of the Audit Commission Act 1998 and for no other purpose.

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

[1] References throughout this report to the Audit Commission Act 1998 are saved transitionally for the purposes of the 2014/15 audit of accounts.

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.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Vale of York CCG as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given 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 report by exception

We report to you if:

- in our opinion the governance statement does not comply with NHS England's guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission determined these two criteria as those necessary for us to consider under its Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all significant respects, NHS Vale of York CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

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

Mark Kirkham
for and on behalf of Mazars LLP

The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

27 May 2015

NHS Vale Of York CCG - Annual Accounts 2014-15

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	**4,425**	4,110
Operating expenses	5	**380,446**	365,874
Other operating revenue	2	**(3,684)**	(4,141)
Net operating expenditure before interest		**381,187**	365,843
Investment Revenue	8	**0**	0
Other (gains)/losses	9	**0**	0
Finance costs	10	**0**	0
Net operating expenditure for the financial year		**381,187**	365,843
Net (gain)/loss on transfers by absorption	11	**0**	0
Total net expenditure for the year		**381,187**	365,843
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	**3,337**	3,123
Operating expenses	5	**3,956**	3,059
Other operating revenue	2	**(249)**	(755)
Net administration costs before interest		**7,044**	5,427
Programme Income and Expenditure			
Employee benefits	4.1.1	**1,088**	987
Operating expenses	5	**376,490**	362,815
Other operating revenue	2	**(3,435)**	(3,386)
Net programme expenditure before interest		**374,143**	360,416

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	**0**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	0
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Movements in other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Net gain/(loss) on assets held for sale		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Share of (profit)/loss of associates and joint ventures		**0**	0
Reclassification adjustments		**0**	0
On disposal of available for sale financial assets		**0**	0
Total comprehensive net expenditure for the year		**381,187**	365,843

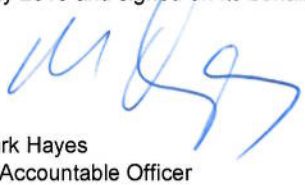
The notes on pages 5 to 49 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	**605**	680
Intangible assets	14	**0**	0
Investment property	15	**0**	0
Trade and other receivables	17	**0**	0
Other financial assets	18	**0**	0
Total non-current assets		**605**	680
Current assets:			
Inventories	16	**0**	0
Trade and other receivables	17	**2,337**	3,755
Other financial assets	18	**0**	0
Other current assets	19	**0**	0
Cash and cash equivalents	20	**145**	38
Total current assets		**2,482**	3,793
Non-current assets held for sale	21	**0**	0
Total current assets		**2,482**	3,793
Total assets		**3,087**	4,473
Current liabilities			
Trade and other payables	23	**(17,398)**	(16,639)
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**(935)**	(280)
Total current liabilities		**(18,333)**	(16,919)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(15,246)**	(12,446)
Non-current liabilities			
Trade and other payables	23	**0**	0
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**0**	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(15,246)**	(12,446)
Financed by Taxpayers' Equity			
General fund		**(15,246)**	(12,446)
Revaluation reserve		**0**	0
Other reserves		**0**	0
Charitable Reserves		**0**	0
Total taxpayers' equity:		**(15,246)**	(12,446)

The notes on pages 5 to 49 form part of this statement

The financial statements on pages 1 to 49 were approved by the Audit Committee on behalf of the Governing Body on 27 May 2015 and signed on its behalf by:



Dr Mark Hayes
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(12,446)	0	0	**(12,446)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(12,446)**	0	0	**(12,446)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(381,187)			**(381,187)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	**0**
Net gain (loss) on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	0	0	**0**
Net actuarial gain (loss) on pensions	0	0	0	**0**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	0	0	0	**0**
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	**0**
Transfers by absorption to (from) other bodies	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	**0**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(381,187)**	**0**	**0**	**(381,187)**
Net funding	378,387	**0**	**0**	**378,387**
Balance at 31 March 2015	**(15,246)**	**0**	**0**	**(15,246)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	0	0	0	0
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	761	0	0	761
Adjusted NHS Commissioning Board balance at 1 April 2013	761	0	0	761
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(365,843)			(365,843)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	0	0	0	0
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
***Net Recognised NHS Commissioning Board Expenditure for the Financial Year**	(365,843)	0	0	(365,843)
Net funding	352,636	0	0	352,636
Balance at 31 March 2014	(12,446)	0	0	(12,446)

*The Net Recognised NHS Commissioning Board Expenditure for the Financial Year 2013-14 was reported as £365,082,000 in 2013-14 Accounts. This was due to a formula error which was outside of the CCG's control.

The notes on pages 5 to 49 form part of this statement

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		**(381,187)**	(365,843)
Depreciation and amortisation	5	**75**	81
Impairments and reversals	5	**0**	0
Movement due to transfer by Modified Absorption		**0**	0
Other gains (losses) on foreign exchange		**0**	0
Donated assets received credited to revenue but non-cash		**0**	0
Government granted assets received credited to revenue but non-cash		**0**	0
Interest paid		**0**	0
Release of PFI deferred credit		**0**	0
Other Gains & Losses		**0**	0
Finance Costs		**0**	0
Unwinding of Discounts		**0**	0
(Increase)/decrease in inventories		**0**	0
(Increase)/decrease in trade & other receivables	17	**1,418**	(3,755)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade & other payables	23	**759**	16,639
Increase/(decrease) in other current liabilities		**0**	0
Provisions utilised	30	**0**	0
Increase/(decrease) in provisions	30	**655**	280
Net Cash Inflow (Outflow) from Operating Activities		**(378,280)**	(352,598)
Cash Flows from Investing Activities			
Interest received		**0**	0
(Payments) for property, plant and equipment		**0**	0
(Payments) for intangible assets		**0**	0
(Payments) for investments with the Department of Health		**0**	0
(Payments) for other financial assets		**0**	0
(Payments) for financial assets (LIFT)		**0**	0
Proceeds from disposal of assets held for sale: property, plant and equipment		**0**	0
Proceeds from disposal of assets held for sale: intangible assets		**0**	0
Proceeds from disposal of investments with the Department of Health		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Proceeds from disposal of financial assets (LIFT)		**0**	0
Loans made in respect of LIFT		**0**	0
Loans repaid in respect of LIFT		**0**	0
Rental revenue		**0**	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(378,280)**	(352,598)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		**378,387**	352,636
Other loans received		**0**	0
Other loans repaid		**0**	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**0**	0
Capital grants and other capital receipts		**0**	0
Capital receipts surrendered		**0**	0
Net Cash Inflow (Outflow) from Financing Activities		**378,387**	352,636
Net Increase (Decrease) in Cash & Cash Equivalents	20	**107**	38
Cash & Cash Equivalents at the Beginning of the Financial Year		**38**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**0**	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**145**	38

The notes on pages 5 to 49 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 *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.
The legacy provision from North Yorkshire & York PCT relating to retrospective continuing healthcare claims is the responsibility of NHS England and is reported within their accounts. The CCG undertakes the administration of these claims on behalf of NHS England.

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Charitable Funds

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the Clinical Commissioning Group is in a "jointly controlled operation", the Clinical Commissioning Group recognises:

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

If the Clinical Commissioning Group is involved in a "jointly controlled assets" arrangement, in addition to the above, the Clinical Commissioning Group recognises:

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 *Critical Judgements in Applying Accounting Policies*

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

Notes to the financial statements

- Secondary Care Activity

Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the CCG with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as block contract arrangements. Although the counting and coding of secondary care is not finalised, this only potentially affects those organisations where there is no year-end agreement in place: Leeds Teaching Hospitals NHS Trust, Mid Yorkshire Hospitals NHS Trust, Harrogate and District NHS Foundation Trust, Hull and East Yorkshire Hospitals NHS Trust and South Tees NHS Foundation Trust. The CCG has used the Provider's forecast outturns wherever a year end agreement has not been in place. The outturn position for Yorkshire Ambulance Service NHS Trust has been finalised.This excludes the charges for Urgent Care practitioners with Yorkshire Ambulance Service of £271,906 which the CCG has challenged.

- Gross/Net Accounting Arrangements for Hosted Services

Scarborough & Ryedale Clinical Commissioning Group (SRCCG) host a Partnership Commissioning Unit (PCU) for the provision of Continuing Healthcare services and the commissioning of Mental Health, Adult Safeguarding and Children's services, on behalf of Scarborough & Ryedale CCG, Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG and Vale of York CCG. All payments relating to these services are transacted through the SRCCG ledger, and expenditure is recharged to the other CCG parties on a risk share basis, the terms of which are defined in the Partnership Commissioning Unit Service Level Agreement.
In 2015/16, although SRCCG will continue to host these arrangements, charges to other CCG's for Continuing Healthcare/Funded Nursing Care, Out of Contract Mental Health will be made on an actual costs basis rather than risk share. Risk share arrangements will remain in place for the PCU Team, Specialist Neurological Rehab and Children's Safeguarding.

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

Continuing Healthcare/Funded Nursing Care
Hambleton, Richmondshire & Whitby CCG 20.23% £11,863,370 (2013-14 20.23% £12,875,572)
Harrogate & Rural District CCG 24.46% £14,344,613 (2013-14 24.46% £15,568,463)
Vale of York CCG 34.64% £20,315,063 (2013-14 34.64% £22,045,444)
Scarborough & Ryedale CCG 20.66% £12,114,345 (2013-14 20.66% £13,147,926)

Mental Health Out of Contract Placements
Hambleton, Richmondshire & Whitby CCG 8.81% £1,188,510 (2013-14 17.78% £1,641,820)
Harrogate & Rural District CCG 12.13% £1,636,349 (2013-14 20.99% £1,937,775)
Vale of York CCG 54.23% £7,318,359 (2013-14 41.42% £3,824,160)
Scarborough & Ryedale CCG 24.84% £3,351,631 (2013-14 19.82% £1,829,920)

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

Hambleton, Richmondshire & Whitby CCG 18.97% £669,403 (2013-14 18.97% £548,109)
Harrogate & Rural District CCG 20.39% £719,337 (2013-14 20.39% £588,996)
Vale of York CCG 45.45% £1,603,353 (2013-14 45.45% £1,321,831)
Scarborough & Ryedale CCG 15.19% £535,979 (2013-14 15.19% £438,861)

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

Children's Safeguarding
Hambleton, Richmondshire & Whitby CCG 18.15% £58,654 (2013-14 18.97% £54,073)
Harrogate & Rural District CCG 21.60% £69,812 (2013-14 20.39% £58,106)
Vale of York CCG 36.12% £116,720 (2013-14 45.45% £129,515)
Scarborough & Ryedale CCG 24.13% £77,983 (2013-14 15.19% £42,305)

Specialist Neurological Rehab
Hambleton, Richmondshire & Whitby CCG 5.00% £111,026 (2013-14 5.00% £90,088)
Harrogate & Rural District CCG 25.00% £555,129 (2013-14 25% £450,441)
Vale of York CCG 50.00% £1,110,258 (2013-14 50.00% £900,881)
Scarborough & Ryedale CCG 20.00% £444,103 (2013-14 20.00% £360,353)

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

Notes to the financial statements

1.7.2 Key Sources of Estimation Uncertainty

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

- Accruals

There are a number of estimated figures within the accounts. The main areas where estimates are included are:
• Prescribing - The full year figure is estimated on the spend for the first 10 months of the year,
• Purchase of Healthcare - The full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner, based on provider predicted forecast outturns.
The CCG has achieved the following level of accuracy in estimation :
Prescribing > 98%
Purchase of Healthcare >99% (based on our main provider)

- Provisions

A number of key assumptions have been included within the accounts concerning the future:
• Bad Debt Provision - there is a specific provision on invoices raised to East Yorkshire Council.
• Continuing Care Provision - The CCG has reflected the PCU estimation of the Continuing Healthcare provision wholly. The clinical commissioning group has made a provision for the backlog of cases that has arisen during the financial year in respect of Continuing Healthcare (CHC). Data is available regarding the number of patients currently awaiting a full CHC assessment. Assumptions around the number of patients ultimately requiring a package and the anticipated price of such packages are derived from current information in the patient database, or from information provided by the clinical team where data is not available. It is expected that the backlog will be cleared within the next financial year.
• IVF - The CCG has reflected an estimation regarding the potential cycles to be completed based on current activity and cost information.

1.8 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period has been calculated and deemed immaterial and has therefore not been recognised in the financial statements.

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment.

1.10 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **Property, Plant & Equipment**

1.11.1 Recognition

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

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

Notes to the financial statements

1.11.2 Valuation

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

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

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

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

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

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

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

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

1.11.3 Subsequent Expenditure

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

1.12 **Intangible Assets**

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

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

Notes to the financial statements

1.13 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

1.16 **Non-current Assets Held For Sale**

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

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

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

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

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

1.17 **Leases**

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

1.17.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Clinical Commissioning Group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 The Clinical Commissioning Group as Lessor

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

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

Notes to the financial statements

1.18 **Private Finance Initiative Transactions**

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

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

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

1.18.3 PFI Liability

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

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

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

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

1.18.4 Lifecycle Replacement

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

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

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

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

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

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

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

1.19 **Inventories**

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

1.20 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group's cash management.

Notes to the financial statements

1.21 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims.

1.25 **Carbon Reduction Commitment Scheme**

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

1.26 **Contingencies**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.27 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

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

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

1.27.1 Financial Assets at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.
The Clinical Commissioning Group does not have any financial assets to disclose.

Notes to the financial statements

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

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

1.27.4 Loans & Receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The Clinical Commissioning Group does not have any loans or receivables to disclose.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 **Financial Liabilities**

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

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

1.28.1 Financial Guarantee Contract Liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

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

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

The Clinical Commissioning Group does not have any financial liabilities to disclose.

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

1.29 **Value Added Tax**

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

1.30 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

Notes to the financial statements

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

Material entities over which the Clinical Commissioning Group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Associates**

Material entities over which the Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Clinical Commissioning Group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **Joint Ventures**

Material entities over which the Clinical Commissioning Group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 **Joint Operations**

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

1.37 **Research & Development**

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

2 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Recoveries in respect of employee benefits	**21**	4	17	0
Patient transport services	**0**	0	0	0
Prescription fees and charges	**123**	0	123	67
Dental fees and charges	**0**	0	0	0
Education, training and research	**0**	0	0	0
Charitable and other contributions to revenue expenditure: NHS	**0**	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	**0**	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	**0**	0	0	0
Receipt of Government grants for capital acquisitions	**0**	0	0	0
Non-patient care services to other bodies	**3,527**	239	3,288	3,737
Income generation	**0**	0	0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**0**	0	0	0
Other revenue	**13**	6	7	337
Total other operating revenue	**3,684**	**249**	**3,435**	4,141

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

Revenue in this note includes cash received from City of York Council of £1,116,557 for Better Care Fund and prescribing and from North Yorkshire County Council of £914,897 for Better Care Fund and prescribing.

3 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	**3,684**	249	3,435	4,141
From sale of goods	**0**	0	0	0
Total	**3,684**	**249**	**3,435**	4,141

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	**3,572**	3,424	148	**2,757**	2,663	94	**815**	761	54
Social security costs	**285**	285	0	**225**	225	0	**60**	60	0
Employer Contributions to NHS Pension scheme	**418**	418	0	**324**	324	0	**94**	94	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**150**	150	0	**31**	31	0	**119**	119	0
Gross employee benefits expenditure	**4,425**	**4,277**	**148**	**3,337**	**3,243**	**94**	**1,088**	**1,034**	**54**
Less recoveries in respect of employee benefits (note 4.1.2)	**(21)**	(21)	0	**(4)**	(4)	0	**(17)**	(17)	0
Total - Net admin employee benefits including capitalised costs	**4,404**	**4,256**	**148**	**3,333**	**3,239**	**94**	**1,071**	**1,017**	**54**
Less: Employee costs capitalised	**0**	**0**	**0**	**0**	0	0	**0**	0	0
Net employee benefits excluding capitalised costs	**4,404**	**4,256**	**148**	**3,333**	**3,239**	**94**	**1,071**	**1,017**	**54**

2013-14	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	**3547**	2959	588	2708	2164	544	839	795	44
Social security costs	**228**	228	0	171	171	0	57	57	0
Employer Contributions to NHS Pension scheme	**328**	328	0	244	244	0	84	84	0
Other pension costs	**0**	0	0	0	0	0	0	0	0
Other post-employment benefits	**0**	0	0	0	0	0	0	0	0
Other employment benefits	**0**	0	0	0	0	0	0	0	0
Termination benefits	**7**	7	0	0	0	0	7	7	0
Gross employee benefits expenditure	**4,110**	**3,522**	**588**	**3,123**	**2,579**	**544**	**987**	**943**	**44**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,110**	**3,522**	**588**	**3,123**	**2,578**	**544**	**987**	**943**	**44**
Less: Employee costs capitalised	**0**	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,110**	**3,522**	**588**	**3,123**	**2,578**	**544**	**987**	**943**	**44**

4.1.2 Recoveries in respect of employee benefits

2014-15				2013-14		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits - Revenue						
Salaries and wages	**(17)**	(17)	0	0	0	0
Social security costs	**(2)**	(2)	0	0	0	0
Employer contributions to the NHS Pension Scheme	**(2)**	(2)	0	0	0	0
Other pension costs	**0**	0	0	0	0	0
Other post-employment benefits	**0**	0	0	0	0	0
Other employment benefits	**0**	0	0	0	0	0
Termination benefits	**0**	0	0	0	0	0
Total recoveries in respect of employee benefits	**(21)**	(21)	0	0	0	0

4.2 Average number of people employed

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**81**	77	4	59
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	0	0	0

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	**1318**	741
Total Staff Years	**81**	59
Average working Days Lost	**16**	13

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	**0**	**0**
£10,001 to £25,000	0	0	0	0	**0**	**0**
£25,001 to £50,000	0	0	0	0	**0**	**0**
£50,001 to £100,000	2	149,777	0	0	**2**	**149,777**
£100,001 to £150,000	0	0	0	0	**0**	**0**
£150,001 to £200,000	0	0	0	0	**0**	**0**
Over £200,001	0	0	0	0	**0**	**0**
Total	**2**	**149,777**	**0**	**0**	**2**	**149,777**

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

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**0**	**0**

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

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

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

Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the NHS Pension Scheme.

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

The above payments were a result of restructuring that occurred within the Partnership Commissioning Unit. Under IAS 18, net accounting principles apply to the reporting of PCU expenditure. The above value, therefore, reflects this CCG's share of the total PCU restructuring costs; 2 payments totalling £329,574. Both payments were early retirement options under the compulsory redundancy scheme.

4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

4.5 Pension costs

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

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

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	**3,303**	2,215	1,088	3,214
Executive governing body members	**1,122**	1,122	0	896
Total gross employee benefits	**4,425**	**3,337**	**1,088**	**4,110**
Other costs				
Services from other CCGs and NHS England	**7,281**	2,604	4,677	5,254
Services from foundation trusts	**242,632**	1	242,631	239,367
Services from other NHS trusts	**27,543**	0	27,543	26,925
Services from other NHS bodies	**0**	0	0	529
Purchase of healthcare from non-NHS bodies	**42,033**	0	42,033	37,916
Chair and Non Executive Members	**0**	0	0	0
Supplies and services – clinical	**402**	0	402	0
Supplies and services – general	**7,162**	58	7,104	5,027
Consultancy services	**187**	144	43	101
Establishment	**333**	258	75	223
Transport	**18**	16	2	12
Premises	**702**	389	313	847
Impairments and reversals of receivables	**0**	0	0	0
Inventories written down	**0**	0	0	0
Depreciation	**75**	75	0	81
Amortisation	**0**	0	0	0
Impairments and reversals of property, plant and equipment	**0**	0	0	0
Impairments and reversals of intangible assets	**0**	0	0	0
Impairments and reversals of financial assets	**0**	0	0	0
· Assets carried at amortised cost	**0**	0	0	0
· Assets carried at cost	**0**	0	0	0
· Available for sale financial assets	**0**	0	0	0
Impairments and reversals of non-current assets held for sale	**0**	0	0	0
Impairments and reversals of investment properties	**0**	0	0	0
Audit fees	**97**	97	0	98
Other non statutory audit expenditure				
· Internal audit services	**38**	38	0	46
· Other services	**1**	1	0	0
General dental services and personal dental services	**0**	0	0	0
Prescribing costs	**48,316**	0	48,316	47,873
Pharmaceutical services	**0**	0	0	0
General ophthalmic services	**106**	0	106	145
GPMS/APMS and PCTMS	**1,795**	0	1,795	1,082
Other professional fees excl. audit	**7**	7	0	33
Grants to other public bodies	**246**	0	246	0
Clinical negligence	**0**	0	0	8
Research and development (excluding staff costs)	**0**	0	0	0
Education and training	**277**	275	2	35
Change in discount rate	**0**	0	0	0
Provisions	**655**	(7)	662	0
CHC Risk Pool contributions	**540**	0	540	0
Other expenditure	**0**	0	0	272
Total other costs	**380,446**	**3,956**	**376,490**	**365,874**
Total operating expenses	**384,871**	**7,293**	**377,578**	**369,984**

6.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**3582**	**30743**	2894	23883
Total Non-NHS Trade Invoices paid within target	**3515**	**30496**	2642	23210
Percentage of Non-NHS Trade invoices paid within target	**98.13%**	**99.20%**	91.29%	97.18%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3263**	**307212**	2346	281315
Total NHS Trade Invoices Paid within target	**3216**	**306847**	2220	280180
Percentage of NHS Trade Invoices paid within target	**98.56%**	**99.88%**	94.63%	99.60%

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2014-15 £000**	2013-14 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities (2013-14 nil).

8. Investment revenue

The Clinical Commissioning Group had no investment revenue in 2014-15. (2013-14 nil)

9. Other gains and losses

The Clinical Commissioning Group had no other gains or losses in 2014-15. (2013-14 nil)

10. Finance costs

The Clinical Commissioning Group had no finance costs in 2014-15. (2013-14 nil)

11. Net gain/(loss) on transfer by absorption

There is no net gain/loss on transfer by absorption.

12. Operating Leases

12.1 As lessee

NHS Property Services, on behalf of Vale of York Clinical Commissioning Group, is finalising a tenancy agreement with the City of York Council for space within West Offices, Station Rise, York. The proposed agreement is for a period of six years, with a four year break, commencing 1st April 2013. The lease will be held by NHS Property Services and the Clinical Commissioning Group was recharged the full cost under a separate agreement from 2014/15.

For 2014/15, NHS Property Services costs have been calculated and invoiced to the Clinical Commissioning Group based on the actual cost of the buildings. The charge to the Clinical Commissioning Group includes rental cost for properties occupied and subsidy and void charges where properties are unused or the organisation liable for rental has not yet been identified by NHS Property Services.

For 2014/15 this equated to a charge of £485,334 for the Clinical Commissioning Group. In addition £94,095 rental was charged to the Clinical Commissioning Group through the Partnership Commissioning Unit's hosted services.The subsidy and void charges will continue in 2015/16 only after which NHS Property Services will be liable for the cost of these buildings.

12.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	579	1	**580**	743
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**579**	**1**	**580**	**743**

12.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payable:					
No later than one year	0	425	12	**437**	276
Between one and five years	0	827	23	**850**	1103
After five years	0	0	0	**0**	0
Total	**0**	**1,252**	**35**	**1,287**	**1,379**

12.2 As lessor

12.2.1 Rental revenue

	2014-15 £000	2013-14 £000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value

	2014-15 £000	2013-14 £000
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

13 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	756	0	5	0	761
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost or valuation At 31 March 2015	**0**	**0**	**0**	**0**	**756**	**0**	**5**	**0**	**761**
Depreciation 1 April 2014	0	0	0	0	76	0	5	0	81
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	75	0	0	0	75
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**151**	**0**	**5**	**0**	**156**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**
Purchased	0	0	0	0	605	0	0	0	605
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**
Asset financing:									
Owned	0	0	0	0	605	0	0	0	605
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	0	0	0	0	0	0	0	0	0
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**	756	0	5	**0**	**761**
Adjusted Cost or valuation at 1 April 2013	**0**	**0**	**0**	**0**	**756**	**0**	**5**	**0**	**761**
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	**0**
Additions purchased	0	0	0	0	0	0	0	0	**0**
Additions donated	0	0	0	0	0	0	0	0	**0**
Additions government granted	0	0	0	0	0	0	0	0	**0**
Additions leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation gains	0	0	0	0	0	0	0	0	**0**
Impairments charged	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	**0**
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 31 March 2014	**0**	**0**	**0**	**0**	**756**	**0**	**5**	**0**	**761**
Depreciation 1 April 2013	0	0	0	0	0	0	0	0	**0**
Adjusted depreciation 1 April 2013	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation gains	0	0	0	0	0	0	0	0	**0**
Impairments charged	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	76	0	5	0	**81**
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	**0**
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	**0**
Depreciation at 31 March 2014	**0**	**0**	**0**	**0**	**76**	**0**	**5**	**0**	**81**
Net Book Value at 31 March 2014	**0**	**0**	**0**	**0**	**680**	**0**	**0**	**0**	**680**
Purchased	0	0	0	0	680	0	0	0	**680**
Donated	0	0	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**0**	**0**	**0**	**680**	**0**	**0**	**0**	**680**
Asset financing:									
Owned	0	0	0	0	680	0	0	0	**680**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**0**	**0**	**0**	**680**	**0**	**0**	**0**	**680**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2013	0	0	0	0	0	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0	0	0	0	0	**0**
Adjusted balance at 1 April 2013	0	0	0	0	0	0	0	0	**0**
Revaluation gains	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Release to general fund	0	0	0	0	0	0	0	0	**0**
Other movements	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	0	0	0	0	0	0	0	0	**0**

Assets transferred from closed NHS bodies as a result of the 1 April 2013 transition relate to ISTC Equipment transferred from North Yorkshire and York PCT.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group had no additions to assets under construction in 2014-15 (2013-14 nil).

13.2 Donated assets

The Clinical Commissioning Group has not had any assets donated in 2014-15 (2013-14 nil).

13.3 Government granted assets

The Clinical Commissioning Group has not had any government granted assets in 2014-15 (2013-14 nil).

13.4 Property revaluation

There have been no property revaluations performed in 2014-15 (2013-14 nil).

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties for assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure (2013-14 nil).

13.6 Write downs to recoverable amount

The Clinical Commissioning Group has had no assets written down to recoverable amounts and no reversals of previous write-downs (2013-14 nil).

13.7 Temporarily idle assets

The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2015 (31 March 2014 nil).

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2014-15 £000	2013-14 £000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	605	680
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	0	0
Total	**605**	**680**

13.9 Economic lives

	Minimum Life (Years)	**Maximum Life (Years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	10	10
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	0	0

14 Intangible non-current assets

The Clinical Commissioning Group had no intangible assets as at 31 March 2015. (31 March 2014 nil)

14 Intangible non-current assets cont'd

14.1 Donated assets

The Clinical Commissioning Group has not had any donated intangible assets in 2014-15 (2013-14 nil).

14.2 Government granted assets

The Clinical Commissioning Group has not had any government granted intangible assets in 2014-15 (2013-14 nil).

14.3 Revaluation

There have been no intangible non-current assets revaluations in 2014-15 (2013-14 nil).

14 Intangible non-current assets cont'd

14.4 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties for intangible assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure (2013-14 nil).

14.5 Write downs to recoverable amount

The Clinical Commissioning Group has had no intangible assets written down to recoverable amounts and no reversals of previous write-downs (2013-14 nil).

14.6 Non-capitalised assets

The Clinical Commissioning Group purchased licences and support for specific software during 2014-15 (2013-14 nil). These are under the control of the Clinical Commissioning Group during the period the licence is purchased for but do not meet the recognition criteria of IAS38 for capitalisation as an intangible asset as the licences are annual and do not allow for the probable flow of future economic benefits.

14.7 Temporarily idle assets

The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2015 (31 March 2014 nil).

14.8 Cost or valuation of fully amortised assets

The Clinical Commissioning Group had no fully amortised assets still in use as at 31 March 2015 (31 March 2014 nil).

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	0	0
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

15 Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2015 (31 March 2014 nil).

16 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2015 (31 March 2014 nil).

17 Trade and other receivables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	616	0	2,274	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	972	0	876	0
Non-NHS receivables: Revenue	718	0	578	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	37	0	25	0
Provision for the impairment of receivables	(15)	0	0	0
VAT	9	0	2	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**2,337**	**0**	**3,755**	**0**
Total current and non current	**2,337**		**3,755**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

17.1 Receivables past their due date but not impaired	**2014-15 £000**	2013-14 £000
By up to three months	207	98
By three to six months	35	0
By more than six months	10	0
Total	**252**	**98**

£0 of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2015 (31 March 2014 nil).

17.2 Provision for impairment of receivables	**2014-15 £000**	2013-14 £000
Balance at 1 April 2014	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(15)	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2015	**(15)**	**0**

	2014-15 £000	2013-14 £000
Receivables are provided against at the following rates:		
NHS debt	0	0

18 Other financial assets

The Clinical Commissioning Group had no other financial assets as at 31 March 2015 (31 March 2014 nil).

19 Other current assets

The Clinical Commissioning Group had no other current assets as at 31 March 2015 (31 March 2014 nil).

20 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	38	0
Net change in year	107	38
Balance at 31 March 2015	**145**	**38**
Made up of:		
Cash with the Government Banking Service	145	38
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**145**	**38**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**145**	**38**
Patients' money held by the Clinical Commissioning Group, not included above	0	0

21 Non-current assets held for sale

The Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2015 (31 March 2014 nil).

22 Analysis of impairments and reversals

The Clinical Commissioning Group had no impairments or reversals of impairments recognised in expenditure during 2014-15 (2013-14 nil).

23 Trade and other payables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	5,690	0	7,605	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	1,873	0	0	0
Non-NHS payables: revenue	1,248	0	1,388	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	8,379	0	7,527	0
Social security costs	32	0	26	0
VAT	0	0	0	0
Tax	39	0	38	0
Payments received on account	0	0	0	0
Other payables	137	0	55	0
Total Trade & Other Payables	**17,398**	**0**	**16,639**	**0**
Total current and non-current	**17,398**		**16,639**	

Other payables include £48,947 outstanding pension contributions at 31 March 2015 (£41,988 at 31 March 2014)

24 Other financial liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2015 (31 March 2014 nil).

25 Other liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2015 (31 March 2014 nil).

26 Borrowings

The Clinical Commissioning Group had no borrowings as at 31 March 2015 (31 March 2014 nil).

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2015 (31 March 2014 nil).

28 Finance lease obligations

The Clinical Commissioning Group had no finance lease obligations as at 31 March 2015 (31 March 2014 nil).

29 Finance lease receivables

The Clinical Commissioning Group had no finance lease receivables as at 31 March 2015 (31 March 2014 nil).

30 Provisions

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	7	0
Continuing care	696	0	273	0
Other	239	0	0	0
Total	**935**	**0**	**280**	**0**
Total current and non-current	**935**		**280**	

	Pensions Relating to Former Directors £000s	**Pensions Relating to Other Staff £000s**	**Restructuring £000s**	**Redundancy £000s**	**Agenda for Change £000s**	**Equal Pay £000s**	**Legal Claims £000s**	**Continuing Care £000s**	**Other £000s**	**Total £000s**
Balance at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**273**	**0**	**280**
Arising during the year	0	0	0	0	0	0	0	696	239	935
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	(7)	(273)	0	(280)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**696**	**239**	**935**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	696	239	935
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**696**	**239**	**935**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG.The total value of legacy NHS Continuing Healthcare risk share provision accounted for by NHS England on behalf of this CCG as at 31 March 2 is £325,037. In 2013/14 the CCG reported a % share of the legacy provision (£3,934,000).In 2014/15 the legacy provision has been replaced by a national risk pool.

31 Contingencies

	2014-15 £000	2013-14 £000
Contingent liabilities		
NHS Litigation Authority Legal Claims	0	2
Net value of contingent liabilities	**0**	**2**

Contingent assets

The Clinical Commissioning Group had no contingent assets as at 31 March 2015 (31 March 2014 nil).

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group had no capital commitments not otherwise included in the financial statements as at 31 March 2015 (31 March 2014 nil).

32.2 Other financial commitments

The Clinical Commissioning Group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2014-15 £000	2013-14 £000
In not more than one year	0	35
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**0**	**35**

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The Clinical Commissioning Group borrows from Government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the Clinical Commissioning Group revenue comes from parliamentary funding, the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	**Loans and Receivables 2014-15 £000**	**Available for Sale 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	616	0	616
· Non-NHS	0	718	0	718
Cash at bank and in hand	0	145	0	145
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**1,479**	**0**	**1,479**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,274	0	2,274
· Non-NHS	0	578	0	578
Cash at bank and in hand	0	38	0	38
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**2,890**	**0**	**2,890**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	**Other 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,563	7,563
· Non-NHS	0	9,764	9,764
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**17,327**	**17,327**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,605	7,605
· Non-NHS	0	8,915	8,915
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**16,520**	**16,520**

34 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2014-15 £'000	2013-14 £'000
Total net expenditure reported for operating segments		
Reconciling items:		
Commissioned Services	381,187	365,843
Total net expenditure per the Statement of Comprehensive Net Expenditure	**381,187**	**365,843**

34.2 Reconciliation between Operating Segments and SoFP

	2014-15 £'000	2013-14 £'000
Total net assets reported for operating segments		
Reconciling items:		
Commissioned Services	3,087	4,473
Total net assets per Statement of Financial Position	**3,087**	**4,473**

	2014-15 £'000	2013-14 £'000
Total liabilities reported for operating segments		
Reconciling items:		
Commissioned Services	18,333	16,919
Total liabilities per Statement of Financial Position	**18,333**	**16,919**

35 Pooled budgets

The Clinical Commissioning Group was not party to any pooled budget arrangements during 2014-15 (2013-14 nil).

36 NHS Lift investments

The Clinical Commissioning Group had no NHS LIFT investments as at 31 March 2015 (31 March 2014 nil).

37 Intra-government and other balances

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	0	0	17	0
· Local Authorities	673	0	107	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	309	0	3,113	0
· NHS Trusts and Foundation Trusts	1,279	0	4,449	0
Total of balances with NHS bodies:	**1,588**	**0**	**7,562**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	76	0	9,712	0
Total balances at 31 March 2015	**2,337**	**0**	**17,398**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	0	0	0	0
· Local Authorities	554	0	107	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	881	0	3,050	0
· NHS Trusts and Foundation Trusts	2,269	0	4,555	0
Total of balances with NHS bodies:	**3,150**	**0**	**7,605**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	51	0	8,927	0
Total balances at 31 March 2014	**3,755**	**0**	**16,639**	**0**

38 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Louise Barker Mental Health Clinical Lead Governing Body Member - Partner works as Consultant Psychiatrist in Tees Esk and Wear Valley Foundation Trust	1,143	0	0	-166
Dr Emma Broughton Governing Body Member - York Out of Hours Service Harrogate and District Foundation Trust	9,485	0	124	0
Dr Emma Broughton Governing Body Member - Partner at Priory Medical Group	950	0	367	0
Dr Tim Hughes Chair of Council of Representatives Governing Body Member - GP Partner at Kirkbymoorside Surgery	83	0	0	0
Dr Tim Hughes Chair of Council of Representatives Governing Body Member - Spouse is Staff Nurse at York Teaching Hospitals Foundation Trust	197,764	0	1,579	-931
Dr Tim Maycock Governing Body Member - Partner at Pocklington Group Practice	155	0	0	0
Dr Tim Maycock Governing Body Member - Spouse works as Deputy Retail Manager at St Leonard's Hospice and Fundraiser for St Leonard's Hospice	1,144	0	0	0
Dr Shaun O'Connell Governing Body Member - Salaried GP at South Milford Surgery	679	0	0	0
Dr Shaun O'Connell Governing Body Member - Spouse an anaesthetist at York Teaching Hospitals Foundation Trust	197,764	0	1,579	-931
Dr Andrew Phillips Urgent Care Lead and Governing Body Member - Locum GP at Drs NJ Wilson & JF Matthews, based at Helmsely Medical Practice (from Aug-14)	48	0	0	0
Dr Andrew Phillips Urgent Care Lead and Governing Body Member - Locum GP at Kirkbymoorside Surgery (until Aug-14)	83	0	0	0
Dr Andrew Phillips Urgent Care Lead and Governing Body Member - Provides Out of Hours sessions for Primecare	260	0	0	0
Michelle Carrington Deputy Chief Nurse Governing Body Member (from 01/12/14 to 5/3/15) - employee of York Teaching Hospitals Foundation Trust on secondment to Vale of York CCG	197,764	0	1,579	-931
John McEvoy Practice Manager Representative Member of the Governing Body (unitl 04/12/2014) - Managing Partner at Haxby Group Practice	411	0	0	0
Dr Guy Porter Governing Body Member - Consultant Radiologist at Airedale NHS Foundation Trust	19	0	10	0
Richard Webb Associate Governing Body Member - Corporate Director of North Yorkshire County Council	4,571	-907	7	-282
Kersten England Governing Body Member - Chief Executive City of York Council	2,117	-700	98	-241
Kersten England Governing Body Member - Spouse is Trustee at York CVS	42	0	0	0
Sian Balsom Co-opted Member of Governing Body (from 01/08/14) - Manager at Healthwatch York, emplpoyed by York CVS	42	0	0	0
Dr Chris Burgin Governing Body - Salaried GP at Tadcaster Medical Practice	337	0	0	0
Paul Edmondson-Jones Ex Officio Governing Body Member (until 07/11/14) - Director of Public Health, Director of Adult Services at City of York Council	2,117	-700	98	-241
Paul Edmondson-Jones Ex Officio Governing Body Member (until 07/11/14) - Member of Advisory Board for Centre for Reviews and Dissemination at University of York	130	0	0	0

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

- NHS England;
- NHS Hambleton Richmondshire and Whitby CCG
- NHS Harrogate and Rural District CCG
- NHS Scarborough and Ryedale CCG
- NHS North Yorkshire and Humber CSU
- York Teaching Hospital NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust
- North Lincolnshire and Goole NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with City of York Council and North Yorkshire County Council.

39 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services.

NHS Vale of York Clinical Commissioning Group has been approved under delegated commissioning arrangements which means that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2015. The Clinical Commissioning Group's notified delgated allocation for primary care co-commissioning in 2015/16 is £38.682m.

There are no other post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group (2013-14 nil).

40 Losses and special payments

The Clinical Commissioning Group had no losses and special payments during 2014-15 (2013-14 nil).

41 Third party assets

The Clinical Commissioning Group had no third party assets as at 31 March 2015 (2013-14 nil).

42 Financial performance targets

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

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

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	385,038	381,187	367,899	365,843
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	385,038	381,187	367,899	365,843
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	8,625	7,044	5,427	5,427

* In the 2013-14 Accounts Revenue resource use on specified matter(s) does not exceed the amount specified in Directions was reported as the total programme expenditure (target and performance).This was an error and the comparatives in this note have been amended to reflect this.

43 Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2014-15 financial year (2013-14 nil).