Item Number: 11

Name of Presenter: Michael Ash-McMahon

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Annual Report and Accounts 2017/18

Purpose of Report *(Select from list)*
To Ratify

Reason for Report

The Annual Report and Accounts (attached) have been approved by the Audit Committee on 23 May 2018. The CCG's external auditors' Annual Audit Letter is also attached.

Strategic Priority Links

☐Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☒Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

Governing Body is asked to ratify the Annual Report and Accounts.

Responsible Executive Director and Title	Report Author and Title
Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse Michael Ash-McMahon, Acting Chief Finance Officer	Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse Michael Ash-McMahon, Acting Chief Finance Office

The documents referred to above have been circulated electronically to members of the Governing Body and are available at http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/

NHS
Vale of York
Clinical Commissioning Group

Annual Report
2017-18

Annual Report and Accounts 2017-18

Issue date:	25 May 2018
Document number:	ARA2017-18**FINAL**
Prepared by:	NHS Vale of York Clinical Commissioning Group Governing Body

Annual Report and Accounts 2017-18

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 2017 and 31 March 2018.

The report is made up of three parts. The first section contains details of the organisation's performance for 2017-18, with the second section covering details of governance and risk. The third is the financial accounts for the year 2017-18.

As a publicly accountable body, the CCG is committed to being open and transparent with its stakeholders. In 2017-18 the Governing Body met monthly (except in August) and the CCG hosted a number of engagement events that involved local patients and other stakeholders. Details of these meetings and events are published on the CCG's website at www.valeofyorkccg.nhs.uk. An electronic copy of this document is also available on the CCG's website. Information contained in this report can also be requested in other languages. If you need this or if would like additional copies of this report, please contact the CCG.


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Performance Report

Phil Mettam

Accountable Officer

24 May 2018

24/5/18

Foreword

By the Accountable Officer and the Lay Chair of the Governing Body

The local health and care system moved into 2017-18 with a large deficit and a forecasted financial deterioration of £40m. It also left behind it a year where important constitutional targets were not consistently delivered.

We are pleased to report that this report and its accounts demonstrate the stabilisation of the local system's financial position in 2017-18. The performance across many of the CCG targets also improved and stabilised in 2017-18. However the financial deficit remains and our work with partners to reduce cost inefficiencies, duplication and unnecessary variation are helping to ensure that the local system delivers our precious resources in ways so they drive improvement and help to achieve better value for money.

'Place' is becoming increasingly important and the move to focus on population and place is allowing us to plan with partners and challenge where things do not work as well as they could for patients. Our review and reform of our governance structure and the CCG's Governing Body plays a key role in this, ensuring there is an even brighter spotlight on clinical issues and good quality outcomes for local patients.

The emphasis on place is also demonstrated in the establishment of localities within the Vale of York that represent three distinct communities and their primary care providers. The localities and their GP representatives will help the CCG to develop commissioning plans, service transformation and quality improvements to address the specific needs of the populations in the City of York, North and South localities.

We launched our Commissioning Intentions in February 2018. One of the most positive features of the commissioning intentions is that they reflect the issues that the local community highlighted at our series of engagement events. These plans, alongside our important work with partners to strategically develop and deliver services in joined-up, integrated ways will help to manage the risks around delivering the local system's financial, performance and quality improvement. We aim to achieve this through the transformation of acute services, the strengthening of our primary care provision and the development of mental health services – all of which were highlighted by local patients and the public as being important to them.

Knowing what is important to the community at the planning stages has proved essential and helps with our work to develop a safer and stronger community, supporting key prevention and behaviour change initiatives that can ultimately reduce demand on more expensive interventions. We continue into 2018-19 with our call to the local community to be involved and tell us what is important to them about local health and care services.

Phil Mettam
Accountable Officer

Keith Ramsay
Lay Chair 2017-18

Foreword

By the Chair of Council of Representatives

This is my third Annual Report forward that has reflected on the previous year. In last year's report I anticipated that the most challenging and ultimately most satisfying work was yet to come as we tried to address not just the financial deficit but also what we wanted the Vale of York health and social care system to look like. We wanted to review what worked well in the past and agree the areas that needed changing, updating or improving.

Therefore I am delighted to concur with my colleagues about the tangible and consistent progress made. This was characterised by significant engagement with the public, with hundreds of events, large and small, throughout the Vale of York. The experiences and views gathered up have been incorporated into the CCG's Commissioning Intentions - the CCG's priority list of work.

The underlying and main priority is to ensure that each contact we have with others has a purpose and meaning, hence reducing those frustrating gaps in the system and enabling focus on quality of care at all levels.

The collaborative relationships with partners in our health and social care system have become more focussed and dynamic now that our three localities are established and I trust that you will see a real, positive, change in services in the next year, the ones that make you say 'Well that makes sense' and 'I feel valued'.

Dr Paula Evans
Chair of the Council of Representatives 2017-18

1. Performance Overview

This section provides an overview of the context in which NHS Vale of York CCG operates, with the main features of 2017-18 summarised, together with a summary of the commissioning intentions for the future. This is followed by a more detailed analysis of performance.

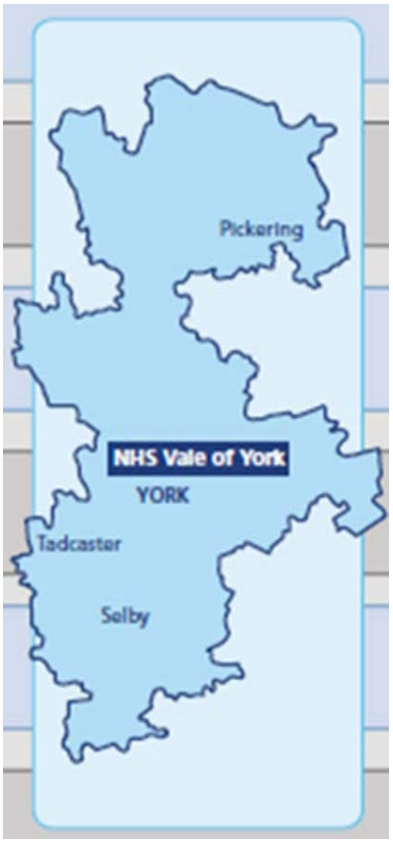

Fig 1: The Vale of York footprint

1.1 CCG footprint

The CCG serves towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of over 350,000 people).

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

In 2017-18, the CCG had 26 member GP practices in its operating area and an annual commissioning budget of £455.1m.

The budget is set by central government and is based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

The CCG's current population as at February 2018 is:

Age Band	Population
0 - 4	16,085
5 - 64	270,809
65+	69,917
Total	**356,811**

Table 1: Vale of York population- February 2018

The CCG's footprint (the area for which it commissions services) includes urban, semi-urban and rural areas. It shares administrative boundaries with three local authorities, City of York Council, parts of North Yorkshire County Council (covering Selby and parts of Hambleton and Ryedale districts) and a part of the East Riding of Yorkshire Council area (Pocklington).

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

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

These localities are co-ordinated alongside the Scarborough and Ryedale localities through the Vale and Scarborough Health and Care Partnership Board, allowing programmes of work across both CCGs to be delivered with strong oversight and joint accountability.
In 2017-18 the CCG has appointed a clinical representative from each of these localities to sit on the Governing Body to support delivery of transformation plans moving forward. These locality leads will provide a critical link between providers, commissioners and wider partners as well as between programmes of work and key committees and the CCG Council of Representatives. In the highly complex geography and challenged financial environment that is apparent in the Vale of York, this is critical as the CCG delivers its operational and recovery plans.

1.1.2 Commissioning intentions

The CCG commissioning intentions capture the plans and programmes of transformation for service delivery which effectively improve the health and care outcomes of the Vale of York population. These are collectively called the Local Place Based Plan. The CCG Commissioning Intentions are discussed in further detail on page 26, and the full text is available on the CCG website at http://www.valeofyorkccg.nhs.uk//our-work/commissioning2018/19/

These plans focus on the priorities the CCG believes will have the greatest impact on delivering the triple aim of financial recovery, performance recovery and quality improvement, through transforming acute services, strengthening our primary care provision and developing mental health services to better meet growing needs.

1.1.3 Partnership working

The majority of CCG programmes of work are delivered jointly with CCG partners (providers of health and care services, other commissioners, NHS England, the CCG regulatory body and local stakeholders and patient representatives including Healthwatch). During 2017-18, the CCG agreed and established the acute service transformation programme which is at the core of the Medium-term System Financial Recovery plan across the Vale of York and Scarborough and Ryedale (“Vale and Scarborough”) system. The delivery of financial efficiency across acute services is a key requirement of the CCG for the next three to five years, and this system plan also now provides a delivery framework for performance recovery for some of the key health

performance targets including Referral to Treatment in 18 weeks (RTT), A&E four hour and Delayed Transfers of Care (DToCs).

The CCG is also working with its primary care partners in localities to develop the out of hospital services required to deliver more integrated care and ensure patients only access hospital services when they need.

Additionally, the Vale and Scarborough system is part of the Humber, Coast and Vale (HCV) Sustainability and Transformation Partnership (STP) and the CCG's collaborative work with STP partners focuses on transformation where there is the greatest possible impact for our local population from working and sharing best practice at this footprint.

This joint partnership working enabled through developing future services outside of the Payment by Results (PbR) contract framework is fundamental to performance and financial recovery in the Vale of York system and ensuring that the CCG delivers the best possible services within the available funding allocation.

1.1.4 Strengthening Joint Commissioning

The CCG has established a Joint Commissioning Committee with NHS Scarborough and Ryedale CCG and NHS East Riding CCG to support the delivery of the Vale and Scarborough System Medium Term Financial Recovery Plan and the CCGs' commitment to commissioning collaboratively.

1.1.5 Moving towards an Integrated Care System in 2018-19

The establishment of the Vale and Scarborough Health and Care Partnership Board in 2017-18 has created the opportunity to develop the principles of an Integrated Care System (ICS) across a footprint that is aligned to the delivery of acute care with the main provider, York Teaching Hospital NHS Foundation Trust, and to support the CCG with its partners in delivering wider system transformation.

This transformation will require the active involvement of wider NHS providers (predominantly GP practice provision at scale, and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)) and also local authority partners representing the interests of the City of York, North Yorkshire, and East Riding.

This formative ICS represents a population of approximately 500,000 and the service transformation required across the acute footprint may also require alignment with the West Yorkshire STP due to the positioning of Harrogate acute services. This is an important foundation for the CCG to support financial and performance recovery moving forward.

1.1.6 Managing risks to delivery

The CCG discharges its duties in delivering high quality, safe and effective healthcare services to its local population while working with partners to mitigate risks to this delivery. The key risks for the CCG and its partners include:

- Significant workforce capacity gaps and pressures, including a lack of qualified nurses, healthcare assistants and medical staff in certain specialties which has proved challenging when delivering services over winter and meeting some of the key performance targets across pathways (including dermatology, head and neck and colorectal services).

- Fragmented patient pathways where services have developed across multiple providers and complex geographical boundaries over time and under the Payment by Results (PbR) framework. This makes developing robust performance improvement plans challenging and time consuming, but the CCG has focused on developing more effective system solutions across partner organisations and clinically-led to ensure that the patient is at the heart of delivery. This is critical when driving improvements in DToCs and A&E 4 hour performance.

- Financial recovery pressures in the Vale and Scarborough system which limit the ability of the CCG to rapidly move healthcare funding around the system to support services and patients with the most need, as well as identify capital investment funding. The CCG has worked to develop non-PbR frameworks for the development of future services moving into 2018-19 which support organisations in coming together within the available system financial envelope to transform services, manage activity and processes across shared care pathways and target interventions which improve performance.

1.2. An overview of 2017-18

1.2.1 Our ‘Big Conversations’ event series

The CCG has focused its attention over the last year on the needs of the local populations by having a series of “Big Conversations” with those living in the Vale of York area over healthcare priorities. During 2017 the CCG asked people: “What is important to you about local healthcare services?” The CCG held and attended over 100 events and forums and talked to over 1,200 people. They ranged from public events with our Accountable Officer and clinical leads to working with the voluntary sector and local Healthwatch as well as hosting library, market and student drop-in sessions to ensure that the CCG captured as wide a range of views as possible.

In particular, between July and October 2017 the CCG held over 40 face-to-face events as part of its ‘Big Conversations’. These sessions specifically focused on the current financial challenges and asked the population what would be their priorities. It was important that the

CCG provided an opportunity to as many people as possible to have their say about the future of health services and to ensure the best outcomes for people.

1.2.2 Our three strategic paths

The CCG's three strategic pathways (development of primary care, joint commissioning with Local Authority partners and acute transformation) were set out in its Commissioning Intentions (see below for further detail) highlight the areas where there is greatest scope for system change. By reducing costs in the acute sector into primary and community care, patients can receive care closer to home. However, such a shift requires co-operation between multiple partners and while the foundations for collaboration are being laid, the route ahead is a complex one.

Among the initiatives to date, the CCG has provided practice resilience funding, supporting its GP practices, established a joint commissioning post with City of York Council, and instigated a number of new initiatives with partners to address urgent care services.
These include continuing to work with Yorkshire Ambulance Service to use Urgent Care Practitioners in local Care Homes and supporting inner-city GP home visits to avoid unnecessary Emergency Department (ED) attendances and admissions, the provision of additional staff in the Out of Hours team to work alongside staff in the ED and again reduce long waits where these are not required, supporting discharge projects with the Acute Trust and local council partners to ensure patients receive the support they need in their home to avoid being a repeat urgent admission, and the continued provision of information for healthcare professionals to support diagnosis and treatment for small children with urgent issues.

Equally there have been a number of projects completed across the wider region that will improve integration between providers and hence access to urgent care. These include the provision of Urgent Treatment Centres to replace previous Urgent Care Centres and Minor Injury Units – the new Centres will have consistent access to diagnostics, x-ray imaging and links with local primary care services to improve the offers that can be made to patients. This links to the new NHS111 phone app that lets patients work through their symptoms, have an outcome suggested and then direct bookings can be made into appropriate specialists or clinics. Work has been done with services supporting options for patients with chronic breathing difficulties – again so they are not transported to ED unless this is required. Over the next year all the urgent care services will continue to come closer together so that patients can get the right urgent care in the right place as quickly and effectively as possible.

In terms of the development of primary care, the CCG has been proactively engaged with the national programme for the GP Forward View, working closely with practices and NHS England to support practices to become more sustainable and resilient, to develop the workforce and signpost towards training, together with supporting increases in patient access, for example by booking appointments and ordering prescriptions online, and by making evening and weekend appointments available.

The CCG has worked closely with general practice on quality assurance of GP services. The practices in the area have scored highly on the annual patient satisfaction surveys, as well as in the Quality and Outcomes Framework national assessment. A new surgery has been constructed for Unity Health, which opened earlier this year, which will provide more consulting rooms, and hence greater capacity, in modern up-to-date premises.

1.2.3 Financial stabilisation

There has been a clear improvement in financial performance through 2017-18 and the CCG is no longer a significant outlier in Yorkshire and Humber. The 2016-17 in-year financial position was a deficit of £17.5m and the 2017-18 outturn was £20.1m after the release of the 0.5% non-recurrent national risk reserve (£2.0m) and Category M drug benefit (£443k). With the nominal exclusion of the exceptional No Cheaper Stock Obtainable (NCSO) additional prescribing expenditure of £1.9m, the 2017-18 in year out turn is largely in line with 2016-17 at circa £18.2m.

The 2017-18 outturn of £20.1m is also largely aligned with the CCG's risk adjusted 2017-18 financial plan of £21.0m submitted in March 2017. There are variances within this but the adjustments above account for the difference.

The CCG's opening underlying position for 2017-18 was a deficit of £22.4m and the exit underlying position has improved to a deficit of £21.7m forming the basis of the financial plan for 2018-19. This demonstrates an overall positive run-rate which is also supported by specific activity and performance measures.

The CCG has agreed a **2017-18 contract settlement** with York Teaching Hospital NHS Foundation Trust at the earliest ever point in the financial year. This was a negotiated settlement by Vale of York for all three of the main commissioners to the contract so mitigates the risk much more widely and has enabled a focus on 2018-19 at a much earlier stage. It is worth noting that the CCG was ready to embark on the Expert Determination process to resolve a long-standing dispute with the Trust but that this has been incorporated, wholly in the CCG's favour, in to the year-end settlement. The agreed outturn figure for 2017-18 is £195.1m against a contract value of £194m and compared to an outturn of £192m in 2016-17, the lowest level of acute cost growth since the CCG was authorised.

The CCG's **contract management** approach has been commended by Governing Body, Finance and Performance Committee and NHS England for the grip, control and detailed reporting and monitoring that takes place. The CCG has also again received 'significant assurance' for the contract management internal audit review. The CCG is leading the drive to implement a new contracting and payment mechanism with York Teaching Hospital NHS Foundation Trust for 2018-19 with agreement in place for an Aligned Incentives Contract approach and work to develop this is now well-advanced.

On **prescribing**, Vale of York remains the lowest in Yorkshire and Humber on weighted per capita prescribing costs and has implemented a Prescribing Indicative Budgets scheme during

2017-18 which incentivises practices to better manage the prescribing budget and there is evidence this is releasing further cost savings

The CCG has achieved a level of **QIPP savings** higher in both financial value and percentage of plan than any previous year with £7.9m of savings delivered in 2017-18. The 2017-18 delivery has been underpinned with robust performance measurement and monitoring of delivery using a combination of Finance and Business Intelligence metrics, bespoke for each QIPP project.

1.2.4 Governance and structures

The CCG has reviewed all terms of reference and membership terms for the committees, including the link in between Executive Committee and the next level of senior management. The scheme of delegation has been updated and a communication strategy developed for staff and stakeholders. A structure chart of the current committee arrangements is included in the Governance Report on page 78.

Both the committee structure and the Governing Body reset are covered within an updated constitution which was submitted to Council of Representatives in April 2018 and will be considered by NHS England in May 2018.

1.3 Governing Body membership

1.1.1 Context

In 2016 the CCG was placed under Legal Directions by NHS England. Prior to this, the CCG's Chief Clinical Officer left the organisation and an interim Chief Officer was appointed.
The interim Chief Officer was not a clinician and so the continuation of a Lay Chair of the Governing Body was contrary to the NHS England guidance. However, NHS England advised that this arrangement would remain in place until such time as the CCG permanently recruited a substantive Chief Officer and should that person not be a clinician, that an appropriately qualified clinician be recruited to the role of Chair of the Governing Body.

These arrangements were made under the terms of the Legal Directions and therefore working contrary to the NHS England guidance was accepted by NHS England. The move to clinical leadership within the CCG and more robust clinical governance of decision making will be a significant factor enabling NHS England to consider lifting the Legal Directions.

1.3.2 Current position

The CCG substantively recruited the Accountable Officer, Phil Mettam, in June 2017. This effectively put the CCG in the position where a Clinical Chair of the Governing Body must be recruited, in order to comply with national guidance. In drawing up plans for how the Governing Body might transition to having a Clinical Chair, consideration was also given to how the CCGs member practices might be appropriately represented on the Governing Body.

In December 2017 the Council of Representatives approved a reset of the Governing Body which included three GP representatives from the localities of NHS Vale of York CCG area. The CCG has undertaken a process with Council of Representatives to identify those representatives, and the new membership is set out below.

As of 1 April 2018 the Governing Body has been reset to include representatives from the localities of the NHS Vale of York CCG area. This has seen the following members of the Governing Body cease their term of office:

Dr Paula Evans
Dr Stuart Calder
Dr Andrew Philips
Dr Shaun O'Connell
Dr Louise Barker
Dr Emma Broughton

And instead the Governing Body will comprise a Clinical Chair, Dr Nigel Wells, and three locality representatives:

Dr Helena Ebbs
Dr Ruth Walker
Dr Andrew Field

The above Governing Body members are in addition to the Executive Team and lay members. This will ensure that the CCG is compliant with NHS England guidance having a management Accountable Officer and a Clinical Chair and that the CCG can demonstrate local clinical leadership.

1.4. Performance analysis

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

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

1. There is continued and sustainable delivery of performance at target where these are already delivering at target.
2. Identification of the trajectory for return to performance target where this is not currently being delivered
3. Development and delivery of agreed actions with partners which support this return to target, including any escalation or proposals for investment in equipment, capacity or

interventions which address pressures on services and are underpinning suboptimal performance (e.g. diagnostic equipment for sleep services; additional support for dementia diagnosis in general practice; winter plans).

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

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

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

Contractually this is formally monitored with providers through the sub-Contract Monitoring Boards (CMB) for Quality and Performance and any escalations taken to the over-arching CMB.

1.4.1 Performance summary 2017-18

A summary of the CCG performance in 2017-18 across key NHS Constitution targets is summarised below.

The performance across many of the CCG targets improved and stabilised in 2017-18. The CCG continued to discharge its duties under legal Directions with monthly Planned Directions meetings and quarterly assurance checkpoints with NHS England, supported by comprehensive performance reporting to Finance and Performance Committee.

Internal audit of performance assurance in January 2018 reported ‘significant assurance’ around the governance of performance assurance in the CCG. This has supported the CCG in agreeing the process and timeline for exiting from legal Directions by quarter two in 2018-19.

The CCG also monitors and delivers improvement plans which support the achievement of NHS England Improvement Assessment Framework (IAF) indicators and reviews these quarterly with NHS England. The 2016-17 IAF assessment for the CCG was ‘inadequate’ due to the CCG being under Legal Directions and having a large financial deficit. However, there was a clear requirement for performance improvement around the clinical priority areas for cancer, mental health and dementia which were all rated as ‘requiring improvement’. Progress in delivering this performance improvement is captured in the performance headlines below.

The full 2017-18 year-end assessment for NHS Vale of York CCG will be available on https://www.nhs.uk/service-search/performance/search from July 2018.

		Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A&E	% of attendances where patient was discharged, admitted or transferred within 4 hours of arrival	≥95%	92.9%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	tbc
Diagnostics	% of patients waiting over 6 weeks for a Diagnostic test	≤1%	3.8%	3.5%	2.8%	2.2%	1.6%	1.6%	2.0%	1.8%	2.1%	3.4%	tbc	tbc
RTT	% of patients on incomplete pathways waiting no more than 18 weeks from referral	≥92%	89.7%	90.2%	90.2%	89.7%	89.3%	88.8%	89.2%	89.2%	88.1%	87.5%	tbc	tbc
Cancer	% seen within 14 days of urgent referral - all cancer types	≥93%	90.5%	89.6%	90.4%	84.8%	84.3%	87.3%	86.8%	96.4%	93.5%	96.1%	tbc	tbc
	% seen within 14 days of urgent referral - breast symptoms	≥93%	91.9%	95.5%	96.6%	96.8%	98.3%	100.0%	97.6%	91.3%	93.0%	93.2%	tbc	tbc
	% of patients receiving first definitive treatment within 31 days of diagnosis	≥96%	95.00%	98.90%	97.80%	97.40%	97.40%	96.60%	95.20%	98.20%	98.30%	98.30%	tbc	tbc
	% of patients receiving second or subsequent treatment within 31 days - Surgery	≥94%	91.50%	97.90%	95.20%	100.00%	97.60%	97.60%	85.10%	94.20%	97.10%	92.90%	tbc	tbc
	% of patients receiving second or subsequent treatment within 31 days - Drug	≥98%	100.00%	100.00%	99.60%	100.00%	99.20%	100.00%	100.00%	100.00%	100.00%	100.00%	tbc	tbc
	% of patients receiving second or subsequent treatment within 31 days - Radiotherapy	≥94%	100.00%	100.00%	100.00%	100.00%	97.70%	100.00%	100.00%	100.00%	100.00%	98.40%	tbc	tbc
	% of patients receiving first definitive treatment within 62 days of urgent GP referral	≥85%	83.60%	74.00%	76.10%	81.80%	87.30%	74.10%	72.50%	87.40%	87.00%	84.90%	tbc	tbc
	% of patients receiving first definitive treatment within 62 days of referral from an NHS cancer screening service	≥90%	83.30%	100.00%	100.00%	100.00%	100.00%	94.40%	88.90%	90.00%	86.70%	100.00%	tbc	tbc
IAPT	Improving Access to Psychological Therapies - Access Rate (3 month rolling basis)	4.2% per quarter	1.96%	1.98%	2.29%	2.47%	2.68%	2.60%	2.66%	tbc	tbc	tbc	tbc	tbc
	Improving Access to Psychological Therapies - Recovery Rate (3 month rolling basis)	50%	47.8%	48.9%	45.6%	45.8%	40.3%	40.0%	45.7%	tbc	tbc	tbc	tbc	tbc
EIP	Early Intervention in Psychosis - % seen within 2 weeks (3 month rolling basis)	50%	44.4%	45.0%	55.6%	50.0%	57.9%	68.8%	88.9%	66.7%	56.3%	tbc	tbc	tbc

Table 2: Vale of York performance against national IAF indicators

1.4.2 A&E 4 hour performance

The local urgent care system continues to struggle to meet the 4-hour A&E standard despite being on trajectory until November 2017, and did not meet the local target of 92% in March 2018. Nationally this is also the case, and a number of systems that were previously achieving this performance standard in 2016-17 have been far less consistent over this most recent year, and the 2017-18 winter period in particular.

However, a number of innovative projects have been scoped and implemented across the whole of this year which all had an incremental effect on the achievement of this performance standard. The CCG and partners have previously implemented a number of schemes to manage attendances at A&E and these continue to be effective, with numbers of attendances remaining static, despite an increasing population. There has also been the introduction of services to reduce the pressure on beds and assist system flow, such as newly commissioned beds for non-weight bearing patients in local care homes rather than hospital; improved support for assessment of Continuing Health Care applicants; out-patient services to provide anti-microbial therapies; the pro-active centralised management of flu campaigns resulting in high vaccination rates across all parts of the system; joint contributions from the CCGs, Local Authorities, acute and community teams to Multi-Agency Discharge Events (MADE) which support the earlier identification of complex patients that require a coordinated future response to prevent repeated A&E attendances; and the CCG continuing to support the focus of the York Integrated Care Team in managing vulnerable patients outside of hospital with a wider winter skill mix that contained more Paramedic and Pharmacy input. Additionally the CCG specifically responded to local General Practitioner requests to repeat the funding of additional patient appointments over the Christmas and New Year period.

The performance against the 4-hour target for the system was as a result 1.8% better in December 2017 as compared to December 2016, and 3.2% better in January 2018 as compared to January 2017. The North region generally has performed well, which may reflect the good communication across local and regional systems and whilst during December York was a national hot-spot for flu, during 2017-18 the system has stopped requiring support from the Emergency Care Improvement Programme (ECIP) and continues to hold their own against similar systems. The CCG is now working on the lessons learnt from a number of recent reviews to draft the ongoing and Winter Plans for the A&E Delivery Board to implement during 2018-19 to maintain the improvement in performance.

1.4.3 Ambulance handovers

Ambulance handovers also continue to be a challenging part of the Urgent Care System; the standards for handovers to take place within 15 minutes of ambulance arrival continue to be met in the majority of cases in York, however, they remain below the 75% the CCG would aspire to for best patient care. The times for crews to then turn around and be made available again for their next jobs are good in York and there is significant willingness of partners such as the Yorkshire Ambulance Service to work with the CCG to continue to improve handover times. Over winter the performance against the standard has deteriorated, reflecting the blockages in flow into the acute system beds and A&E. A significant piece of work took place during the early part of 2017, which highlighted the opportunity for ambulance crews to ‘self-

handover' their patients into other parts of the urgent care system that are more appropriate to patient needs rather than taking all patients directly to A&E. More work is planned for 2018-19 looking specifically at 'diversionary pathways'; ways to ensure that patients with complex needs can be redirected to their local services and reduce the need for handover and potential delays for this group of patients.

1.4.4 Referral to Treatment 18 weeks (RTT)

	% of Incomplete Pathways within 18 weeks (Target 92%)																		
	Cardiology	Cardiothoracic Surgery	Dermatology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Neurology	Neurosurgery	Ophthalmology	Oral Surgery	Other	Plastic Surgery	Rheumatology	Thoracic Medicine	Trauma & Orthopaedics	Urology	CCG Total
Feb-17	93.3%	80.0%	95.3%	90.7%	87.8%	98.8%	85.9%	100.0%	89.5%	96.9%	95.7%	94.0%	100.0%	94.1%	84.7%	93.8%	84.3%	88.6%	82.4%	90.5%
Mar-17	93.6%	83.3%	96.4%	93.4%	85.2%	99.1%	88.3%	100.0%	89.4%	95.4%	91.9%	91.5%	-	95.0%	82.0%	96.3%	83.5%	88.6%	80.7%	90.6%
Apr-17	92.7%	85.7%	95.5%	92.3%	91.1%	97.6%	87.5%	100.0%	89.3%	95.6%	90.5%	87.7%	-	94.3%	81.8%	96.3%	82.2%	86.6%	78.1%	89.7%
May-17	92.6%	85.7%	94.0%	94.0%	91.1%	98.4%	88.5%	100.0%	90.1%	93.4%	94.7%	88.9%	-	94.7%	85.6%	94.2%	78.9%	86.6%	82.1%	90.2%
Jun-17	92.5%	85.7%	90.7%	92.0%	93.2%	96.9%	89.4%	100.0%	89.4%	92.5%	88.6%	89.1%	-	95.1%	88.3%	93.9%	77.8%	88.1%	83.2%	90.2%
Jul-17	90.1%	80.0%	90.3%	90.5%	90.5%	95.3%	90.3%	99.2%	90.2%	92.8%	92.3%	86.8%	-	94.6%	89.9%	93.9%	79.8%	89.8%	82.9%	89.7%
Aug-17	93.3%	50.0%	86.4%	89.1%	92.5%	95.7%	88.0%	97.4%	90.8%	94.1%	94.4%	86.5%	-	93.8%	87.7%	91.7%	79.5%	91.8%	83.7%	89.3%
Sep-17	93.4%	71.4%	86.5%	89.8%	92.2%	96.5%	87.4%	98.8%	89.7%	94.5%	93.8%	85.9%	-	93.6%	81.3%	92.3%	78.1%	91.3%	82.7%	88.8%
Oct-17	94.1%	90.0%	87.3%	90.4%	93.3%	98.9%	87.1%	98.0%	90.7%	96.5%	87.5%	85.3%	-	94.1%	82.2%	93.6%	80.2%	91.7%	82.9%	89.2%
Nov-17	93.4%	85.7%	85.5%	90.2%	95.0%	98.9%	86.8%	100.0%	92.3%	94.6%	100.0%	85.4%	-	94.3%	83.4%	93.7%	78.3%	91.8%	83.1%	89.2%
Dec-17	92.7%	100.0%	86.2%	89.3%	94.8%	98.9%	86.0%	99.0%	91.5%	92.9%	92.9%	81.8%	-	93.3%	82.3%	91.7%	77.7%	92.8%	80.9%	88.1%
Jan-18	91.3%	75.0%	86.7%	87.0%	91.8%	97.8%	85.6%	98.9%	90.3%	94.2%	89.5%	81.5%	-	93.9%	82.1%	93.1%	76.9%	92.2%	80.6%	87.5%

Table 3: Referral to Treatment 18 weeks

RTT performance had improved slightly over the year until January 2018, when the impact of national requirements to suspend all non-urgent elective care to support winter non-elective care pressures, caused RTT performance to decline to the current level of 84.1% against the national target of 92%.

Through 2017-18 the CCG has worked with the acute Trust to support the specialties where there have been the greatest pressures on capacity, including dermatology and colorectal services and performance is now improving. Likewise the CCG and Trust have worked to further utilise the local Referral Support Service (RSS) in managing demand pressures on all specialties, resulting in an overall reduction in GP referrals to acute elective care by -3.2%, and this focus on managing demand will continue into 2018-19.

Specialties where there continue to be pressures include head and neck, ENT, ophthalmology, general surgery (particularly vascular surgery) and urology. Some of these pressures are due to long-term vacancies in medical staffing establishments.

1.4.5 Cancer performance

All cancer performance targets are now delivering at target as at March 2018, including the two week urgent referrals, 31 day and 62 day targets. The performance has improved over the winter period due to lower pressures on elective care specialties, and the CCG will continue to work to ensure this performance becomes sustainable in 2018-19. The lung, prostate and

colorectal cancer pathways remain challenged in delivering the cancer 62 day performance mostly due to delays caused by a lack of diagnostic capacity at local acute providers in York, Leeds and Hull. The CCG is working with the Cancer Alliance to implement rapid assessment and diagnostic pathways in these areas. There has been work during 2017-18 to roll out the new bowel cancer screening programme and support pressures on the two week urgent referrals capacity. Similarly the provision of dermatoscopes for general practice to support provision of images for skin urgent referrals has resulted in improvements in two week performance in dermatology.

A key focus for 2018-19 will be beginning the data collection to support the new 28 day cancer definitive diagnosis performance target and the new cancer waiting time system from April 2018.

1.4.6 Diagnostics

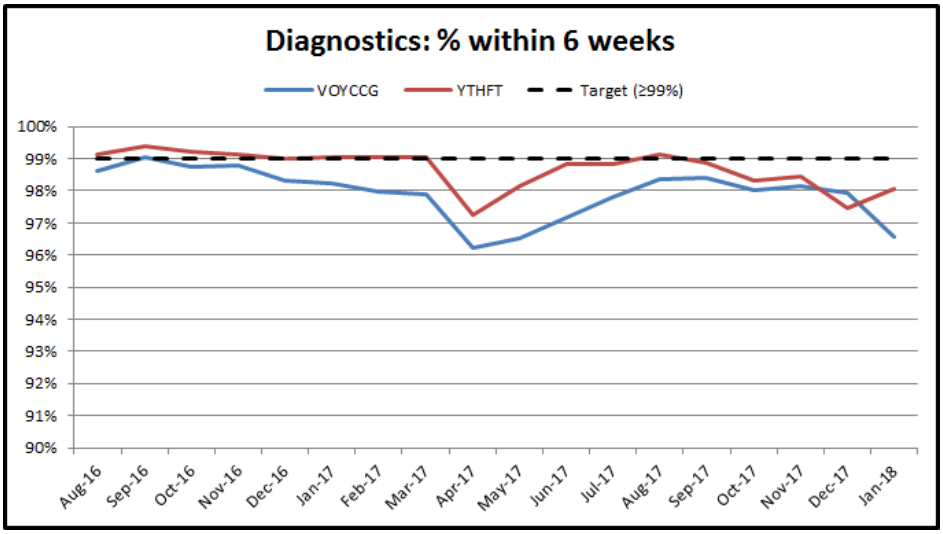

Fig 2: Diagnostic % within six weeks

The CCG achieved 96.6% against the 99% target for patients waiting less than 6 weeks for a Diagnostic Test in January 2018. There were a total of 120 breaches out of 3,506 on the waiting list.

One of the biggest diagnostic challenges is CT capacity at Hull and East Yorkshire Hospitals NHS Trust (HEY). In January 2018 the number of breaches increased to 20 for Vale of York CCG patients and a further 19 breaches for Scarborough and Ryedale CCG patients. The new CT scanner at HEY is now operational and CT scans are also being subcontracted out to Spire until the end of March 2018 to provide extra capacity and clear the current backlog. MRI capacity at York Hospital is also an ongoing issue and in January 2018 there were 17 MRI breaches. The Trust has submitted a bid to NHS England to provide additional funding to increase MRI capacity to accommodate the 'winter backlog' and the MRI patients waiting for GA clinics.

Sleep Studies breaches has been another ongoing issue over the last few months and a business case for new equipment has been approved by the CCG to replace old equipment and improve efficiency of the service.

York Teaching Hospitals Foundation Trust's overall performance was 98.1% in January 2018 and did not meet the diagnostic target of 99%. Un-validated data for February shows York Teaching Hospital NHS Foundation Trust's performance at 97.9%.

1.4.7 Delayed Transfers of Care (DToCs)

DTOC: YTHFT Delayed Bed Days					
Acute			Non-acute		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
802	660	⇩	556	483	⇩

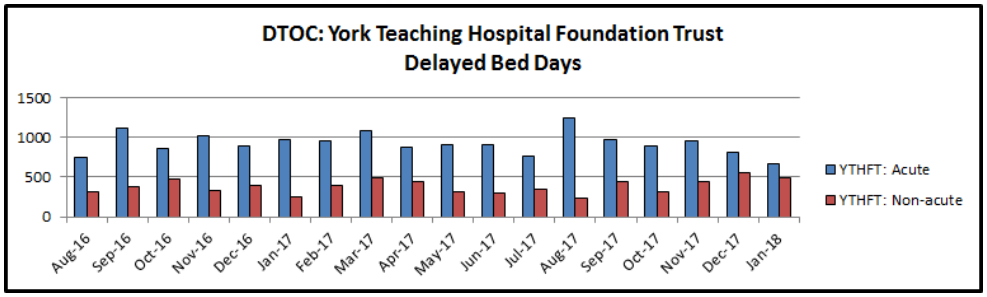

Table 4: Delayed Transfers of Care

DTOC: York UA Delayed Bed Days					
Acute			Non-acute		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
399	227	⇩	626	599	⇩

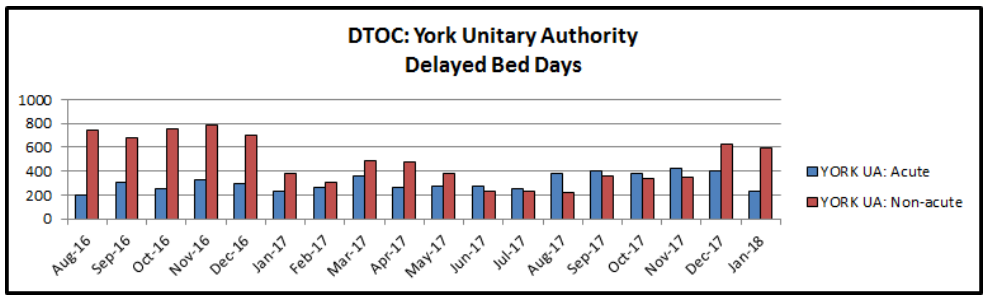

Table 5: Bed days re Delayed Transfers of Care

The number of bed days for acute DToCs reduced to 660 in January 2018 from 802 in December 2017. There was also a reduction in the bed days for non-acute DToCs from 556 in December to 483 in January 2018.

York Hospital experienced sustained pressure linked to the influenza strains and respiratory viruses within the local community in December and January 2018. Flu patients have been cohorted on Ward 23 for the past 2 months and wards have also been affected by Norovirus. Symptomatic patients on these wards are unable to be discharged and whilst this impacts on bed capacity, they do not count as delayed transfers of care.

Actions to address the poor performance include:

- With effect from Saturday 2 December 2017 Social Workers and Care Staff are working 7 days per week to facilitate discharges from York Hospital.

- Discharge Liaison Team at York Hospital are operating 7 days per week with effect from February 2018.
- CYC increased the number of hours for packages of home care from providers in January 2018 to assist with discharges.

1.4.8 Dementia diagnosis

Dementia diagnosis coding rates in primary care continue to prove a challenge. Progress has been made through the year and the recorded rate has risen to above 60% of modelled rate.

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

Significant support has been provided to the CCG from the local Clinical Network with a view to raising the coding rates and this has had some success.

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

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

1.4.9 Improved Access to Psychological Therapies

Following the NHS England-NHS Improvement Intensive Support Team review of the Vale of York's Improved Access to Psychological Therapies (IAPT) service in February 2017, TEWV and the CCG worked on a combined action plan to clear the backlog and develop a new assessment and treatment pathway. Given the scale of the challenge, NHS England consented to the CCG's access target being 15% during Quarter 4 rather than the national expectation of 16.8%.

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

For the first time ever since the introduction of the national target for accessing psychological services was introduced, the local service achieved this in January 2018 and the staff in the service should be commended for achieving the target following a period of change and service improvements.

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

1.4.10 Children's and Adolescents' Mental Health Services

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

A capacity and demand gap analysis received by the CCG indicates a need for greater investment, and is under review. The CCG is working with local authority colleagues to better understand the pressures into the range of services and how to both prioritise and de-escalate these.

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

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

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

1.4.11 Early Intervention in Psychosis

The national target for Early Intervention in Psychosis (EIP) programmes should offer patients experiencing a first episode psychosis who commence a NICE concordat package of care within 2 weeks of referral. The position over the year has deteriorated and has been challenging for the provider because of a combination of recruitment pressures and an increase in demand for this level of service. The provider reports increased numbers of referrals.

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

1.4.12 Continuing Health Care

The two key performance areas for continuing health care are the 28 day referral to decision on Decision Support Tool (DST) assessments which should be 80% by end of March in accordance with the CCG's improvement plan, and no more than 15% of DSTs undertaken in an acute hospital.

The delivery of this has been challenging due to the backlog identified in 2017, the difficulties of managing performance information separately to the clinical system, workforce and recruitment challenges both across social care and with Continuing Health Care (CHC) nurse assessors. Although this target has not been met there has been benefit from streamlining the pathway and further recruitment is ongoing to increase and diversify the professional mix of the CHC assessors.

The CCG has achieved the reduction required in DSTs undertaken in an acute hospital by Q4 through creating a discharge to assess pathway and supporting the hospital discharge hub with skilled CHC practitioners. As a result the associated delayed transfers of care have reduced.

1.5 Commissioning Intentions 2018-19

The commissioning intentions identify what will be done in 2018-19 to ensure that that the services that are commissioned by Vale of York CCG are safe and effective and that they are commissioned within the financial parameters that apply; at the same time initiating the changes that are needed to the health and care system to achieve stability and long term sustainability.

This needs all organisations within the health and care system to work together in concert, putting people and communities ahead of individual organisational concerns. There is a commitment to do this; the challenges that are faced are beyond the ability of individual organisations to solve, but by working together we will be able to achieve the fundamental shift that is needed.

There is a real opportunity to act in 2018-19 so that commitment in principle becomes a reality in practice - to achieve the best outcomes for the people that we serve.

1.5.1 What does this mean in practice?

This will start with improving the ability of individuals and communities to take responsibility for their own physical and mental health and well-being. Based on the “primary care home” model, they will be supported to do this by professionals working together across traditional health and care boundaries and by making full use of the valuable resources offered by the voluntary sector. By strengthening primary and out of hospital care, better personalised and preventative care can be provided for local communities; when health care is needed, this can be provided closer to home in a way that is easier to navigate, which in turn will reduce reliance on hospital services.

This is consistent with national and local strategies – and importantly, it is what people in the Vale of York told us they wanted.

1.5.2 How will this affect people and communities?

There will be greater emphasis on supporting people to take more responsible for their own health and well-being, with improved access to primary care and simplified care pathways that are better integrated and easier to navigate. As well as allowing people e.g. with long term conditions to have greater choice and control through personalised health budgets.

1.5.3 How will this affect general practice and primary care?

General Practice and Primary care has a unique understanding of the needs of local communities. Locality working will be central to making sure that the different needs of local communities are reflected in the decisions that are made. This is reflected in changes to CCG governance that puts the clinical voice at the centre of decision making; GPs now have the opportunity to be the voice of their local area.

1.5.4 National context; operational planning and contracting guidance 2017-19

The nine 'must do' priorities identified in 2016-17, remain priorities for 2018-9 and need to be delivered within the financial resources available:

1. Being part of and contributing towards a Sustainability and Transformation Partnership (STP);
2. Improving the financial position;
3. Improving Primary Care in line with the GP Forward View;
4. Improving Urgent and Emergency Care;
5. Improving Referral to Treatment times and Elective Care; (including implementation of the national maternity services review, Better Births, through local maternity systems).
6. Improving cancer services and waiting times;
7. Improving services for people with mental ill health;
8. Improving services for people with learning disabilities and;
9. Improving quality in organisations.

These have been used in conjunction with the CCGs Strategic Priories, as a framework to describe commissioning intentions for 2018-9.

1.5.5 Wider system collaboration

The CCG is a member of the Humber Coast and Vale Sustainability and Transformation Partnership (HCVSTP)[1] who have identified six priorities:

- healthier people,
- better "out of hospital" care,
- better "in hospital care"

[1] http://humbercoastandvale.org.uk/our-vision/

- better mental health care,
- better cancer care and
- balancing the books

The focus for achieving the first two priorities will be addressed through “place based” programmes of work, where Vale of York is working in collaboration with Scarborough and Ryedale CCG, York Teaching Hospital NHS Foundation Trust (YTHFT) and Local Authority partners. The remaining programmes will be approached with partners across the STP, reflecting the way that local people use health and care services.

1.5.6 York-Scarborough recovery and transformation

The recovery and transformation programme that has been developed jointly with NHS Scarborough and Ryedale CCG works across:

- the place-based strategies of the two respective CCG systems;
- a single acute transformation programme across the planning footprint of York Teaching Hospital NHS Foundation Trust.

Using the combined acute commissioning resources of the two CCGs, the overarching aims are to:

- maximise the use of evidence based prevention;
- establish whole system clinical pathways that operate optimally to maximise service productivity and efficiency;
- adopt a ‘Home First’ approach to supporting the frail and elderly;
- integrate planning and commissioning of wider community services such as Continuing Healthcare and Mental Health.

The overall system redesign will shift the emphasis away from hospital and bed-based care towards a greater focus on primary and community based care, supporting patients in their home wherever possible.

The development of locality “hubs” as a means of improving population health through better community engagement and as a locus for primary care development is central to achieving this.

The establishment of the Scarborough and Ryedale Multi-speciality Community Provider (MCP) and the emergence of Primary Care Home in the Vale of York are evidence of how this approach is being put into practice.

1.5.7 Our strategic priorities

The focus in 2018-9 will be on meeting the core requirements of patient safety, achievement of national-constitutional standards and financial sustainability, while making progress on three strategic objectives; development of primary care, joint commissioning with Local Authority partners and acute transformation, all of which are designed to achieve the strategic change needed for long term financial and service stability and sustainability.

The shift needed: Achieved through:

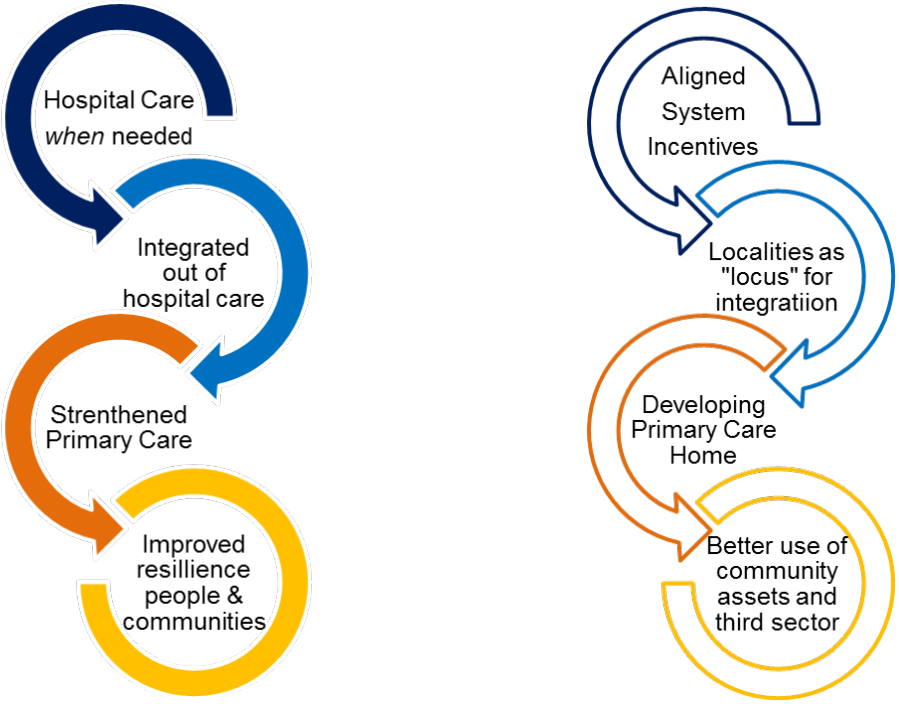

Fig 3: Achieving our strategic priorities

1.5.8 Patient and public engagement

The following themes emerged from the consultation events that took place during 2017:

- the need to improve access to and the quality of primary care
- the importance of having timely access to good quality mental health services
- increasing the focus on prevention and using the third sector-community assets more effectively support people to look after themselves
- the need to consider the needs of different communities; increasing the scope of local services to prevent people having to travel to use hospital services

All of which are consistent with the overall approach that is outlined above.

1.5.9 Commissioning landscape; financial context

The financial challenges facing Vale of York are well recognised, there is a recurrent deficit position of £21.7m, which needs to be closed to get back to annual balance.
The CCG's medium term (four year) financial strategy was approved by the Governing Body in March 2017. Its aim is to reach a balanced and sustainable financial position, which also:

- aligns with existing system plans, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan (which the CCG is a partner to);
- meets key statutory financial targets and business rules;
- is consistent with the CCG's vision and support the delivery of the CCG objectives;
- recognises and meets the scale of the challenge in the Five Year Forward View;
- delivers operational and constitutional targets.

The approach, which was supported by NHS England, was to focus on achieving stability in 2017-18, moving on to address longer term sustainability. There is evidence that this is being achieved (e.g. the agreed year end position was in line with the previously reported forecast outturn). The focus in 2018-19 will be to consolidate progress made and continue to addresses the underlying causes of financial deficit.

The CCG believes that in order to deliver real change, a radical new approach to system leadership, commissioning and delivery is required. This view is shared by organisations across the Vale of York, East Riding and Scarborough and Ryedale NHS system, with a shared commitment to support principles that reflect the collective responsibility for the needs of patients, and which recognises the importance of genuine collaborative clinical leadership and the importance of financial and contracting structures that facilitate a shared view of NHS resources and patient needs, and which provide the incentives that shift the focus from individual organisational need to "system benefit".

The priorities for 2018-19 are aimed at achieving this objective.

1.5.10 Acute services

The aim is to work to the principal that where possible care should be delivered as close to home as possible and hospital services used only for those people whose care requires it. This will ensure that best use is made of relatively scarce and expensive clinical resources, is consistent with evidence based practice and the views of patients and public. This approach will also remove perverse incentives that hinder the use of technology to support care and treatment e.g. the use of telephone rather than face-to-face consultation.

1.5.11 Mental health and learning disability services

The current contract agreement with Tees, Esk and Wear Valleys Foundation Trust (TEWV) is based on a mutual recognition that where possible care should be provided in community-

based settings using hospital services only when necessary. The contract is outcomes-based and includes the requirements of both parties to work together to achieve this objective. In addition, as a result of the opening of a new mental health inpatient facility the CCG will work with TEWV to rationalise the estates.

1.5.12 Primary care

In line with national priorities, there is a commitment to properly resourcing primary care, so that services are sustainable and are able to develop in a way that supports the ambition of reducing dependency on the secondary care sector.

The plan will be to fully utilise the investment identified for primary care in 2018-19. There is agreement from the CCG Executive Committee:

- to make the £3.00 per head available in full in 2018-19 for schemes for improved sustainability;
- to make the £3.34 per head available in full in 2018-19 for schemes for extended hours.

In addition, the £313,000 will be available from the Primary Medical Services (PMS) premium for investment in primary care.

1.5.13 Joint commissioning

The intent is to increase the commitment to joint commissioning with partner organisations; the details of this will be confirmed in the early part of 2018-19.

1.5.14 Improving efficiency and effectiveness of commissioning

The recovery and transformation programme that has been developed with NHS Scarborough and Ryedale CCG utilises the combined acute commissioning resources of the two CCGs and uses a joint approach where this creates greater consistency for providers.

The CCG will work with NHS Scarborough and Ryedale CCG to further concentrate expertise and resources in 2018-9, providing more effective contract management through economies of scale. The aligned single contract for acute services will allow more effective contract management, simplification of contracting arrangements will also benefit the provider e.g. there will be no requirement to provide multiple sets of information.

In addition, contracting intentions will be aligned across the HCV STP to ensure a consistent approach to financial planning.

1.5.15 Quality Innovation Productivity and Prevention (QIPP)

The approach taken in 2017-8 was to ensure that there was a firm evidence base to inform decisions in relation to areas of cost reduction (e.g. using age profiles and of the benchmarking information) which resulted in effective delivery of targets and evidence that performance for QIPP has improved. This approach will continue in 2018-19.

QIPP summary	2017-18	2018-19
	£m	**£m**
Plan	14.4	14.6
Capped Expenditure Commitment	7.9	
TOTAL	**22.3**	**14.6**

Table 6: QIPP summary plans

1.5.16 Prescribing; drugs, devices and products; joint approach with NHS Scarborough and Ryedale CCG

CCGs have made significant savings from prescribing budgets, but there are opportunities to go further. Restrictions can be applied to; not prescribing drugs available as over the counter medications; closer adherence for prescribers on NICE guidelines and further restrictions on use and choice of medicines, products and devices.

The priority for 2018-19 will be to target more radical options to reducing spend on products such as continence, drugs and expensive devices.

1.5.17 Regulatory Environment

There have been well recognised challenges for the Vale of York CCG and the wider health economy. The CCG aims to take itself out of legal directions in 2018-19 and to respond positively to the CQC review. We recognise that there may be challenges for other organisations in relation to regulation; we will work with them to make sure that the needs of patients are paramount when addressing any issues.

1.5.18 Clinical Priorities

There are a number of opportunities presented by Right Care for improvements in efficiency and clinical outcome, as well as those where there is an opportunity to provide care more effectively out of hospital (as detailed below); these provide the basis for prioritising specific programmes. The priorities for 2018-19 cover the following areas:

1. Primary Care and General Practice
2. Joint Commissioning
3. Acute Transformation
4. Urgent and emergency care
5. Planned care; improving Referral to Treatment times and Elective Care
6. Maternity services; Better Births
7. Cancer services and waiting times
8. Services for People with Mental ill-health
9. Services for people with learning disabilities
10. Services for people of all ages with autism
11. Services for children with special needs in education
12. Commissioning For Quality

The CCG's three strategic pathways (development of primary care, joint commissioning with Local Authority partners and acute transformation) and the Operational Planning Guidance and "nine must do's" were used as a framework for this.

For further detail on the CCG's Commissioning Intentions, the full text can be found on the CCG website: http://www.valeofyorkccg.nhs.uk/our-work/commissioning2018-19/ .

1.6 Financial performance

1.6.1 Preparation of the Annual Accounts

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

1.6.2 Accounting policies

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

Additional detail in relation to provisions, critical judgements and sources of estimation of uncertainty has been added. These occur when management has made specific decisions in applying the CCG's accounting policies and where these have had the most significant effect on the amounts recognised in the financial statements.

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

1.6.3 Financial transactions

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

Additional detail in relation to provisions, critical judgements and sources of estimation of uncertainty has been added. These occur when management has made specific decisions in applying the CCG's accounting policies and where these have had the most significant effect on the amounts recognised in the financial statements.

1.6.4 Financing transactions

There have been no financing transactions undertaken by the CCG.

1.6.5 Cash

The CCG delivered its key financial statutory duty to have a cash balance at the year-end within 1.25% of the monthly cash draw down.

The CCG also has its own internal key financial measures which include delivering this target on a monthly basis. This was delivered throughout 2017-18 apart from on two occasions. The first of these was in August 2017 when this was not achieved, although this was done so as planned and in agreement with the NHS England Cash Management Team. The second was in September when the CCG fractionally missed this following receipt of a VAT refund of £45k from HMRC on the last working day. The VAT return was submitted on 26th September and the refund was received on 29th September.

The CCG has put additional controls and measures in place to reduce the risk of this happening again and is therefore planning to meet all of its cash targets, both statutory and otherwise in 2018-19.

1.6.6 Summary of expenditure

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

1.6.6.1 Programme costs

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

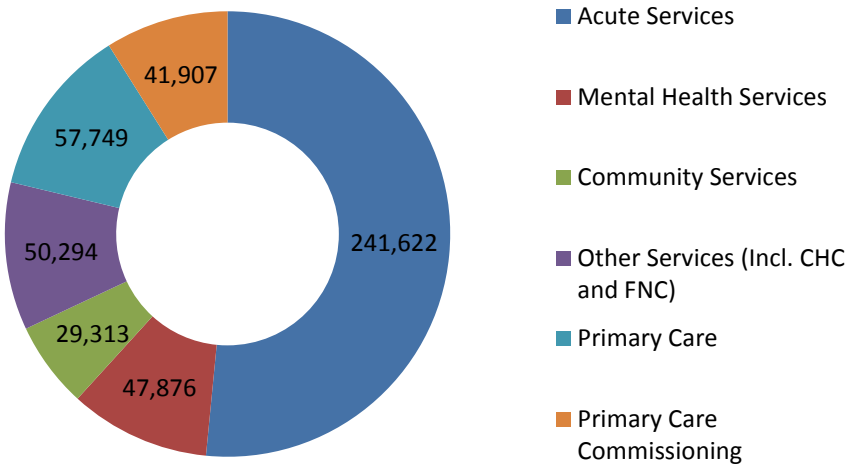

Fig 4: An analysis of the Programme costs expenditure

1.6.6.2 Running costs

Payment is allocated to CCGs based on £21.07 per head of ONS population to pay for non-clinical management and administrative support, including commissioning support services.

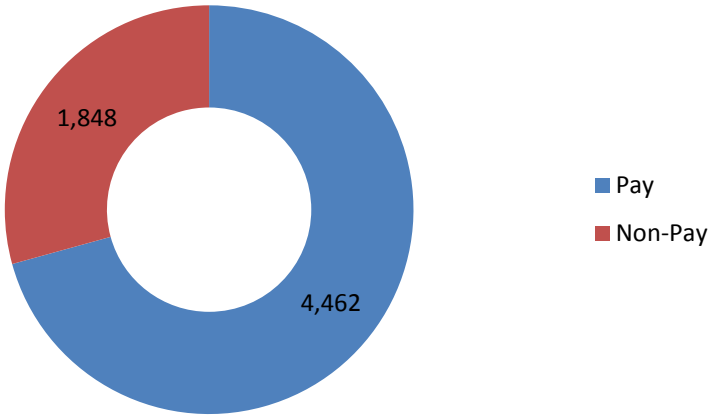

Fig 5: An analysis of the Running costs expenditure

1.6.7 Underlying recurrent position

Excluding the effect of all non-recurrent elements in in the 2017-18 position, the CCG has an underlying recurrent deficit of £21.7m as it moves into 2018-19 having started the year with an underlying deficit of £22.4m.

1.6.8 Quality, Innovation, Performance and Productivity

The CCG has had a strong performance in terms of its Quality, Innovation, Performance and Productivity (QIPP) delivery (£7.9m) achieving significantly more savings than in previous years. However, it has not been able to deliver against all of its planned schemes identified at the start of 2017-18.

The 2017-18 delivery has been underpinned with robust performance measurement and monitoring of delivery using a combination of Finance and Business Intelligence metrics, bespoke for each QIPP project.

Two significant initiatives that have contributed significantly toward this target have been:

- Demand Management in planned care through Health Optimisation and via the Referral Support Service (RSS) - £2.7m
- Prescribing savings and cost avoidance through a variety of targeted projects - £1.6m

These two initiatives have laid a firm foundation for the CCG to continue into 2018-19 with sound systems and processes to evolve demand management initiatives working in conjunction with York Teaching Hospital NHS Foundation Trust under an Aligned Incentive Contract. The CCG measurement and reporting developed in 2017-18 will allow the NHS

system to work across pathways to design and implement clinically-led demand management projects and under the Aligned Incentive Contract there will be no tariff benefit to the CCG. Similarly the Prescribing projects will involve reducing expenditure on drug spend in secondary care, which will also financially benefit the Trust. Primary Care benefit will be seen when patients continuing to receive care out of hospital will then continue to be prescribed lower cost alternative drugs.

1.6.9 Statement of Going Concern

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

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

1.6.10 Data quality

The CCG received a business intelligence service from the commissioning support team at eMBED Health Consortium. This team checked and validated data internally. The Governing Body and the CCG's committees were reviewed during 2017-18 and no concerns were raised regarding the quality of data supplied by eMBED Health Consortium. The format of reporting at the Finance and Performance Committee was altered to increase the amount of data presented to the committee to provide added detail of system pressures.

1.6.11 Better Payments Practice Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements and are summarised in the tables below for 2017-18.

Non-NHS invoices						
Month	Total Paid	Invoices Paid on Time	% Paid Within Target	£ Total Paid	£ Value Paid on Time	% Paid Within Target
Apr-17	380	377	99.21	9,305,146.97	9,303,666.47	99.98
May-17	380	372	97.89	5,965,132.07	5,929,617.75	99.40
Jun-17	341	333	97.65	9,204,314.24	9,149,711.60	99.41
Jul-17	336	329	97.92	7,735,673.94	7,539,252.67	97.46
Aug-17	323	310	95.98	6,877,348.85	6,750,861.40	98.16
Sep-17	395	378	95.70	6,261,717.02	6,147,867.94	98.18
Oct-17	316	310	98.10	5,472,662.05	5,424,828.92	99.13
Nov-17	384	375	97.66	5,977,781.00	5,965,233.00	99.79
Dec-17	347	337	97.12	5,807,153.46	5,708,632.68	98.30
Jan-18	366	343	93.72	5,102,384.00	5,058,254.00	99.14
Feb-18	523	508	97.13	6,392,474.10	6,360,357.07	99.50
Mar-18	538	509	94.61	7,650,746.43	7,612,605.26	99.50
Totals	**4,629**	**4,481**	**96.80**	**81,752,534.13**	**80,950,888.76**	**99.02**

Table 7: Non-NHS invoices in 2017-18

NHS invoices						
Month	Total Paid	Invoices Paid on Time	% Paid Within Target	£ Total Paid	£ Value Paid on Time	% Paid Within Target
Apr-17	273.00	272.00	99.63	31,812,491.86	31,811,691.86	100.00
May-17	247.00	246.00	99.60	31,118,977.75	31,096,548.75	99.93
Jun-17	312.00	312.00	100.00	31,853,663.65	31,853,663.65	100.00
Jul-17	233.00	228.00	97.85	30,694,670.38	30,348,242.95	98.87
Aug-17	315.00	309.00	98.10	26,236,239.25	26,149,562.75	99.67
Sep-17	332.00	326.00	98.19	25,958,698.79	25,939,554.29	99.93
Oct-17	252.00	252.00	100.00	26,355,629.79	26,355,629.79	100.00
Nov-17	219.00	216.00	98.63	26,014,024.00	26,008,341.00	99.98
Dec-17	292.00	287.00	98.29	27,035,866.93	26,474,736.98	97.92
Jan-18	278.00	266.00	95.68	27,285,342.25	27,193,457.18	99.66
Feb-18	229.00	222.00	96.94	26,435,641.45	26,328,648.51	99.60
Mar-18	281.00	279.00	99.29	28,787,141.58	28,782,919.58	99.99
Totals	**3,263.00**	**3,215.00**	**98.53**	**339,588,387.68**	**338,342,997.29**	**99.63**

Table 8: NHS invoices in 2017-18

1.7 Sustainable development

1.7.1 Introduction

The definition of sustainable development has long been held to be “Development that meets the needs of the present without compromising the ability of future generations to meet their own needs." The NHS is one of the largest employers in the UK and is therefore able to hold considerable influence over the ability to ensure that national sustainability targets are met.

The national Sustainable Development Unit (SDU) makes an annual collection of sustainability data from NHS organisations, which it publishes, as well as providing the Sustainable Development Assessment Tool (SDAT) which replaces the former Good Corporate Citizen GCC) assessment. The CCG had completed the GCC assessment, using the results to inform its Sustainable Development Management Plan (SDMP), and will be working on completing its SDAT assessment during 2018-19. The CCG’s SDMP for 2016-2020 is available on the CCG website: http://www.valeofyorkccg.nhs.uk-about-us-sustainability-and-commissioning-for-sustainable-development/ .

1.7.2 Premises

The CCG occupies a repurposed historic building in the centre of York, the former railway station, which has been renovated to be a model of sustainable architecture. The overall environmental design was conceived to work with redevelopment of the existing building, utilising existing features to enhance comfort and reduce energy demand. It makes the most of the thermal mass of the existing structure to pre-cool incoming air and provides an efficient night-time cooling strategy.

The heavy masonry walls of the existing building that now form part of the internalised space provide the thermal mass required for the building to be largely naturally ventilated. Low carbon heating technologies and heat recovery (from server rooms, for example) also form part of this strategy.

The north light roof optimises the beneficial natural daylight whilst minimising solar gain. The north light roof features solar photo-voltaic (PV) panels on the south facing planes. South facing planes of the roof structure house solar PV panels, from which all of the energy generated is used within the building.

A number of features have been designed into the building to help to reduce energy demand. For example, lower lighting levels and automatic light switching combine with heat recovery from file server rooms to reduce energy demand.

Rainwater harvesting and water saving controls are all integrated into a building management system which allows all aspects of building services to be remotely monitored. A gas fired combined heat and power unit acts as the lead boiler and generates electricity. The basement also houses biomass boilers. Most of the heat demand is provided by bio mass boilers which deliver thermal energy with a minimal carbon footprint. Gas fired boilers are also installed to

meet the peak demands and to provide backup. The peak summer cooling loads are provided by a chilled water system that is generated by an absorption chiller. Passive ventilation and de-stratification fans are also integral to the internal environmental control.

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

Facilities include secure bike sheds constructed from reclaimed train platform canopies, shower and changing facilities, pool bikes, etc. Close proximity to train station and bus services, as well as on site meeting facilities, help to reduce the need for car travel.

1.7.3 Travel

The City of York prides itself on being a "Cycling City" and has an extensive network of cycle lanes. The CCG encourages its staff to make use of the building's facilities for cycling, as well as providing interest-free cycle loans.

CCG staff participated in the Ride to Work initiative from 12-18 March 2018, a national scheme that promotes cycling, with a team set up by Dr Dan Cottingham. More people riding to work also reduces congestion and pollution (which contributes to 40,000 premature deaths annually in the UK), making us all safer and our communities cleaner, greener and more liveable. For further details of the scheme, see Ride to Work Week at lovetoride.net-york.

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

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

1.7.4 Commissioning

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

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

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

Recent examples of commissioning for sustainability include the re-commissioning of patient transport services, with a focus on energy-efficient means of transport.

1.7.5 Provider carbon reduction targets

Details of the environmental targets for the CCG's main providers, York Teaching Hospital NHS Foundation Trust, and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), are published on the SDU website, as part of a spreadsheet covering national metrics: https://www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx .

York TH NHS FT has published details of its carbon reduction targets in its SDMP here: https://www.yorkhospitals.nhs.uk/about-us/reports-and-publications/ .

TEWV has provided information here: http://www.tewv.nhs.uk/site/content/About/How-we-do-it/Caring-for-the-Environme

1.7.6 Pharmaceutical prescriptions

The CCG is continuing to work with GPs to ensure that regular reviews of medication take place, in order to reduce wastage in unwanted medication. A number of well-publicised campaigns have taken place locally throughout 2017-18.

1.7.7 Staff wellbeing

The CCG has an active Staff Engagement Group, which has supported and promoted a number of wellbeing initiatives, including taking a regular "temperature check" survey of staff. Activities supported within the CCG include on-site yoga classes, a weight-loss club and badminton. Staff participate in charitable events and are encouraged to join in with public engagement events to see the difference they can make in the community.

In May 2017 staff participated in a range of events as part of Sustainability Week, which included guided walks, and talks on cycle maintenance, as well as awareness-raising of environmental issues.

1.7.8 Global sustainability goals

The CCG is supportive of the UN's 17 Global Goals for Sustainable Development, and while it contributes directly to Goal 3, Good Health and Wellbeing, it is also working to reduce inequalities and form part of a sustainable city.

Fig 6: The United Nation's Global Goals for Sustainable Development

The CCG is a signatory to the One Planet York environmental initiative. For further details see: https://www.york.gov.uk/info/20252/one_planet_york/1846/one_planet_york

1.8 Improving quality and patient experience

1.8.1 Quality and Patient Experience Committee

Quality is the cornerstone of the CCG's plans, assurance and programmes of work. The CCG has a dedicated Quality and Patient Experience Team which is led by the Executive Director of Quality and Nursing.

The Quality and Patient Experience Committee continues to meet bi-monthly and reports directly into Governing Body. The committee's role is to ensure that commissioned services are safe, effective and provide good patient experience. Additionally, services must evidence continuous improvement that are in line with the NHS Constitution (2011) and are underpinned by the CCG Quality Assurance Strategy.

1.8.2 Patients who wait for 12 hours or more on trolleys in the Emergency Department

12 hour trolley waits in the Emergency Departments at York and Scarborough Hospitals have continued to be a concern, particularly on the Scarborough site. These continue to be during periods of high activity. There were a total of 25 across both sites between 1 December 2017 and 23 February 2018. Five of these cases were related to Vale of York patients.
Through a process of investigation and scrutiny we know that no CCG patients came to any direct harm as a result of the delays, yet it is acknowledged by both York Teaching Hospital NHS Foundation Trust, and by the CCG, that this cannot only adversely affect patient experience but could have unintended consequences for patients during their admission. The

CCG continues to seek assurance on any potential impact for patients such as a longer than expected hospital stay, unexpected complications and-or any complaints.

1.8.3 Healthcare associated infections

Healthcare associated infections remain a major cause of potential avoidable patient harm. The CCG is committed to a reduction of these infections and a robust, collaborative approach exists both to review cases and communicate any identified learning.

As commissioners of local healthcare services, the CCG has the responsibility for working across organisational boundaries and taking a whole health economy view so that sharing of good practice and any learning is widely disseminated. The CCG ensures that provider organisations have appropriately trained and competent staff in place and seeks ongoing assurance that the principles of infection prevention and control are fully embedded in all environments.

The CCG also ensures, through the Community Infection Prevention Service, that information and support for Care Homes and Primary Care including staff and patient education is easily accessible.

Work has progressed against the requirement for the challenging reduction in the number of E.coli Bacteraemia across the whole healthcare economy and Vale of York has made significant progress although from the reviews conducted there do not appear to be any discernible themes which makes focussed improvement work challenging.

The CCG provides a supportive role and maintains oversight of the whole patient journey in all healthcare settings. This promotes opportunities to work collaboratively to improve infection prevention practices and reduce healthcare acquired infections whilst contributing to antimicrobial stewardship improvement.

The Head of Quality Assurance continued to attend community and provider post infection reviews of MRSA and C. difficile cases which have provided insight into organisational progress in infection prevention and control practices and the issues that influenced or impacted on this. York Teaching Hospital NHS Foundation Trust has restructured its Infection Prevention team and the CCG is looking forward to further increased collaborative working with the new team in the coming year.

C. difficile infection has had a continued presence although the overall picture is improved on 2016-17 data. There is a proposal to change the categorisation of C. difficile cases from April 2018 to mirror those used in Europe and it is envisaged joint reviews between community and secondary care will be necessary going forward, in which the CCG will be a key partner. Whilst norovirus has remained a continued presence both in York Teaching Hospitals NHS Foundation Trust and in the community, particularly care homes, the number of community outbreaks across the Vale of York to date has been lower than last year. This is thought to be due to alterations in the circulating strain of norovirus which changes in the same way cold and flu viruses do. Prompt identification and implementation of infection prevention and

control measures reduces the spread so the work of the Community Infection Prevention team with the homes has been essential. Norovirus has been present intermittently in York Teaching Hospitals NHS Foundation Trust but to date less so than previous years-probably due to the reduction in community cases.

1.8.4 Influenza

Influenza has been a significantly challenge this season with a number of strains evident, making isolation of affected patients difficult. An increased incidence of influenza was anticipated due to surveillance provided from the southern hemisphere, combined with awareness that incidence has been low over several preceding years. A national review of the flu campaign and the season is imminent to understand what can be improved on in the future. Flu vaccination uptake has gone well, with CCG data demonstrating uptake above the Yorkshire and Humber average. Uptake in all categories is in line with or above targets except for those under the age of 65 who are at risk. Further work to examine practice level data to reduce variation and provide support for improvement will continue.

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

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

1.8.5 Serious Incidents and Never Events

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

Throughout 2017-18 the CCG continued to work closely and in various ways with its providers to reduce patient harm. The CCG continues to attend falls and pressure ulcer panels with our commissioned providers where Serious Incidents are robustly reviewed and learning

identified. Significant improvements have been evident with the requirements to comply with Duty of Candour.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) continue to invite the CCG to contribute to their Serious Incident panel where cases are robustly discussed by a multidisciplinary team to reduce the risk of recurrence and to comply with Duty of Candour. The multi-disciplinary discussions ensure relevant learning is identified and translated into actions.

The CCG has a responsibility to report and investigate incidents that occur within its own organisation. It also needs to ensure the Governing Body is aware of Serious Incidents that occur and action plans are monitored by the Quality and Patient Experience Team. The CCG had two serious incidents in 2017-18, one related to a delay in referral from primary care and the relevant learning has been implemented. The second also relates to a delay in referral on a two week wait pathway and is still currently under investigation.

Never Events are serious incidents which may occur if guidance or safety recommendations that provide strong systemic protective barriers are not robustly implemented by all healthcare providers. There have been concerns about the number and similar type of Never Events reported by York Teaching Hospital NHS Foundation Trust in 2017-8. The CCG continues to work closely with the provider to gain assurance of embedding of learning. The CCGs are also planning to participate in quality visits to meet staff and observe practices relating to preparation for theatre including checking processes.

Clinical Quality Visits have taken place with TEWV services. The CCG visited Huntington House in December and Lime Trees and the CAMHS service in early January. Information on performance, themes from Serious Incidents and information from staff about any changes they are aware of as a result of incidents and complaints were scoped before the meeting and informed the visit and questioning of staff. The visits were hugely positive. The services were welcoming and appreciative of the visits and there was evidence of positive aspects of patient care and service delivery. Actions were agreed for the CCG and the provider and summarised in feedback letters. The action plan will be reviewed at both the Quality and Performance sub groups of CMB.

1.8.6 Maternity services

1.8.6.1 STP local maternity system

Work progresses across the STP Local Maternity System (LMS) to progress implementation of Better Births. An interim project manager has been recruited to and the LMS plan was ready for re-submission at the end of January. This included identification of resources required to implement the plan as accompanying bids for funds released by NHS England were required.

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

1.8.6.2 Smoking status at time of delivery

The submission of Smoking at Time of Delivery figures for Q3 2017-18 shows that York Teaching Hospitals NHS Foundation Trust has improved on both recording of smoking status over Q2 and overall performance appears to have improved with rates falling from 12% to 8% of deliveries still recorded as smoking when they deliver. The Yorkshire and Humber average is 13.4%.

1.8.6.3 Maternity Services Liaison Committee

Significant progress was made in 2017-18 against the Maternity Services Liaison Committee's key priorities of home birth, reduction of still birth, breast feeding and perinatal mental health. The committee has been active in obtaining feedback and using this to inform developments in the maternity services, in particular perinatal mental health. In line with the recommendation in Better Births, it is envisaged that the Maternity Services Liaison Committee will evolve into a Maternity Voices Partnership as co-production is a pivotal point of development of the LMS plan.

1.8.6.4 Perinatal Mental Health

Perinatal Mental health services provide differing levels of support to women experiencing mental health issues during their pregnancies and afterwards. It is vitally important for infant and mother bonding, attachment and infant development that a mother is as well as she can be to parent. There is a well-recognised discrepancy in service provision nationally and the need for specialist teams with expert experience well evidenced. The CCG have agreed to support the sustainability of a bid for funds submitted to NHS England to develop the perinatal mental health services within York and North Yorkshire.

1.8.7 Patient experience

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

Patient experience data is collected from the CCG's commissioned services and gives an important insight from the patient's perspective as well as providing people with the opportunity to have their say.

The CCG also continues to use information from other organisations to provide additional context. Examples of this include information received from Healthwatch, Care Opinion and NHS Choices. This feedback has continued to ensure that patient experience is heard, lessons are learned and that the information is used to influence commissioning decisions that promote the delivery of high quality services.

An example of how patient experience and feedback has been utilised in commissioning decisions can be described when the CCG worked with its partners at NHS Scarborough and Ryedale CCG to procure a new community podiatry service. As part of designing the new service the CCGs were obliged to examine a number of aspects including quality of care, equity of access, value for money and the clinical needs of the population.

The patients who did not meet the clinical criteria were discharged from the service and given advice, guidance and information with the aim of them or their carers to better care for themselves. However, following feedback, it became clear that there was a cohort of patients for whom the options given on discharge were not feasible which caused them a significant amount of distress. The risks of implementing contract changes without due consideration of the impact on all service users were escalated and raised at the CCG's Executive Committee. Following discussions with commissioning and contracting colleagues in both CCGs, additional options for signposting were given to the patients who had contacted the CCG directly. This information will also be provided by the podiatry staff when patients are discharged from their service in the future.

1.8.8 Safeguarding adults and children

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

- A programme of staff training in recognising and reporting safeguarding issues is in place and is line with statutory guidance.
-
- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements with bi–monthly safeguarding reports as part of those arrangements.

- Appropriate arrangements are in place to co-operate with local authorities and other partner agencies in the operation of Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs), membership on both Boards by the Executive Director of Quality and Nursing and Designated Professionals for Safeguarding.
- Has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood.
- The CCG has a Named GP for safeguarding children and adults and, as part of collaborative arrangements with the 3 remaining North Yorkshire CCGs, has secured the expertise of a Nurse Consultant for Primary Care (safeguarding adults and children).
- A Designated Professional for Safeguarding Adults including lead for the Mental Capacity Act and Prevent, supported by the relevant policies and training shared across North Yorkshire CCGs.

- A review of the safeguarding adults' shared arrangements across the 4 NY CCGs has been completed in 2017. This has included a second designated professional post alongside the existing designated professional and two safeguarding officers.
- Through contractual arrangements the CCG ensures that it commissions safe services and continues to be an active partner working with agencies to keep adults and children safe from abuse, neglect and harm.

In 2016-17 NHS England undertook a Safeguarding Assurance Audit. The final report identified that the CCG has robust arrangements in place, with only three areas of non-partial compliance. An action plan to address the outstanding areas is now complete.

In December 2016 the CCG received notification of a Care Quality Commission Children Looked After and Safeguarding Review for City of York. A further review was undertaken across North Yorkshire in February 2017. The Designated Nurse has worked with colleagues in the CCG and with provider organisations to take forward the action plan arising from the review recommendations. Updates against the action plans are monitored via provider- CCG contract monitoring processes and highlights were shared as part of the safeguarding children report to the Quality and Patient Experience Committee.

Significant changes to local multi-agency arrangements to safeguard children have been established through the Children and Social Work 2017. The Act will see the abolition of Local Safeguarding Children Boards from 2019 and the requirement for police, health (CCGs) and the local authority to make arrangements locally to safeguard and promote the welfare of children in their area. The CCG is working with North Yorkshire Police and the Local Authorities to develop these new arrangements with planned implementation for April 2019.
During 2017-18 NHS England commissioned a Significant Incident Investigation following the killing of a young child from City of York in January 2017. The CCG continues to contribute towards the investigation process and it is anticipated a draft report will be shared with key stakeholder in the spring of 2018.

1.8.9 Quality in primary care

The CCG continue to have full delegated responsibility for primary care commissioning and as such have worked in partnership with primary care colleagues on the development of assurance processes for the quality and safety of services. The Primary Care Commissioning Committee have agreed a set of performance and quality indicators for primary care to monitor the contract, outcomes and processes within primary care and will further define this in the coming year. This work will be further progressed in the forthcoming year. The Care Quality Commission (CQC) has rated all GP practices in the Vale of York as 'good' and the CCG have established regular contact with the CQC Primary Care Inspector so that early plans for inspections and sharing of good practice are realised.

The Quality Lead for Primary Care has offered support to general practice both in preparation for and support after CQC inspections.

The CCG are dedicated to supporting the practice nursing workforce development and have continued to focus on recognising the valuable role of the Practice Nurse.

The monthly Practice Nurse Forum continues to provide opportunities for Continued Professional Development which is required to meet the mandatory Nursing and Midwifery Council guidelines on Registered Nurse Revalidation. The valuable position of CCG Lead Practice Nurse has also provided a credible link to the Practice Nurse population whilst positively influencing workforce development, the Practice Nurse Forum and the Practice Nurse website and communications.

Each STP area across the Yorkshire and Humber has held Practice Nurse awards to celebrate their important contribution. They have been positive events supported by the CCG and highlighted the fantastic work that Practice Nurses are involved in across our GP Practices. Ten out of 24 awards went to Vale of York CCG GP Practice Nurses.

1.8.10 Care homes

The CCG has developed a new Senior Quality Lead role that has worked in partnership with key stakeholders from Health, Social Care and the third sector in committing to supporting care homes to provide high quality, cost effective care for all residents within the Vale of York.

Priorities for supporting the care home sector were identified following:

- engagement with care homes, listening to residents and staff feedback;
- understand local health and social care needs in conjunction with the national context;
- consideration of strategic developments at CCG, regional and national level.

There are 83 care homes with a bed base of 2683 across the Vale of York and collectively they rate higher than the national average CQC ratings. The CCG recognises that there is a need to improve collaborative working to support frail, older people to remain healthy and independent and avoid admission to hospital. This has been reflected in the CCG work to support care homes and has built on successes; sharing learning and different ways of working to develop sustainable high quality care.

Key programmes of work from 2017-2018 include the following:

- The CCG Quality Team accompanies local authority colleagues on assurance visits to care homes, when visits are required for action- improvement plans or where concerns are raised. This supports care homes with a proactive approach and demonstrates joint working between health and social care in action, ensuring appropriate interventions can be facilitated in a timely manner, preventing homes entering special measures.
- The CCG leads the ‘Partners in Care’ meetings which are held bimonthly. These forums support information sharing and discussion to bring stakeholders together in achieving the delivery of high quality care to residents. This has encouraged closer working relationships between the CCG and care home sector.
- “React to Red” is a NHS England initiative which includes an education package and the use of a simple, yet effective framework to support carers in recognising when an individual may be at increased risk of pressure ulcer development. The framework

prompts carers to consider key areas important in maintaining skin integrity. The CCG has already engaged 20 homes with a plan for wider roll out over the next year.

- In order to facilitate the implementation of the 'React to Red' programme and to help embed and sustain change Safety Huddles are being introduced, supported by the Improvement Academy. Some homes are also using the safety huddle as an intervention for falls prevention with measurable success.
- The Care Home bed State tool is described as a 'web based capacity portal' developed by North of England Commissioning Support in conjunction with NHS England and is aimed primarily at reducing delayed transfers of care in hospital. The CCG is leading this initiative with support from colleagues in the three local authorities and York Teaching Hospital NHS Foundation Trust. It is anticipated that residents will have an improved experience of the discharge process owing to improved communication across the system.
- The Quality Team actively contribute towards the process of equipment procurement; ensuring reviews have a focus on quality and clinical perspective alongside the necessary financial considerations.

1.8.11 Quality Impact Assessment process

- During the year the CCG has further developed the process for ensuring any decisions it wishes to make to change services is more robust.
- This revised process includes an assessment of whether consultation is required with the public and what level this consultation should take.
- The QIA process covers all areas of quality such as safety, effectiveness, patient experience and equality alongside an assessment to ensure any change is in line with the NHS Constitution and fulfils the CCG's statutory functions.
- The CCG has provided in-house training and support and has also shared the process with neighbouring CCGs with an aim to standardise the process across STP footprints where possible.

1.9 Engaging people and communities

1.9.1 Engagement with patients, partners and the public

The engagement and involvement of patients, partners and other stakeholders is intrinsic to the commissioning and procurement of services. The CCG works closely with its communities to ensure that the services it plans and buys on their behalf best meet the needs of the Vale of York population.

The CCG has created a range of engagement and involvement opportunities to gather views. The information it has received is rich in personal experience and helps the CCG to shape commissioning decisions, service specifications and improvement programmes.

1.9.2 The duty to engage

The Health and Social Care Act 2012 (section 14Z2) sets out the legal duty for the CCG to involve the public in the commissioning of services for NHS patients, and in the decisions about services that will be provided to them. As part of the statutory duty the CCG is required to implement a number of key engagement activities; however the CCG is committed to going above and beyond these minimum requirements to ensure that that patients' needs are at the heart of everything it does.

1.9.3 Engagement principles

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

- Hold open, clear, informed and collaborative conversations
- Ensure engagement is core to planning, prioritising and commissioning activities
- Develop innovative and interactive approaches to holding engagement conversations
- Seek and listen to views of partners, patients, carers and local citizens
- Be honest and transparent in offering opportunities and discussing constraints and challenges to the delivery of services

1.9.4 How the CCG engages with its population

The CCG engages with its public formally and informally. Public engagement and patient experience is formally reported through the Quality and Patient Experience Committee (QPEC), which meets every two months.

The CCG believes that involvement is not just the role of an individual, or one team; but the responsibility of everyone in the CCG. The CCG already uses a variety of mechanisms to involve its local population, and gather feedback including:

- Focus groups
- Informal discussions
- Formal consultations
- Public meetings
- Regular stakeholder newsletters
- Social media
- Surveys
- Meetings with voluntary groups

The CCG also has a number of forums and channels where patients and members of the public are represented, involved and informed, including:

- Close partnership working with Healthwatch York, Healthwatch East Riding and Healthwatch North Yorkshire and voluntary sector services.

- Attendance of voluntary and patient groups at committee meetings – such as the Maternity Services Liaison Committee (MSLC), the Quality and Patient Experience committee (QPEC) and the Wheelchair and community equipment service user group.
- Quarterly meetings between the Accountable Officer and the MPs that cover the Vale of York footprint, to discuss constituents' needs.
- Regular attendance at General Practice Patient Participation Groups (PPG). These are groups of volunteer patients, the practice manager and one or more GPs who meet on a regular basis to discuss the services on offer and how improvements can be made for the benefit of patients and the practice.
- Updates on the 'Get involved' section of the CCG's website – highlighting the areas where patients and the public can become involved in the work of the CCG.
- Staff attendance and involvement at forums across the Vale of York - including carers' advisory groups, older people's assemblies, Healthwatch and voluntary sector meetings and patient participation groups.

1.9.5 Working with stakeholders and partners

Working in partnership with health colleagues, local government, voluntary organisations and the wider community is vital for helping to achieve best outcomes for the CCG's population.

The CCG could not engage with and care for residents without the continued support of the community and voluntary sector partners and the CCG would like to thank all of the organisations who have supported the most vulnerable members of the population.

The CCG has an extensive list of stakeholders and takes a proactive approach to networking to ensure that it keeps everyone up-to-date on the CCG's work and enables them to get involved. The CCG holds regular meetings with colleagues from Healthwatch and attends voluntary sector forums, assemblies and events – ranging from learning difficulties and the older people's forums, to carers' advisory groups and patient participation groups. During 2017-18 CCG staff attended over 100 such events.

The CCG engages in close partnership working with Healthwatch York, Healthwatch East Riding and Healthwatch North Yorkshire and voluntary sector services, working with them on a number of projects, having their presence at meetings and committees and mutually sharing news and information.

1.9.6 Listening to the population – the CCG's 'Big Conversations' event series

What is important to the community about health and care is important to the CCG. That is why during 2017 the CCG asked local people: "what is important to you about local healthcare services?"

During 2017 the CCG held and attended over 100 events and forums and talked to over 1,200 people. In particular, during the peak of engagement activity between July and October 2018

the CCG hosted over 40 face-to-face events as part of the ‘Big Conversations’. These sessions specifically focused on the current financial challenges and asked the population what would be their priorities for healthcare. The system spends more on health than it can afford and as a result the CCG will have to work in a new way to help improve outcomes and achieve value for money. It was important that the CCG gave people the opportunity to have their say about the future of health services.

The events focused on enabling the local community to share their views on how the CCG can work together to ensure a sustainable health and social care system. They ranged from public events with the CCG’s Accountable Officer and clinical leads to working with the voluntary sector and local Healthwatch as well as hosting library, market and student drop-in sessions to ensure that the CCG captured as wide a range of views as possible and we thank each and every person that took part.

1.9.7 Commissioning on behalf of the local community

The CCG has developed its 2018-19 commissioning intentions based on what the local population has said. The CCG’s priorities for the next year reflect the views of local people who attended the series of ‘big conversation’ engagement events.

Topics including cancer, dementia, mental health, access to health prevention and education and access to primary care services were identified by participants.

Collecting these views at the draft planning stage has proved essential and this will help the CCG to develop:

- a safer and stronger community
- support key prevention and behaviour change initiatives, and
- reduce the demand on expensive healthcare interventions.

1.9.7.1 Working with earning disability and difficulties partners

In September 2017 GPs and nurses from the Quality team attended a Learning Difficulties (LD) Forum. Attendees discussed the potential barriers of attending screening and accessing primary health care. These focused on the length of GP appointments not always being long enough to communicate issues, the need for more accessible information for patients and health professionals, and for easy read invite letters to encourage the uptake of screening.

In response to the feedback CCG colleagues have been working on an action plan to address these potential barriers, and updates and feedback has been provided at the LD forum in December 2017 and to an advocacy group member in January 2018. Some of the key areas include:

- Design of a template for a patient to complete prior to seeing their GP or nurse. This includes a list of their concerns, accompanied by an easy read body map and visual pain score.

- Work on a central repository for links to Easy Read leaflets, patient information and guidance for health professionals.
- Survey to establish baseline figures across primary care to determine current cancer screening uptake for patients with a learning disability
- Improving communications with primary care and raising awareness of LD support available for healthcare professionals.

1.9.7.2 Patient stories at committee meetings

As part of commitment to ensuring the patient, carer and public voice is heard within the organisation, this year the CCG began to show patient stories as a regular item at the Quality and Patient Experience Committee (QPEC).

A patient story is an account of someone's experience of health or social care, and enables the organisation to understand the impact from their perspective. These stories bring an experience to life and help the CCG to focus on the patient as a whole person rather than a clinical condition or outcome.

The powerful stories are to be used to foster a culture of learning from experience and used to influence policy direction and service improvements. During the 2017-18 year, the committee heard a patient story from a parent carer, a family member of a resident of a care home who was part of the continuing healthcare assessment, and the voice of child in care.

1.9.7.3 Increasing awareness of carers within GP practices

The CCG has been working with the local Carers' Centre to provide free training to healthcare professionals within GP practices to help raise awareness of how to identify and support unpaid carers. Two training sessions focusing on were held in 2017 and two more have been held in early 2018.

It was an opportunity for professionals to learn more about the support available for unpaid carers across the city. The aim was to Increase understanding of carers, their role and its effect on their lives, and was an opportunity to explore how professionals working in the health and social care field can help to: identify carers early; recognise them as 'partners' in care, and help carers to maintain their own health and wellbeing.

Regular meetings take place with the local carers' centre and carers advisory groups across the patch, so that the CCG can listen to the voice of the carer community and ensure that their concerns are fed back into commissioning decisions.

1.9.7.4 The wheelchair and community equipment service user forum

Following extensive engagement with patients and local stakeholders to understand issues relating to services at the time, and how to improve these, the CCG and a number of other North Yorkshire commissioners made the decision to re-procure Community Equipment and Wheelchair services in 2016.

During the procurement process, in partnership with Healthwatch, a service user forum was established. The forum provided a unique opportunity not only for service users to get together, but also to work with the CCG to design new service contracts for wheelchairs and community equipment. This helped the CCG make changes to services via its procurement process.

As part of the CCG's commitment to ensuring that patient experience is listened to and acted upon, the CCG continued to host the service user forum, post its one year anniversary. Quarterly meetings are held with wheelchair and community equipment service users, the voluntary sector and the equipment and service providers to discuss and share experience and best practice.

A video about the success of the forum and involvement of service users can be found on YouTube here: https://www.youtube.com/watch?v=6HIEtjWB3Sc&feature=youtu.be

1.9.7.5 Care home engagement

The CCG is working with its partners in care to promote quality and improve joint working between the NHS and the care home sector.

Partners in Care meetings take place bi-monthly where care home managers and staff share experiences and best-practice and receive latest updates from the CCG. The forums provide the space for information sharing and discussion to bring stakeholders together in achieving the delivery of high quality care to residents.

A number of focused engagement events with care home staff and residents have taken place and feed into the care homes work across 2018, including visits to care homes to ask staff and residents about what matters most to them. Strong themes came through around person-centred compassionate care as well as conversations with the management team around leadership and supporting staff to do their job well.

1.9.8 How the CCG is developing its understanding of local communities

The CCG's engagement activities are just one way through which the CCG finds out what local people think about local services. The CCG also collates feedback through a range of other methods including national surveys, such as the Friends and Family Test and GP Patient Survey; local patient feedback surveys run by different services such as Care Opinion; and complaints and incidents. These are reported through the Quality and Patient Experience Committee, which meets every two months.

1.9.9 Supporting staff with engagement

To ensure that engagement is embedded throughout the CCG's work, the CCG has launched an internal engagement toolkit to support more consistent delivery of engagement activities. This toolkit helps staff leading on engagement to define their involvement activities and scope the activities required for each commissioning intention.

The CCG also publishes a weekly communicationss and engagement newsletter containing information on future events, feedback from our population and links to useful articles, documents and videos about patient and public participation

The CCG provides opportunities for staff to attend and help out at engagement events and over the course of the year, over 30 members of staff participated in engagement sessions.

1.9.10 Consultations

The CCG actively encourages patients, residents, and community organisations to take part in and contribute to its work. Taking part in consultations and public engagement exercises is an important way for the population to give feedback on issues that may affect them.

This last year the CCG has asked for formal feedback on a number of areas:

- Gluten Free Foods prescribing
- Improving access to General Practice through evening and weekend appointments
- Non-emergency transport services
- Perinatal mental health services

1.9.11 The next steps

Building on the engagement strategy and engagement action plan the CCG will continue to involve its patients, public and partners in the CCG's work.

- **Close partnership working with stakeholders:** Continuing to work in partnership with key partners such as Healthwatch, patient participation group (PPGs) and voluntary organisations and identify how the CCG uses their experience and networks to involve patients and the public in areas of commissioning.
- **Conversations with local population:** The CCG will ask its population what they see as the public and patient engagement priorities for the next year.
- **NHS Vale of York CCG engagement network**: The CCG will look to establish a CCG patient network – a group which supports patients and the public to learn about healthcare in the Vale of York community, feeds into CCG priorities and quality improvement and takes key messages back into its communities.
- **Identification of groups who are 'seldom heard'** and ensuring that they have the opportunity to engage with the CCG. Establishing the preferred way of engaging these communities or groups and explore new communication methods – e.g. SMS text and social media and by producing materials in alternative formats.
- **Patient experience and insights**: Continue to develop a system to record patient experiences and insights to feed into the CCG; improving upon how the CCG can listen, review, triangulate and act on patient feedback and, capturing patient stories and ensure that they are incorporated into meetings, briefings and events to put the patient at the heart of everything we do.

- **NHS 70:** The National Health Service (NHS) is turning 70 on 5 July 2018. Across the country there will be celebrations, including ceremonies for NHS staff in York Minster and Westminster Abbey. The CCG will work with partners, patients and public to create a series of celebrations and use it as a vehicle to help raise awareness of a number of key strategic priorities around prevention and self-care, tackling loneliness and isolation, showcasing healthcare innovation and creating a sustainable NHS.

1.9.12 Engagement highlights – a year in brief:

April 2017	The CCG enjoyed meeting with Healthwatch and local carers organisation to find out what matters to them, listening to their feedback at their regular sessions. The CCG surveyed patients and the public about their experience of using non-emergency transport. This feedback will be used to help inform the service specification and procurement of a new medical non-emergency transport service.
May 2017	CCG staff met patient representatives and practice staff at Millfield, Tollerton and Pickering PPGs to find out more about patient experience and the pressures within primary care. The engagement action plan was launched at the Governing Body meeting on 4 May.
June 2017	The CCG supported Carers Week, attending events in York and promoting information through our staff engagement channels. Stakeholders, voluntary sector and the public joined CCG staff for an interactive session on tackling the issues of health language and communications. The Wheelchair and Community Equipment Service user group met with providers to share feedback from those using services. The CCG's Chief Nurse and Joint Medical Director presented to 40 residents of Pocklington about commissioning and current health topics.
July 2017	The CCG's series of big conversations was launched. Hosting over 40 events between July and October, staff went out to speak to communities in areas such as Easingwold, Selby, New Earswick, Helmsley and York. The Student Health Needs Assessment (SHNA) report was presented at the York Health and Wellbeing Board, following conversations and feedback from over 1,800 students within York. The SHNA was commissioned following recognition that students

	form a significant proportion (around 15%) of the York population and have a specific set of health needs, with a particular focus on mental health concerns of York students.
August 2017	The CCG continued to tour around the Vale of York patch as part of 'our big conversations' to listen to the views of the population. This month CCG staff visited libraries and market stalls to ask the population their thoughts on local health services.
September 2017	During September the CCG attended a number of Freshers' Fairs with the local university and York College to chat to students about how the younger generation accesses health care and what they do if they were unwell. Work began with the local Learning Disabilities community on how to overcome the barriers associated with accessing GPs and cervical screening. The CCG held its Annual General Meeting to present the Annual Report and Accounts, where stakeholders and voluntary organisations were invited to have a stall at the event and chat with local GPs.
October 2017	The CCG started filming its first patient story – which will become a standing item at the beginning of each Quality and Patient Experience Committee. It was good to get out across the patch and speak to staff and members of the public visiting Pickering and Sherburn's one-stop-shop library service.
November 2017	Attendance at Haxby and Millfield surgery Patient Participation Groups (PPG) this month allowed the CCG to capture feedback about GP services. The PPG received a presentation on the financial position of the CCG, and some of the transformation policies going forward. The CCG began a formal consultation around the prescribing of Gluten Free Foods. Members of the CCG attended the St Leonard's Hospice 'Vision Board Development Day, and gave a presentation on 'Palliative and End of Life Care – Commissioning Vision and Strategy', opening up discussions around collaborative working.
December 2017	The first patient story was played at a meeting of the Quality and Patient Experience Committee, the story of a parent carer. The 'Stay well this winter' campaign launched. Created with partners and the voluntary sector the series of videos are designed to help

	people in the Vale of York self-treat common illnesses such as cold and flu at home.
January 2018	Dr Kev Smith (Executive director for Primary Care and Population Health) gave an update to the York Healthwatch Assembly about the priorities and commissioning intentions for this year. The focus was on how the CCG can help people to support themselves and delivering services that make sense for the population within the Vale of York. The City of York Youth Council and the Children in Care Council met with a member of the CCG's mental health team. They discussed the Child and Adolescent Mental Health Services' Local Transformation Plan, so that the CCG captured the young person's voice and priorities for mental health.
February 2018	The CCG's commissioning intentions were launched, built on the conversations with its community. The priorities for the next year reflected the views of local people who attended the series of 'big conversation' engagement events. Topics including cancer, dementia, mental health, access to health prevention and education and access to primary care services were identified by participants and will remain a focus for the year ahead. The CCG visited a number of care and residential homes and forums to speak to staff and residents about what matters most to them. These important conversations fed into the care homes strategy and ensured that the focus is on person-centred care and quality.
March 2018	Improving access to GP services survey was launched and the CCG asked the Vale of York population to complete a short survey to help shape how this additional service is delivered. Events at train stations, colleges and with partners, in addition to an online survey ensured that the CCG captured thoughts and feedback form a wide selection of our population around the introduction of weekend and evening appointments.

Table 9: Key moments from the CCG's conversations in 2017-18

1.9.12 Engagement annual report

This year the CCG has produced its first separate patient and public participation annual report. This can be found on the CCG website: http://www.valeofyorkccg.nhs.uk/get-involved/

1.10 Reducing health inequality

1.10.1 Health inequalities

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

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

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

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

You can find out more about the Health and Wellbeing Board here, including the new joint Health and Wellbeing Strategy here: https://www.york.gov.uk/info/20139/health_and_wellbeing_partnerships/973/health_and_wellbeing_board/1

As part of the Health and Wellbeing Board the CCG uses the joint strategic needs assessment (JSNA) to help identify the health and wellbeing needs of our local population and to inform the development of services to reduce health inequalities.

There is a dedicated website for York's JSNA to help to make sure the information in the JSNA is more widely accessible. To view the website go to www.healthyork.org.
North Yorkshire County Council publishes Vale of York Summary as part of the Joint Strategic Needs Assessment Annual Update, the latest update can be found at: https://www.datanorthyorkshire.org/JSNA/articles/north-yorkshire-jsna-annual-update-2016-ccgs/ .

The East Riding of Yorkshire Joint Strategic Needs Assessment focuses on the following three areas:

- improving the mental and emotional health of children and young people;
- supporting independent living for older people;
- reducing health inequalities.

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

1.10.2 Health inequality in the Vale of York

People within the Vale of York have good health overall, with life expectancy at birth above the national average. However, there exist a number of health inequalities and areas where Vale of York is doing less well than the national or regional average as can be seen below.

- Life expectancy varies for men and women considerably across this area. With the widest variation in York where the life expectancy gap at birth in York is 7.4 years for males and 5.8 years for females and Selby where it is 4.7 years for males and 6.9 years for females. Life expectancy varies across social groups, and targeting groups to promote health equality is part of the CCGs approach to service development.
- The CCG recognises that there is a strong link between poverty and poor health, across the Vale of York seven areas rank within the 20% most deprived in England, (five in York and two in Selby). Almost 12,000 people live in these areas.
- Excess weight in adults is an issue for the area, particularly in Selby where it is also an issue for primary school children. The rate for adults in Selby is significantly higher (70%) compared to the national average (65%).
- Binge drinking adults is a significant issue for the area with 28.8% of the adult population estimated as binge drinkers compared with 20% nationally.
- Stroke mortality rates in those aged over 75 years (708 per 100,000 population) are significantly higher than the England average (609 per 100,000). Linked with this are a high number of admissions for myocardial infarctions, stroke, respiratory disease, and stage 5 kidney diseases in people with diabetes. The CCG has implemented revised diabetes pathways to support better community management of diabetes patients to help prevent hospital admission.
- The rate of admission for alcohol-related cancer conditions is also higher than the England average, and in 2013-14 there were 207.8 admissions per 100,000 population recorded locally, compared with 176.5 per 100,000 recorded nationally and 196.8 per 100,000 across the Yorkshire and Humber region in the same period. However, the percentage of deaths from cancer (all ages) was lower in our residents (25.8%, 2013) than nationally (28.2%) or regionally (27.9%) in the same period.
- A significantly lower proportion of diabetes patients meet the three treatment targets around cholesterol, blood pressure and HbA1c than in similar CCGs (31.8% locally

compared with 36.3% across similar CCGs). Cardio-Vascular Disease (CVD) prevalence is higher in the Vale of York at 3.5% compared to the national average of 3.3%. Detection of hypertension is lower at 52.5% compared with the national average of 54.3%. As risk factors for developing CVD, low disease registers may indicate a large population at risk, linked with the fact that the NHS Health Check uptake rate in Vale of York CCG (44.2%) is lower when compared to England (49%). Opportunities to identify this at risk population earlier could be improved, resulting in a reduced rate for premature mortality related to stroke which the area is currently an outlier for. The CCG is working closely with partner CCGs through the Humber, Coast and Vale footprint to improve pathways for stroke and CVD.

- Smoking quit rates (at 4 weeks) are also significantly worse than in similar CCGs (480 per 100,000 locally compared to 818 per 100,000 across similar CCGs) or England (868 per 100,000).
- There are around 950 complex patients, typically with 3 different conditions, resident in the CCG area who are admitted to hospital on average 6 times a year. Almost half (44%, 417 patients) are aged over 75. The most common main condition in this group of patients is circulation-related conditions, often accompanied by neurological or respiratory conditions. The embedding of Care Hubs across the Vale of York is designed to target this cohort of the population to provide multi-disciplinary support to older people and those with multiple health needs.
- Isolation was regarded as one of the key concerns, based on engagement input into the JSNA, which particularly affects older people.
- Although child poverty is lower than the national and regional index, the North Yorkshire Child Poverty Needs Analysis, compiled in 2011, shows that child poverty in Vale of York is most prevalent around urban areas like Selby. Child poverty is also found in some rural locations, most particularly in Central Ryedale, and the southernmost area of the Selby locality.
- During 2010-11, there were 60,789 people on the GP depression disease register in North Yorkshire, equivalent to a prevalence of 13.3%, above the national average of 11.2%.
- Although the total number of BME people identified in the Census is lower than the UK average, the report *Mapping rapidly changing minority ethnic populations: a case study of York by the Joseph Rowntree Foundation,* reports that York has a very diverse BME population with 78 different first languages spoken by its residents. York also attracts a large number of overseas students making up 17% of their student population and this diversity needs to be considered by the CCG in its decision making process.
- The Gypsy, Roma and Traveller community experiences some of the poorest health and the York's Gypsy, Roma and Traveller Strategy 2013-18 says: "There are approximately 350 Gypsy, Roma and Traveller (GRT) families in York, living on traveller sites, houses and on the roadside (Gypsy and Traveller Area Assessment 2009. The JSNA Topic Summary for Gypsy Travellers and Show People estimates just over 1100 GRT people

in York. In Selby, the figure is estimated at 478 living in 151 households. In Ryedale: 318 people living in 100 households.

1.10.3 Equality and diversity

The CCG is committed to reducing health inequalities and to promoting equality and diversity. The CCG sees its work around equality and diversity as an integral part of its work to reduce health inequalities.

This section of the annual report highlights the work the CCG has undertaken and provides evidence of how the CCG is meeting its public sector equality duties under the **Equality Act 2010**, and includes an update on the equality objective, Equality Delivery System 2 (EDS2) and the NHS Workforce Race Equality Standard (WRES).

In publishing this report NHS Vale of York CGG is providing assurance and demonstrating that it has consciously thought about the three aims of the Equality Duty as part of its decision-making process.

For further information on the Equality Act 2010 click here: https://www.gov.uk/guidance/equality-act-2010-guidance

Further information on the approach to equality and diversity and the legal requirement can be found in the “Equality, Diversity and Human Rights Strategy” section on the CCG’s website.

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

The CCG recognises the importance of leadership in driving forward the equality agenda and that this is critical to our success as commissioners of local NHS services. The CCG plans to use the Care Quality Commission’s (CQC) *Equally outstanding: Equality and human rights – good practice resource 2017* to help it embed equality into mainstream work. Although the report is primarily focused on provider trusts, the human rights principles of fairness, respect, equality, dignity and autonomy at the heart of good care provision is equally applicable to commissioning services that meet local need, focus on health improvement and reduce health inequalities.

The report highlights the importance of senior leadership commitment to equality and diversity and that this is reflected in organisational culture and practice. It identified the following factors for success:

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

In line with the requirements of the Equality act 2010, the CCG has reviewed its equality objectives and used the CQC factors above as the foundation for the new **equality objectives** 2017-2020. The CCG's action plan is available on the website and progress will be updated in the annual report as part of our publication of evidence in meeting our public sector equality duties.

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

To support the comprehensive use of EIAs during 2017, the CCG delivered updated training for staff that looked at the links between engagement, equality and health inequalities and the use of EIAs.

You can find further information on the CCG polices and EIAs on the website at http://www.valeofyorkccg.nhs.uk/publications/policies/ .

This year the CCG has carried out EIAs on projects such as the review of Gluten Free Prescribing; the 'Big Conversation' and Minor Eye Condition Services.

National changes to how we commission and deliver health and care services mean that we are working more closely with NHS Scarborough and Ryedale CCG. This means that we are increasingly working on joint EIAs for improvement projects.

1.10.4 Commitment to patients and carers

Tackling inequalities is one of the CCGs key priorities: it is committed to making sure that equality and diversity is a priority when planning and commissioning local healthcare. The CCG will work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs.

The CCG has been using the national **NHS Equality Delivery System 2** (EDS2), designed to support it in its commissioning role - and its providers of services - to deliver better outcomes for the local population and better working environments for staff, which are personal, fair and diverse. You can find out more about EDS2 at https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

In November 2017, the CCG and York Teaching Hospital NHS Foundation Trust held a workshop that brought together key stakeholders including the voluntary and community sector to review progress against their EDS2 priorities. The workshop looked at progress against existing shared priorities and also focused on progress and gaps against EDS2 Goal 1 'Better Health Outcomes' - the table below provides an update of key achievements against the shared priorities for 2017-18 and agreed future actions for 2018-19.

Shared priorities	Key achievements 2017-18	Agreed actions for 2018-19
Directory of Services	Healthwatch developed a Directory of Services for older people.	To develop an Information guide-booklet on accessing health services when transitioning from young people's services to adult services Improve transition pathway between children's and adults' services for young people with cystic fibrosis.
Information sharing	The CCG and Trust have shared areas of interest and good practice via two clinical summits (GP's and hospital staff).	Identify and agree key messages to be shared e.g. 6 monthly updates on EDS progress Identify and agree mechanisms for dissemination particularly through existing VCS networks
Develop options for improved representation and communication about EDS2	There has been a presentation of an EDS2 report to the Council Governors to help raise awareness.	Review current EDS2 invitee list and identify any gaps, particularly around specific protected groups and rural areas Review methods and approaches for EDS2 engagement Agree engagement plan and hold panel - engagement event in Spring 2019

Table 9: Key achievements against 2017-18 shared priorities and agreed actions for 2018-19

The CCG and York Teaching Hospital NHS Foundation Trust plan to hold a further EDS2 engagement event in Spring 2019.

The **Accessible Information Standard** became mandatory in July 2016. The aim of the standard is to make sure people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support they might need. This includes making sure people get information in different formats, for example large print, Braille, easy read and support such as a British Sign Language interpreter, deafblind manual interpreter or an advocate. Although the CCG is exempt from delivering the standard, it is required to pay due regard and will make sure that when it communicates with the public it considers the requirements of the standard. The CCG is required to seek assurance from

provider organisations of their compliance with the standard, including evidence of how they are planning to meet the standard. As the CCG is now co-commissioning Primary Care, this will include GP practices. The CCG is currently working with the provider trust to agree how the standard will be implemented and monitored.

1.10.5 Commitment to our staff

To ensure that staff members do not experience discrimination, harassment and victimisation the CCG has a range of policies to support staff including flexible working, bullying and harassment, employing disabled people, home working and retirement. All its policies can be found on the CCG website here: http://www.valeofyorkccg.nhs.uk/publications/policies/ .

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

All relevant policies have had an EIA completed. The CCG recognises that in order to remove the barriers experienced by disabled people, it needs to make reasonable adjustments for its disabled employees. The CCG does this on an individual basis and involves occupational health services as appropriate. The CCG has signed up for the new Disability Confident Employer scheme (which replaces the Two Ticks scheme) as Disability Confident Committed and intends to progress to full Disability Confident Employer status.
.
The CCG has welcomed the national focus on the **NHS Workforce Race Equality Standard** (WRES) and the progress that its local NHS providers are making in improving workforce race equality. Further information on the standard can be found here: https://www.england.nhs.uk/publication/workforce-race-equality-standard-technical-guidance-2017/

Due to the small number of staff within the CCG and the risk of breaching confidentiality, the CCG is not required to publish statistical data for the WRES. However, the CCG is collecting and analysing this data to inform the ongoing development of its action plan. In addition, any issues identified are also taken to the Staff Engagement Group.

In the coming year the CCG will also be preparing for the **Workforce Disability Equality Standard** (WDES) which becomes mandatory in April 2018. During 2018, baseline data will need to be collected, with the first report to be published in August 2019 and will initially apply to NHS provider trusts.

You can find further information on the WDES on the NHS England website at https://www.england.nhs.uk/about/equality/equality-hub/wdes/ .

1.10.6 Monitoring NHS provider organisations

As a commissioner of healthcare, the CCG has a duty to ensure that all of its local healthcare service providers are meeting their statutory Public Sector Equality Duties under the Equality Act 2010. As well as regular monitoring of performance, patient experience and service access the CCG will work with providers to consider their progress on their equality objectives, EDS2, the WRES, the WDES and the implementation of the Accessible Information Standard, which became law in July 2016. Each provider organisation is subject to the specific duty and has published its own data. As commissioners of primary care the CCG is also working with its practices to ensure they meet their equality duties. This work with providers is seen as crucial in supporting the CCG in a whole system approach to addressing health inequalities experienced by patients, carers, local people and staff.

1.11 Health and wellbeing strategies

1.11.1 Developing strategies for the Vale of York area

The CCG is a member of three Health and Wellbeing Boards: City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council During 2017-18, the Chair of the CCG was Vice-Chair of the York Health and Wellbeing Board.

There are therefore three distinct Health and Wellbeing Strategies, but with common features in that all three take a life-course approach, dividing goals by age group as follows: maternity, infancy and childhood; working age; and old age and end of life care. The CCG has contributed towards the development or achievement of a range of projects and work.

1.11.1.1 City of York area

- Development of the Pharmaceutical Needs Assessment
- Development of a new Mental Health Strategy
- CQC Whole System Review (review of health and social care joint working)
- Reducing health inequalities through cultural commissioning

1.11.1.2 North Yorkshire area

- Development of the Pharmaceutical Needs Assessment
- North Yorkshire Dementia Strategy
- Healthy Weight, Healthy Lives Strategy

1.11.1.3 East Riding of Yorkshire area

- Development of the Pharmaceutical Needs Assessment
- System-wide workforce strategy
- Review of children with long-term health conditions or disabilities
- Review of early onset dementia
- Loneliness and Isolation programme
- ReSPECT programme for advance care planning
- Future in Mind CAMHS policy

In addition there has been a programme of joint work to deliver improvements agreed as part of the Better Care Fund (BCF) initiative, with the respective Health and Wellbeing Boards having an oversight role in the delivery of BCF targets.

The relevant Health and Wellbeing Boards have been consulted on the content of this section.

Section 2

Accountability Report

Phil Mettam
Accountable Officer
24 May 2018

24/5/18.

2.1 Members Report

Please see the Report of the Chair of the Council of Representatives at the beginning of the Annual Report on page 9.

2.1.1 Member practices

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

Practice	Website address
Beech Tree Surgery	www.beechtreesurgery.co.uk
Dalton Terrace Surgery	www.daltonterracesurgery.nhs.uk
East Parade Surgery	www.eastparademedical.co.uk
Elvington Medical Practice	www.elvingtonmedicalpractice.co.uk
Escrick Surgery	www.escricksurgeryyork.co.uk
Front Street Surgery	www.frontstreetsurgery.nhs.uk
Haxby Group Practice	www.haxbygroup.co.uk/york/
Helmsley Surgery	www.helmsleymedicalcentre.co.uk
Jorvik Gillygate Practice	www.jorvikmedicalpractice.co.uk
Kirkbymoorside Surgery	www.thekirkbymoorsidesurgery.co.uk
Millfield Surgery	www.millfieldsurgery.co.uk
MyHealth	www.myhealthgroup.co.uk
Old School Medical Practice	www.oldschoolmedical.gpsurgery.net
Pickering Medical Practice	www.pickeringmedicalpractice.co.uk
Pocklington Group Practice	www.pocklingtongps.nhs.uk
Posterngate Surgery	www.posterngatesurgery.nhs.uk
Priory Medical Group	www.priorymedical.com
Scott Road Medical Centre	www.scottroad.org.uk
Sherburn Group Practice	www.sherburnsurgery.nhs.uk
South Milford Surgery	www.southmilfordsurgery.co.uk
Stillington Surgery	www.stillingtonsurgery.co.uk
Tadcaster Medical Centre	www.tadcastermedicalcentre.co.uk
Terrington Surgery	www.terringtonsurgery.nhs.uk
Tollerton Surgery	www.tollertonsurgery.co.uk
Unity Health	www.unityhealth.info
York Medical Group	www.yorkmedicalgroup.nhs.uk

Table 11: Member practices in the Vale of York

2.1.2 Council of Representatives meeting attendances in 2017-18

Y = Attended
A = Apologies
PM = Practice Manager represented Practice - attended with member
GPR = GP Registrar
m = male, f = female
N = Neither attended nor sent apologies

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

Table 11: Council of Representatives meeting attendances in 2017-18

2.1.3 Composition of the Governing Body in 2017-18

The Governing Body met seven times in public and was quorate on each occasion. A Governing Body workshop was held for members to take part in Risk Tolerance Training.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Keith Ramsay	CCG Governing Body Chair	7-7
Dr Louise Barker	Clinical Director	6-7
David Booker	Lay Member and Chair of Finance and Performance Committee	6-7
Dr Emma Broughton	Clinical Director	6-7
Dr Stuart Calder	GP, Council of Representatives Member	4-7
Michelle Carrington	Chief Nurse-Executive Director of Quality and Nursing	6-7
Dr Paula Evans	GP, Council of Representatives Member	7-7
Dr Arasu Kuppuswamy	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust - Secondary Care Doctor Member	4-7
Dr Tim Maycock to 31 August 2017	Clinical Director	1-3
Phil Mettam	Accountable Officer	7-7
Denise Nightingale from 10 July 2017	Executive Director of Transformation and Delivery	4-5
Dr Shaun O'Connell	Joint Medical Director	3-7
Dr Andrew Phillips	Joint Medical Director	5-7
Rachel Potts to 28 September 2017	Executive Director of Planning and Governance	3-3
Sheenagh Powell	Lay Member and Audit Committee Chair	6-7
Tracey Preece	Chief Finance Officer	7-7
Dr Kevin Smith from 1 October 2017	Executive Director of Primary Care and Population Health	2-3
Attendees – Non voting		
Dr Aaron Brown From 1 September 2017	Local Medical Committee Liaison Officer, Selby and York	3-4
Dr John Lethem to 31 August 2017	Local Medical Committee Liaison Officer, Selby and York	1-3
Sharon Stoltz	Director of Public Health, City of York Council	2-7

Table 12: Composition of the Governing Body in 2017-18

Full details of the Governing Body membership from 1 April 2017 to 31 March 2018 follows.

Keith Ramsay – Lay Chair (to 31 March 2018)

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

Phil Mettam – Accountable Officer

Phil joined the CCG in October 2016. He previously worked in Primary Care Trust's (PCTs) and at Strategic Health Authority level. Phil believes commissioning can make a real difference, but only when aligned with clinical insight and involving service users. Phil is a chartered secretary by profession and is a sport and music enthusiast with a passion for the beauty of the natural world.

Tracey Preece – Chief Finance Officer

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

Rachel Potts – Executive Director of Planning and Governance (to 29 September 2017)

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.

Michelle Carrington - Executive Director of Quality and Nursing

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

Denise Nightingale - Executive Director of Transformation, Complex Care and Mental Health (from 10 July 2017)

Denise joined us from NHS Bassetlaw CCG where she was the Chief Nurse. Previously she has worked as an Executive in an acute setting. She has led a hospital re-provision and has undertaken significant service re-configurations. Denise has held roles within the Department of Health and a Strategic Health Authority implementing the Choice and Independent Treatment Centre agendas. Denise believes her current role in the CCG offers a real opportunity to deliver targeted improvements through working closely with local partners.

Dr Kev Smith – Executive Director of Primary Care and Population Health (from 1 October 2017)

Kev's expertise and leadership skills are charted throughout his career in senior roles including Principal Adviser to NHS England for Yorkshire and the Humber and as the national Medical Adviser for Specialised Services and Screening in the Department of Health. Kevin was also the head of the Healthcare team in Public Health England Yorkshire and the Humber where he has supported three local STP areas in their work to develop future models of health and care. Before working in public health, Kev worked in clinical medicine. He was a Senior Lecturer at the School of Health and Related Research at Sheffield University, one of the largest and most dynamic Schools of health research in the UK. He is a member of the Yorkshire Senate and continues to teach at universities in York, Leeds and Sheffield.

	**Dr Andrew Phillips – Clinical Director** (to 31 March 2018) 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 combined 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 supporting primary care functions throughout innovations in healthcare.
	**Dr Shaun O'Connell – Clinical Director** (to 31 March 2018) Dr O'Connell was 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 Louise Barker – Clinical Director** (to 31 March 2018) Louise is a GP at the Haxby Group Practice and is the CCG's GP Lead for Mental Health. Louise graduated from Liverpool Medical School and completed her GP training in Yorkshire. In her work at the Haxby Practice she is involved in offering women's health services, minor surgery procedures and teaching medical students at Hull York Medical School.
	**Dr Emma Broughton – Clinical Director** (to 31 March 2018) 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 Tim Maycock – Clinical Director (to 31 August 2017)

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

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

David trained as a social worker and worked in a number of roles in local government and third sector organisations. His latest role was as UK Director for Volunteering at 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

Sheenagh Powell - Lay Member and Chair of the Audit Committee

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

Dr Arasu Kuppuswamy - Secondary Care Governing Body Member

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

Dr Paula Evans - Chair of CCG Council of Representatives

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

Dr Stuart Calder - Deputy Chair of the Council of Representatives

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

Non-voting attendees

Sharon Stoltz - City of York Council Director of Public Health

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

	**Dr Aaron Brown - Local Medical Committee Liaison Officer for Selby and York** (from 1 September 2017) Aaron is a GP with the York Medical Group. He has been a member of YORLMC, the only statutory body with a duty to represent GPs at a local level, since 2012. He became a member whilst a GPR and was elected as Liaison Officer of the Vale of York division in 2017.
	**Dr John Lethem - Local Medical Committee Liaison Officer for Selby and York** (to 31 August 2017) 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 LMC for 15 years.

On the 1 April 2018 Dr Nigel Wells became the new Clinical Chair of the Governing Body.

The CCG has a number of committees which report to the Governing Body and the structure in 2017-18 was as set out in the diagram below:

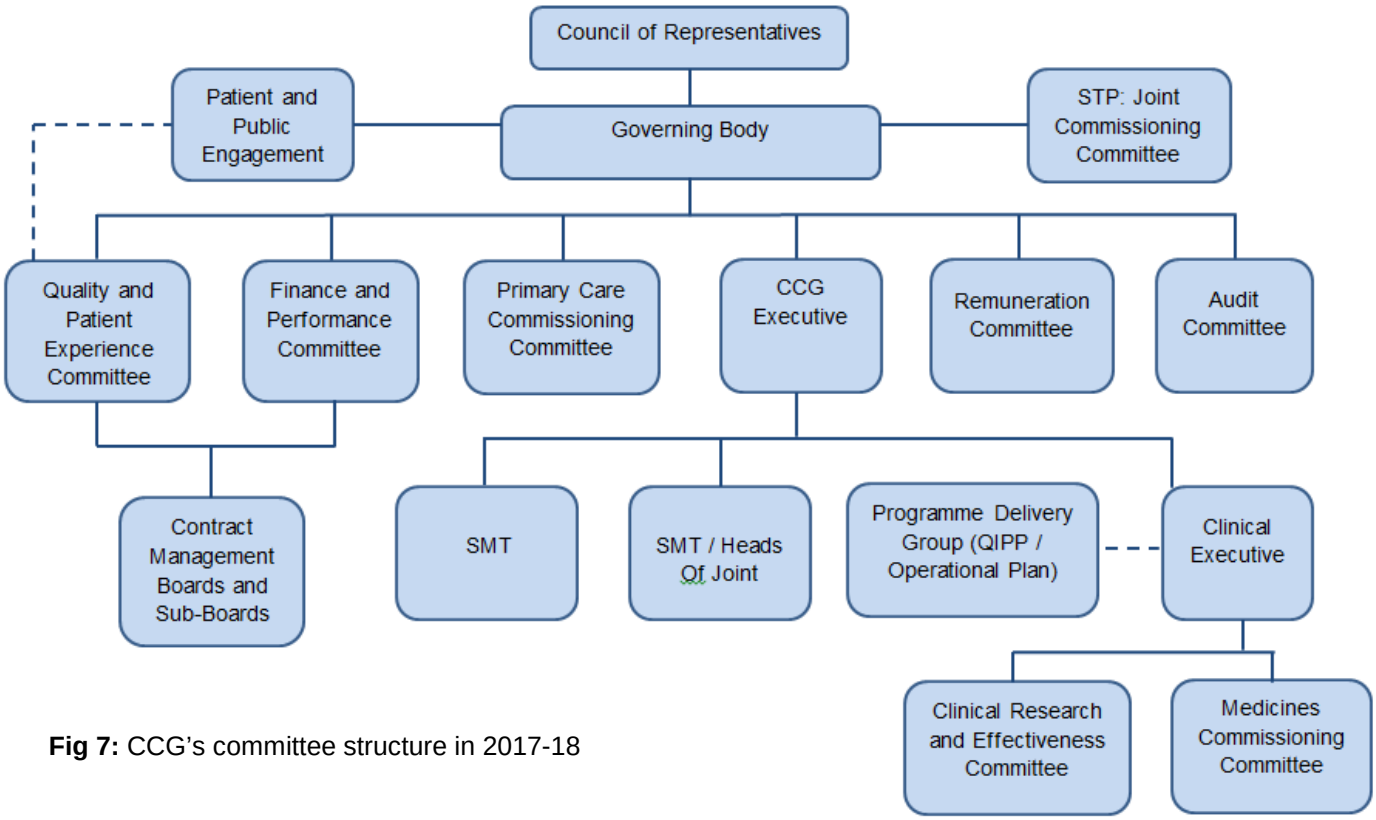

Fig 7: CCG's committee structure in 2017-18

2.1.4 Committees

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

Strategic committees	
Committee	**Role and performance highlights**
Audit Committee	Chaired by the Lay Member with the lead role in governance and conflict of interest, the Audit Committee provides the Governing Body with independent assurance through critically reviewing the CCG's financial reporting and internal control principles and ensuring an appropriate relationship with both internal and external auditors is maintained. It has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions including counter fraud and security management, financial reporting, and Auditor Panel function. The Committee met six times in 2017-18 and was quorate on each occasion. There is a schedule of preceding private meetings of members with internal and-or external audit. **Members** Sheenagh Powell (Committee Chair), Lay Member with the lead role in governance David Booker, Lay Member and Chair of Finance and Performance Committee Dr Arasu Kuppuswamy, Secondary Care Clinician **Performance highlights** ▪ Review of Committee terms of reference and work plan ▪ Regular updates on key financial policies and progress against Financial Recovery Plan ▪ Review of draft Annual Report and Annual Accounts ▪ Regular assurance from internal and external audit on reports issued to management ▪ Approving internal audit and external audit plans linked to the assurance framework ▪ Monitoring the implementation of audit recommendations ▪ Annual review of Internal Audit Charter and Working Together Protocol ▪ Review of Assurance Framework and Risk Register processes

Strategic committees

- Review of Information Governance assurance
- Regular updates on counter fraud and security including approval of annual work plan and review of the organisation's annual self-review against NHS Protect's standards
- Review of Commissioning Support assurance
- Review of Partnership Commissioning Unit assurance
- Review of Primary Care Commissioning assurance
- Processes for review of Committee effectiveness, internal audit effectiveness, counter fraud and security effectiveness, and external audit effectiveness

Remuneration Committee

Chaired by the CCG Governing Body Chair, the Remuneration Committee makes recommendations to the Governing Body on:
terms and conditions of employment for employees of NHS Vale of York CCG including the use of recruitment and retention premia, annual salary awards where applicable, allowances under any pension scheme it might establish as an alternative to the NHS pension scheme, severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money', and policies and instructions relating to remuneration.
The Committee convened six times in 2017-18, one of which was via teleconference, and was quorate on each occasion.

Membership

Name	Role	Membership from	Attendance
Keith Ramsay	CCG Governing Body and Remuneration Committee Chair	April 2017	6-6
David Booker	Lay Member and Chair of Finance and Performance Committee	April 2017	6-6
Sheenagh Powell	Lay Member with a lead role in governance and Audit Committee Chair	April 2017	4-6

One meeting was via teleconference and the December meeting, which David Booker joined by phone, resumed in January to complete the business.

An extraordinary single item meeting was held by teleconference. Keith Ramsay, David Booker and Sheenagh Powell all took part in this.

Strategic committees

Non Remuneration Committee member attendances

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

Janet Thacker, Head of Human Resources and Learning and Developments, eMBED Health Consortium, was on the teleconference in the capacity of external adviser.

Emma Collins, HR Business Partner for eMBED Health Consortium, was on the teleconference in the capacity of external adviser in addition to Janet Thacker.

Kerry Ryan, HR Business Partner for eMBED Health Consortium, attended five meetings in the capacity of external adviser.

Mrs Thacker, Mrs Collins and Miss Ryan also provided a range of general HR advice to the CCG during the 2017-18 financial year. They were employed by eMBED Health Consortium who were contracted to provide an HR service to the CCG. The Committee is satisfied that the advice received was objective and independent. There was no additional fee paid other than the contracted commitment to eMBED Health Consortium through the Service Level Agreement (SLA).

Phil Mettam, Accountable Officer, attended all six meetings but was only on the teleconference for one item as the other agenda item related to him. He also took part in the extraordinary single item teleconference.

Tracey Preece, Chief Finance Officer, attended one meeting for a specific item.

Dr Kevin Smith, Executive Director of Primary Care and Population Health, attended one meeting for a specific item and also took part in the extraordinary single item teleconference.

Abigail Combes, Head of Legal and Governance, attended one meeting for a specific item.

Performance highlights

- Appointment of Executive Director of Transformation and Delivery and Executive Director of Primary Care and Population Health
- Approval in principle for establishment of a joint Director level post with City of York Council and of 'Heads of' posts with North Yorkshire County Council
- Remuneration for Accountable Officer
- Review of Senior Management Team remuneration

Strategic committees

	▪ Report on off-payroll working in the public sector – reforms to the Intermediaries Legislation (IR35) ▪ Review of CCG commitment to the Living Wage Foundation rate ▪ Review of Committee terms of reference ▪ Mechanism for engaging Clinical Chair and Governing Body GP representation and rates of remuneration ▪ Remuneration for GPs with medical portfolio roles
Finance and Performance Committee	The paramount role of the Committee, which met 12 times in 2017-18 and was quorate on each occasion, is to oversee the financial recovery of the CCG operating under legal Directions, which became effective from 1 September 2016, through scrutiny of all financial recovery plans on behalf of the Governing Body. **Members** David Booker, Lay Member - Committee Chair Caroline Alexander, Assistant Director of Delivery and Performance Michael Ash-McMahon, Deputy Chief Finance Officer Fiona Bell, Assistant Director of Transformation and Delivery Michelle Carrington, Chief Nurse - Executive Director of Quality and Nursing Phil Mettam, Accountable Officer Dr Shaun O'Connell, Joint Medical Director Dr Andrew Phillips, Joint Medical Director Rachel Potts, Executive Director of Planning and Governance (to 28 September 2017 Tracey Preece, Chief Finance Officer **In attendance (Non-voting)** Rachel Cooke Head of Finance (from July 2017) Natalie Fletcher, Head of Finance (to June 2017) Jim Hayburn, Strategic Programme Consultant (to 28 September) Keith Ramsay, Lay Chair of the Governing Body Sheenagh Powell, Lay Chair of the Audit Committee Liza Smithson, Head of Contracting Jon Swift, Director of Finance, NHS England North (or deputy) Elaine Wyllie, Strategic Programme Consultant (to 21 September) Following review, the membership from October was: David Booker, Lay Member – Committee Chair Michelle Carrington, Chief Nurse-Executive Director of Nursing and Quality

Strategic committees

	Phil Mettam, Accountable Officer Denise Nightingale, Executive Director of Transformation Dr Shaun O'Connell, Joint Medical Director Dr Andrew Phillips, Joint Medical Director Tracey Preece, Chief Finance Officer Keith Ramsay, Lay Chair of the Governing Body (in attendance until November and full member from December) Dr Kevin Smith, Executive Director of Primary Care and Population Health (from November) In attendance: Sheenagh Powell, Lay Chair of Audit Committee Jon Swift, Director of Finance, NHS England North (or deputy) **Performance highlights** ▪ Monthly Financial Performance Report including QIPP, Integrated Performance Report, Contract Report and Better Care Fund update ▪ Progress reports towards development of a system financial envelope ▪ Review of Committee terms of reference ▪ Progress reports towards establishing Aligned Incentive Contracts ▪ Monitoring of progress against constitutional targets including Child and Adolescent Mental Health Services, Improving Access to Psychological Therapies, Dementia coding and Cancer ▪ Monitoring of concerns relating to Continuing Healthcare, Transforming Care and Section 117 ▪ Winter Planning
Quality and Patient Experience Committee	The Quality and Patient Experience Committee, which meets bi-monthly, met six times in 2017-18, one of which was a single item agenda, and was quorate on each occasion. The overall objective of the Committee is to ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement in line with the NHS Constitution (2011) underpinned by the CCG Quality Assurance Strategy. In line with the NHS Constitution, this also includes actively seeking patient feedback on health services and engaging with all sections of the population with the intention of improving services and, as a membership organisation, working with NHS England, to support primary medical and pharmacy services to deliver high quality primary care, including patient experience. **Membership** Keith Ramsay, CCG Governing Body and Committee Chair Jenny Brandom, Deputy Chief Nurse-Deputy Executive Director for Quality

Strategic committees

	and Nursing Michelle Carrington, Chief Nurse-Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience) Abigail Combes, Head of Legal and Governance (from October) Dr Arasu Kuppuswamy, Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Governing Body Member Dr Shaun O'Connell, Joint Medical Director Dr Andrew Phillips, Joint Medical Director Rachel Potts, Executive Director of Planning and Governance (to 28 September 2017 Debbie Winder, Head of Quality Assurance and Maternity In attendance (Non-voting) Barry Dane, Healthwatch representative Karen Hedgley, Designated Nurse Safeguarding Children Victoria Hirst, Senior Engagement Manager Christine Pearson, Designated Nurse Safeguarding Adults Gill Rogers, Patient Experience Officer Co-opted member of Scarborough Ryedale CCG as required **Performance highlights** ▪ Quality and Patient Experience Report ▪ Safeguarding Adults and Children updates ▪ Review of Committee terms of reference ▪ Introduction of patient stories ▪ Single item meeting on Child and Adolescent Mental Health Services ▪ Care Quality Commission York Local System Review ▪ Care homes work plan
Primary Care Commissioning Committee	Chaired by the CCG Governing Body Chair, the Primary Care Commissioning Committee met six times in public and was quorate on each occasion. **Membership is NHS Vale of York CCG unless otherwise stated** Keith Ramsay, CCG Governing Body and Committee Chair David Booker, Lay Member and Chair of Finance and Performance Committee Michelle Carrington, Chief Nurse-Executive Director of Quality and Nursing Chris Clarke, Senior Commissioning Manager Primary Care, NHS England North (Yorkshire and the Humber (May meeting)

Strategic committees

	Heather Marsh, Head of Locality Programmes, NHS England – North (Yorkshire and the Humber) (from July 2017) Phil Mettam, Accountable Officer Tracey Preece, Chief Finance Officer Sheenagh Powell, Lay Member and Audit Committee Chair Dr Kevin Smith, Executive Director of Primary Care and Population Health (from November 2017) In Attendance (Non-voting): Nigel Ayre, Healthwatch North Yorkshire representative Dr Lorraine Boyd, GP, Council of Representatives Member (to December 2017) Kathleen Briers, Healthwatch York representative Dr Aaron Brown, Local Medical Committee Liaison Officer, Selby and York (from 3 September 2017) Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York (to 2 September 2017) Shaun Macey, Head of Transformation and Delivery Dr Shaun O'Connell, Joint Medical Director Dr Andrew Phillips, Joint Medical Director and Clinical Executive Chair Sharon Stoltz, Director of Public Health, City of York Council Standing attendees (non-voting) also include up to two GPs from each locality and a Practice Manager who to date have not attended. **Performance highlights** ▪ Regular updates on General Practice visits and engagement ▪ Development of a Primary Care Dashboard - Assurance Report ▪ Enhanced Services review ▪ Nuffield Trust report *Evaluating a New Model of Primary Care* ▪ Review of Committee terms of reference ▪ Proposed bids for primary care estates investment ▪ Prescribing Indicative Budgets ▪ Principles and process for 2018-19 £3 per head and Personal Medical Services funding ▪ Primary Care Update from NHS England North

Table 14: Committee performance and highlights

2.1.5 Register of Interests

All CCG staff are required to complete a declaration of interests form on an annual basis. Should their circumstances change and a conflict arise, they are asked to complete a new form within 28 days of becoming aware of the conflict. If staff are unsure whether they have a conflict of interest, they are asked to err on the side of caution - if in doubt, declare it. The CCG's registers of interest are reviewed monthly and published on its website here: http://www.valeofyorkccg.nhs.uk/about-us/our-registers-of-interest/ .

A conflict of interest occurs when someone's ability to exercise judgement, or act in a role is, could be, or is perceived to be impaired or otherwise influenced by their involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

Although conflicts of interest are inevitable in commissioning, it is how they are managed that is important. Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what CCGs (and NHS England) must do in terms of managing conflicts of interest.

The four types of interest are:

- **Financial interests:** when an individual may receive direct financial benefits.
- **Non-financial professional interests:** when an individual may obtain a non-financial professional benefit, i.e., increasing their professional reputation or status.
- **Non-financial personal interests:** when an individual may benefit personally in ways which are not directly linked to their professional career or a direct financial benefit.
- **Indirect interests:** when an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest.

A recent audit of the CCG's management of conflicts of interest by Deloitte LLP was positive overall. Although there were a number of recommendations in terms of making some processes more robust, no exceptions were found relation to the day to day management of conflicts of interest within the CCG, including the CCG's Conflicts of Interest Policy; the recording of interests and registers of interests held; procurement decisions and contract monitoring; or the management of conflicts of interest in committees and meetings.

The Deloitte LLP audit also covered the management of gifts of hospitality and, again the findings were positive overall.

In February 2018, NHS England released the e-learning Conflicts of Interest training which must be completed by all CCG staff by 31 May 2018.

2.1.6 Freedom of information requests

The Freedom of Information (FOI) Act 2000, creates a public "right of access" to information held by public authorities. There are restrictions and exceptions, but, essentially, the Act means anybody can ask the CCG for any recorded information it holds. FOIs have to be responded to within 20 working days (i.e., not weekends or UK bank holiday) from the day after receipt of the request, which must be made in writing, with the full name of the requestor, and an address to respond to them, usually an email address.

More information about Freedom of Information and the CCG's disclosure log (a list of previous FOI responses) can be found on the CCG's website here: http://www.valeofyorkccg.nhs.uk/about-us/freedom-of-information-new/ .

April 2017 – March 2018	Total
Number of FOIs	282
Number of FOIs replied to within 20 working days	238
Percentage replied to within 20 working days	84.4%
Average number of days to respond	12.82
Median number of days to respond	18.75

Table 15: FOIs received in 2017-18

April 2016 – March 2017	Total
Number of FOIs	310
Number of FOIs replied to within 20 working days	306
Percentage replied to within 20 working days	98.71%
Average number of days to respond	10.665
Median number of days to respond	15.98

Table 16: FOIs received in 2016-17

2.1.7 Personal data related incidents

The CCG year on year maintains a satisfactory level of compliance with the NHS Information Governance Toolkit.

The CCG is mindful of the high profile data breaches nationally and the CCG is committed to embedding the information governance agenda across the CCG, enabling staff awareness of the importance of reporting all information security incidents and near misses.

The CCG adheres to the requirement to categorise and assess all incidents involving loss of personal confidential data. These are considered serious untoward incidents and any assessed as level 2 must be reported via the online Incident Reporting Tool.

This allows incidents to be escalated to regulatory bodies such as the Department of Health and Social Care and the Information Commissioner's Office, where appropriate. The HSCIC publishes a quarterly report all incidents reported and categorised at Level 2 or above.

2.1.8 CCG Incidents

A summary of serious untoward incidents involving person identifiable data classified 0-1; from 1 April 2017 – 31 March 2018.

Category	Nature of incident	Number
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 document.	0
iv	Unauthorised disclosure	2
v	Other (Access to data not adequately restricted)	2

Table 17: Serious untoward including person identifiable data in 2017-18

2.1.9 Raising concerns (whistle blowing)

The CCG has appointed a Freedom to Speak Up (FTSU) Guardian. There have been no incidents to date reported to the FTSU Guardian.

2.1.10 Statement of Disclosure to Auditors

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

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

2.1.11 Modern Slavery Act

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

2.2 Statement of Accountable Officer's Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).
- Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.
- In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

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

- To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

- The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2017-18 expenditure performance is £20.072m over the income received. It has therefore breached its duty under the NHS Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, which sets statutory duties for CCGs to ensure that their capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (the Revenue Resource Limit and Capital resource Limit). A formal notification of this position was made in January 2018 by the Clinical Commissioning Group's external auditors, Mazars LLP, to the NHS Commissioning Board (NHS England) and also the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014.

I also confirm that:

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

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

2.3 Governance Statement

2.3.1 Introduction and context

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

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

As at 1 April 2017, the clinical commissioning group is subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 as follows:

2.3.2 The main provisions of the Legal Directions

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

"(4) The Board directs that:

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

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

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

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

(5) The Board further directs that:-

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

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

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

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

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

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

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

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

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

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

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

Executive Team and Senior Appointments

(6) The Board directs that:

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

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

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

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

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

provision of information, documents and records requested by the Board and making senior officers available to meet with the Board.

(7) The Board further directs that:

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

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

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

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

In response to these directions, the CCG has developed an Improvement Plan, and it continues to work closely with NHS England to deliver against the agreed actions. The full text of the directions can also be viewed on the NHS England website at: https://www.england.nhs.uk/commissioning/regulation/ccg-assess/directions/

2.3.3 Scope of responsibility

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

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

2.4 Governance arrangements and effectiveness

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

The role of the Membership v the Governing Body is clearly set out in Sections 5, 6 and 7 of the Constitution. This includes sections setting out the delegation to the Governing Body and subsequently to the committees of the Governing Body and secondly the role of the Council of Representatives. The Constitution will be submitted to NHS England for approval in May 2018 as it has been revised following the 1 April 2018 reset of the Governing Body. The CCG is also undertaking a review of the scheme of delegation and committee structure following the recruitment of new clinical members of the Governing Body.

For further information on the committee structures, membership and meetings, please see the Corporate Governance section beginning on p.67.

2.4.1 UK Corporate Governance Code

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

2.4.2 Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

2.4.3 Risk management arrangements and effectiveness

The CCG has an agreed Risk Management Strategy and Policy, which is published on the CCG's
website. http://www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/corporate-policies/cor03-risk-management-strategy-and-policy-4-0.pdf

The strategy-policy has been reviewed and refreshed in year following a review of the organisation structure and governance arrangements.

The strategy-policy sets out the CCG's definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management.

Risk management and monitoring responsibilities are included in committee Terms of Reference and are summarised below.

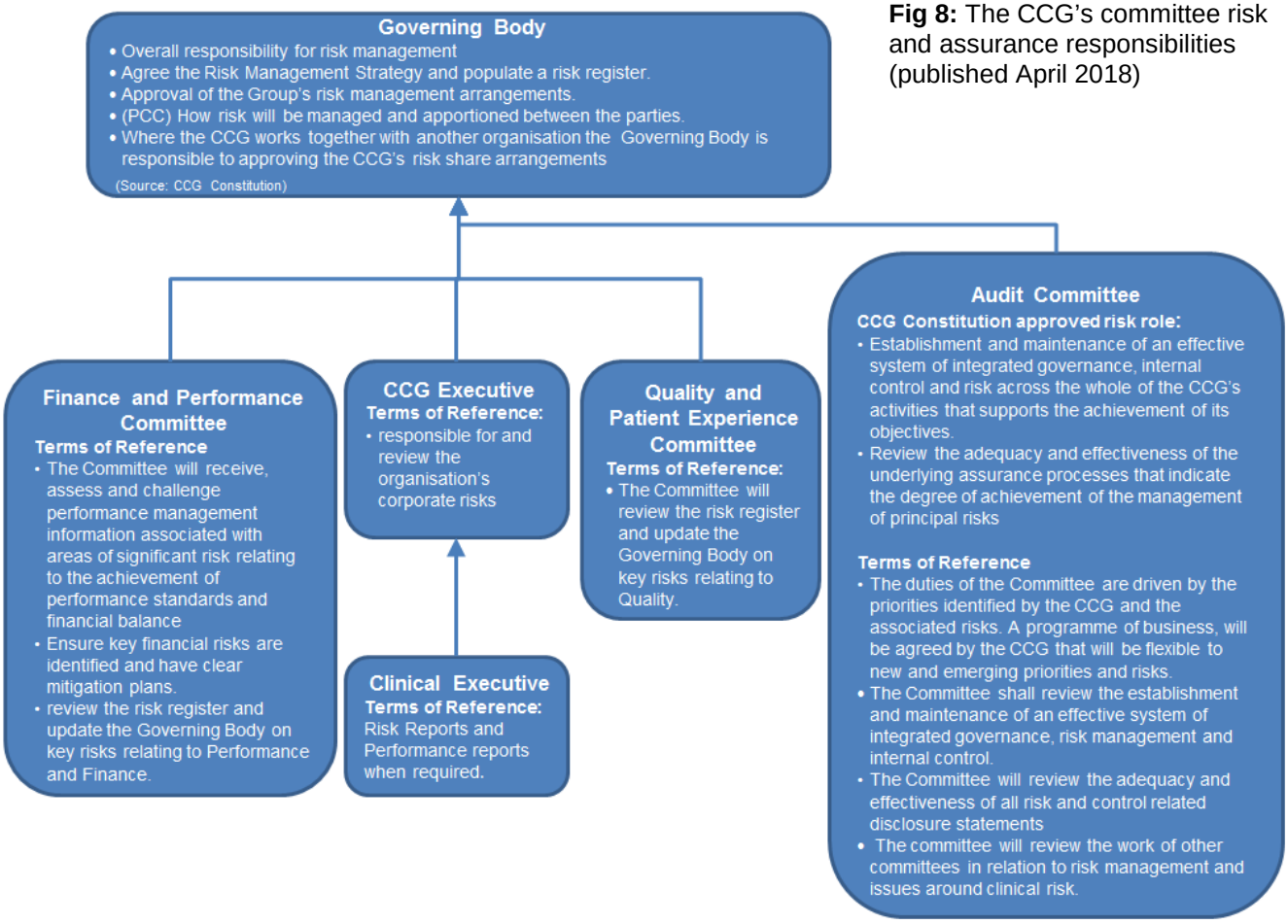

Fig 8: The CCG's committee risk and assurance responsibilities (published April 2018)

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

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

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

The CCG has developed a Risk Appetite Statement which determines how risks will be managed. The statement is included in the refreshed strategy-policy document. All risks are reviewed on a regular basis. Risks are managed at the appropriate level as detailed below:

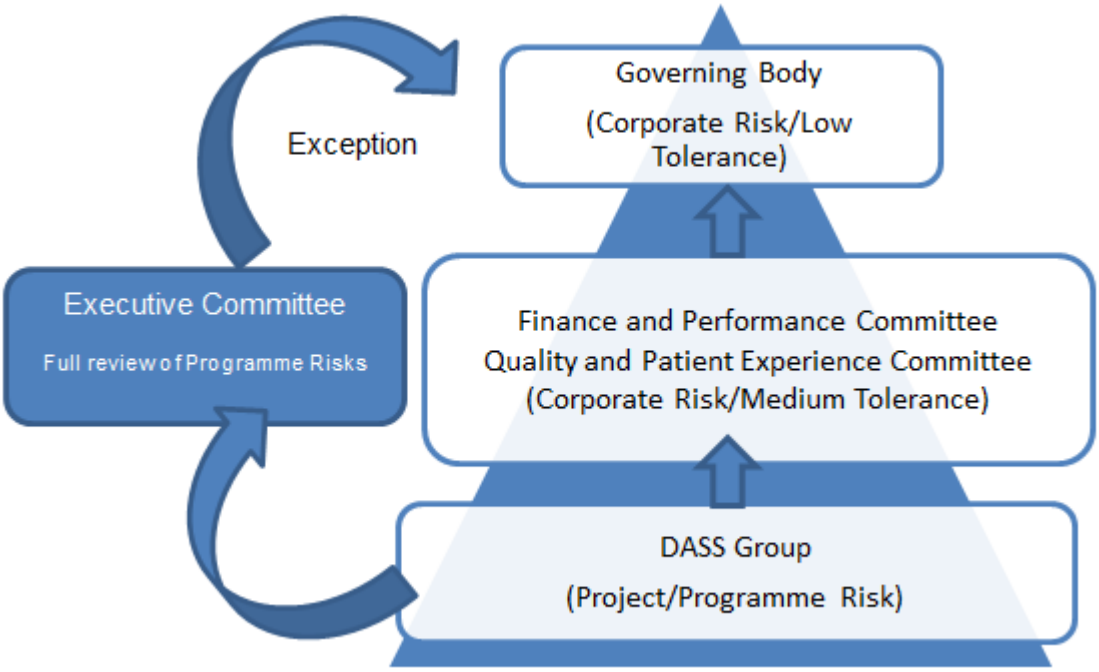

Fig 9: The CCG's management of risk

2.4.4 Capacity to handle risk

Leadership is given to the risk management process; including:

- The effectiveness of governance structures;
- The responsibilities of Directors and committees;
- Reporting lines and accountabilities between the Governing Body, its committees and subcommittees and the executive team;
- The submission of timely and accurate information to assess risks to compliance with the clinical commissioning group's statutory obligations; and,
- The degree and rigour of oversight the Governing Body has over the clinical commissioning group's performance.

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties.

2.4.5 Risk Assessment

Risks that impact delivery of strategic objectives; compliance with the CCG licence; CCG statutory duties and the CCG's Operational Plan are classified as Corporate Risks.

All corporate risks are assessed using a risk matrix methodology. The CCG has adopted a risk assessment tool, which is based upon a 5 x 5 matrix. Risks are measured according to the following formula:

Probability (Likelihood) x Severity (Consequences) = **Risk**

All risks are rated on two scales, probability and severity, the highest probability being 5, and the highest Impact-Severity being 5 making a maximum score of 25.

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

Table 18: Probability of risk scale

All corporate risks are assigned a risk lead at a Director level and a risk owner who monitors risk levels and trends.

The CCG also maintains project, programme and team risk registers. Programme Managers are responsible for engaging project stakeholders in the identification of project risks. These risks are managed and mitigated within teams; however, there is a defined escalation path for team risks. A team risk may be escalated to the Corporate Register if the impact of the risk has potential to the impact delivery of strategic-corporate objectives and cannot be managed within team.

Corporate risks that materialise are classified as events and are reported to sub-committees of the Governing Body-Governing Body as identified through application of the CCG's Risk Appetite Statement.

The CCG's greatest risk during 2017-18 was minimising the threat of failure to deliver financial recovery and performance recovery for specific constitutional targets whilst delivering transformational priorities.

2.4.6 Other sources of assurance

2.4.6.1 Internal control framework

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

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

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

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

2.4.6.2 Annual audit of conflicts of interest management

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

The annual internal audit of conflicts of interest was completed in March 2018 by Deloittes. There were no major (Priority 1) issues in relation to the day to day management of conflicts of interest within the CCG, including the CCG's Conflicts of Interest Policy; the recording of interests and registers of interests held; procurement decisions and contract monitoring; or the management of conflicts of interest in committees and meetings.

2.4.6.3 Data quality

The CCG receives a business intelligence service via eMBED Commissioning Support, with data checked and validated internally. The Governing Body and Committee reports were reviewed during 2017-18 and no concerns have been raised regarding data quality. The

format of reporting is reviewed on a regular basis to ensure that data is reported to the levels of detail required.

2.4.6.4 Information governance

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 organisation fosters a culture of personal responsibility, ownership and commitment to high standards in information handling to comply with the rights and pledges detailed in the NHS Constitution.

The NHS Information Governance Framework sets out 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. All NHS organisations and organisations providing healthcare are required to demonstrate compliance with required data security and information management standards and procedures through the Information Governance Toolkit annual submission process. This provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. For 2017-18 the CCG continued to maintain Level 2 compliance with the Information Governance Toolkit. An independent review of toolkit scores and evidence provided significant assurance.

The CCG has reviewed and refreshed its Information Governance Strategy in year. The strategy is published on the CCG's website:
http://www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/i-g/ig11-information-governance-strategy-v3-0-approved.pdf

The Information Governance Strategy outlines the CCG's approach to Information Governance taking account of General Data Protection Regulations which come into force in May 2018. The information governance management framework is outlined in the strategy. There is also a number of supporting Information Governance policies and procedures which detail control arrangements in place.

The CCG has established information risk assessment processes and procedures and Information Asset Owners have been assigned to systems and records to ensure that data is appropriately managed and safeguarded in line with statutory responsibilities.
All staff are required to undertake annual information governance training and we have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

Staff are provided with updates and briefings regarding Information Governance standards, processes and procedures to ensure that they remain up to date.

All incidents and near misses are taken seriously and there are processes in place for reporting and investigating incidents. The CCG undertakes a root cause analysis procedure to ensure that lessons are learned. Any Serious Incidents involving mismanagement of data are reported through the Information Governance Toolkit.

2.4.6.5 Business critical models

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

2.4.6.6 Third party assurances

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

2.5 Control Issues

The CCG's legal directions are discussed at the beginning of the governance report. The following control issues are in line with those reported to NHS England at December 2017 and are discussed regularly by the CCG's Governing Body.

Control Issue	Mitigation
Finance - the CCG has not met its statutory duty to ensure that expenditure in a financial year does not exceed income in 2017-18. The CCG has a 2017-18 deficit of £20.1m which is closely aligned to its original risk adjusted plan approved by the Governing Body but does not meet the NHS England requirement to work to a control total	The CCG is showing clear signs of stabilising the financial position as the actual exiting underlying outturn is in line with the opening underlying deficit position at the start of the year. The CCG has set up a Financial Recovery Programme Board. QIPP delivery is at the highest level the CCG has ever achieved both in percentage and cash releasing terms and the CCG is accessing delivery support from the National QIPP Support Programme. The CCG is ensuring tight contract management across all contracts. The CCG has commitment from the main acute provider to work to a new non-PbR contracting form from 2018-19 to create aligned incentives to reduce cost in the system. 2018-19 planning assumptions have been subject to similar 'confirm and challenge' process as for 2017-18.

Control Issue	Mitigation
Governance - the CCG is updating the Governance structure, namely the Governing Body arrangements and Constitution.	The CCG has recruited a Clinical Chair of the Governing Body who is in post from 1 April 2018. The practices making up the Council of Representatives, and their respective populations, have elected three locality representatives to the Governing Body. The constitution has been revised to reflect the new arrangements and will be submitted to NHS England for approval.
Governance - the CCG is now formally working with other CCGs and Commissioners in arrangements for consistent delivery of services. These arrangements are developing and formal and appropriate governance arrangements will follow in some cases.	The CCG is working with the Head of Legal and Governance and partner agencies to further develop joint arrangements. This includes the use of s75 agreements, joint committees etc.
PCU Realignment and Transition - during the PCU realignment, the CCG has taken a number of services in-house which have previously been hosted by another CCG and delivered by the PCU. In some functional areas, there is a risk of a lack of resource to deliver these services, a lack of system understanding and a lack of experience and knowledge of the history of these services resulting in financial risk.	The CCG has agreed transition arrangements with partners who have previously hosted arrangements to ensure that experience and knowledge is not lost. Staff are now part of the wider team. This should ensure a safe transition is possible and that only once staff are confident in their ability to deliver, the in house service will the transition arrangements cease.

Control Issue	Mitigation
PCU Realignment and Transition - the CCG is not yet fully aware of the potential liabilities and risks arising from the PCU re-alignment. For example the number of retrospective continuing healthcare cases is unknown and un-quantified at this stage. This is an additional financial risk-pressure on the CCG.	The CCG has additional staff working to scope out the extent and implications of retrospective CHC cases. The CCG has a dedicated Director of Transformation and Continuing Healthcare in post to progress this work.
Assurance - the CCG has failed to achieve an assured position for 2017-18.	The CCG successfully delivered all elements within the Improvement Plan during 2017-18, addressing all the areas identified as requiring improvement under Legal Directions in September 2016. The CCG and NHS England have continued to meet monthly through Planned Directions meetings to provide on-going assurance that all elements of the Improvement Plan remain embedded and the CCG is now considered to have strong and effective leadership, governance and delivery processes and capacity and capacity have been reviewed twice in order to support deliver and change as required by the medium-term system recovery plans with partners. Audits of contracting and performance in the CCG have reported 'significant assurance' in December 2017. NHS England and NHS Improvement have agreed the CCG (along with Scarborough and Ryedale CCG and York Teaching Hospitals NHS Foundation Trust) Medium Term System Plan and associated five year financial plan for delivery from April 2018. This has been alongside the self-imposed 'turnaround' framework in the CCG which has supported the CCG in prioritising its core programmes of work for further financial and performance recovery and strengthening again the delivery and improvement processes within the organisation. The final CCG structure for 2018 has now been agreed and the CCG governance structures are similarly being refreshed to ensure that delivery moving forward is clinically-led and captures the new locality structures across the York-Scarborough system. Key areas of focus for assurance from NHS England moving into 2018-19 will be around the development of an Accountable Care System, strengthening effective working relationships with system partners and performance recovery (particularly around cancer and the emergency care standards).

Control Issue	Mitigation
Performance - Constitution targets as follows:- Urgent Care - failure to meet 4 hour A&E target Planned care - RTT incomplete pathway 18 week target; cancer 14 day fast track and 62 day treatment; diagnostics (3 month consecutive fails in MRI, cystoscopy and CT scanning). Mental health - IAPT, dementia diagnosis and CAMHS.	While delivery of core performance targets within the NHS Constitution have remained challenged throughout 2017-18 there have significant improvements in a number of areas as stronger recovery plans have been developed, which have been clinically-led and jointly developed with partners. The CCG is now performing more strongly than the other CCGs in the STP in most areas, particularly RTT (despite this remaining challenged overall in the local system as financial recovery continues) and engagement around the key challenges underpinning performance with partners has never been stronger. Overall there were significant improvements in A&E 4 hour performance, dementia diagnosis rates and cancer performance in 2017-18, noting the seasonal impact on the recovery trajectories for A&E 4 hour, RTT and cancer as a very challenged system with significant workforce and diagnostics capacity issues has worked hard to manage demand on urgent and emergency care. For CHC assessment performance, a programme of review and improvement has now been in place for 9 months and an improvement plan is emerging which presents the recovery trajectory. RTT performance has deteriorated throughout the year despite significant reductions in GP referrals to the acute provider and the recent central government request to suspend elective care to support managing winter pressures will have a further impact on RTT. Subsequently the provider is now working with their regulator NHS Improvement Productivity Team and the Cancer Improvement Support Team to review pathways, capacity and processes and optimise their capacity in outpatients, theatres and diagnostics. As a system the financial recovery plans moving forward may result in further short-term deterioration of RTT performance but will support the development of a realistic performance recovery trajectory through 2018-19 to 2019-20 based on capacity being in the right places across pathways and within the financial envelope. IAPT performance remains a concern for the CCG with a recent drop in performance after improvement earlier in the year; again recovery plans are currently being refreshed with providers. CAMHS performance is also a key area of recovery and linked to the CCG priority to improve young peoples' mental health outcomes. The CCG's commissioning intentions clarify this is a priority area and recovery and improvement plans are being refreshed.

	Diagnostics performance locally and across the STP is dependent on additional CT, MRI and radiography equipment and workforce capacity being mobilised and shared across all providers and meeting the needs of the associated cancer and elective care pathways in a more efficient way. This is being driven at STP level with support from the Cancer Alliance and in the meantime local work with the acute provider is focusing on one stop clinics and additional CT scanner capacity through mobile units as required. Performance reporting in the CCG (as formally reported in the recent audit with significant assurance) has improved and there has been a stronger focus on accessing and analysing the right performance information to support identifying the reasons performance is challenged (e.g. cancer 62 day breach analysis). The CCG will work with NHS England to outline the key performance improvement priorities for 2018-19 (including any new areas of performance improvement required through the refreshed NHS England CCG Integrated Assurance Framework [IAF] and capture these as part of the Special Measures framework moving forward. (For further details of 2017-18 performance, see the Performance section of this report.)

Table 19: Control issues and mitigation by the CCG

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

During 2017-18 the CCG's overall financial performance, including the key statutory financial duties measures, was monitored and managed on a regular basis by the Finance and Performance Committee. The Governing Body also received a finance report at each of its meetings. Monthly briefings and additional reports were provided to the NHS England regional team.

The CCG has delivered in full the Improvement Plan agreed with NHS England under legal Directions from October 2016 and confirmation of this delivery was captured in the letter of July 2017 following the Q4- Annual review of the CCG.

The CCG has continued to deliver all its duties in relation to finance, delivery and governance throughout 2017-18 without any external intervention from NHS England and the established CCG Leadership team has achieved financial stability with a year-end deficit of £20.1m after the release of the 0.5% non-recurrent national risk reserve (£2.0m) and Category M drug benefit (£443k). Once these are taken in to account and with the nominal exclusion of the

exceptional No Cheaper Stock Obtainable (NCSO) additional prescribing expenditure of £1.9m, the 2017-18 in-year deficit is largely in line with 2016-17 position at circa £18.2m.

The 2017-18 outturn is also largely aligned with the CCG's risk adjusted 2017-18 financial plan of £21.0m submitted in March 2017. There are variances within this but the NCSO adjustments above accounts for the difference.

Importantly, the CCG's opening underlying position for 2017-18 was a deficit of £22.4m and the exit underlying position has improved to a deficit of £21.7m forming the basis of the financial plan for 2018-19. This demonstrates an overall positive run-rate which is also supported by specific activity and performance measures.

Furthermore, there has been external validation from both NHS England and audit of the significant assurance around contracting, performance, quality assurance and financial governance, and financial recovery in 2017-18 has achieved a 56% (£7.9m) delivery of planned QIPP targets (a significant improvement from 16% delivery in 2016-17) with strong demand management programmes resulting in the elimination of all referrals growth in one year.

Additionally, the CCG Leadership team has developed a Vale-Scarborough five year financial recovery and acute transformation plan with fellow commissioners and provider partners through the Capped Expenditure process while delivering a 10% reduction in running costs and establishing a joint system team to lead delivery of this medium term plan. This provides a strong foundation for the CCG to refresh its financial and operational plans for 2018-19 working with system partners to deliver both local CCG place plans and the approved System Medium Term Financial Recovery Plan.

The CCG's year-end position for the national Quality of Leadership indicator as published on MyNHS will not be available until after the publication of the CCG annual reports. The latest available results can be seen on MyNHS (Quarter 3 2017/18) and the year-end results for the Quality of Leadership indicator will be available from July 2018 at: https://www.nhs.uk/service-search/performance/search

2.7 Delegation of functions

The CCG has not delegated any of its functions during the 2017-18 financial year.

2.8 Counter fraud arrangements

The CCG has an accredited Local Counter Fraud Specialist (LCFS) that is contracted to undertake counter fraud work proportionate to identified risks. In February 2018, NHS

Counter Fraud Authority issued *Standards for commissioners – fraud, bribery and corruption* to LCFSs and Chief Finance Officers.

The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action.

The work plan for 2017-18 followed the format of these standards and described the tasks and outcomes which informed anti-fraud activity during 2017-18. The standards are as follows:

Strategic governance	the requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-crime measures are embedded at all levels across the organisation
Inform and Involve	the requirements in relation to raising awareness of crime risks against the NHS, and working with NHS staff and the public to publicise the risks and effects of crime against the NHS
Prevent and Deter	the requirements in relation to discouraging individuals who may be tempted to commit crime against the NHS and ensuring that opportunities for crime to occur are minimised
Hold to Account	the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes, and seeking redress

Table 20: NHS Counter Fraud Authority Standards

The Chief Finance Officer is proactively and demonstrably responsible for tackling fraud, bribery and corruption. In May 2017 the Chief Finance Officer requested an effectiveness review of the CCGs current arrangements in tackling fraud, bribery and corruption within the NHS. This awareness survey was intended to help the CCG to ensure counter fraud resources are used effectively and to test perceptions of the CCG's overall arrangements for preventing and detecting fraud and corruption. The outcome was reported to the Audit Committee with actions the LCFS would be undertaking.

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

The CCG's Audit Committee reviews and approves an annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter prevent, detect and, where

not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Chief Finance Officer and Audit Committee.

The Counter Fraud Team also complete an annual self-assessment of compliance against the NHS Protect's Standards for commissioners: fraud, bribery and corruption, which is reviewed and approved by the Chief Finance Officer prior to submission to NHS Protect. The 2016-17 assessment was completed and submitted in March 2017 with an overall assessment of green and this task was undertaken in March 2018 for counter fraud work undertaken in 2017-18.

2.9 Head of Internal Audit Opinion

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 2018

Roles and responsibilities

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

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

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

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

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

Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

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

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

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

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

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

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

During 2016-2017 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have focussed on the mandated areas of NHS England's Improvement and Assurance Framework.

The consideration of risk is a standing agenda item on committee agendas with risk registers regularly being reviewed. The Corporate Risk Register is reviewed by the Governing Body at each meeting. The Governing Body is well sighted on the risks facing the organisation, including the financial risks identified and which materialised during the year, through the Corporate Risk Register and via the Quality and Finance Committee.

The 'refresh of the Board Assurance Framework' was discussed at the January 2018 Governing Body meeting. The CCG's Statement of Risk Appetite was also presented for approval following which the Risk Management Strategy and Policy would be updated accordingly and presented for approval.

The Risk policy was approved and the governance pathways were agreed by Governing Body on 8 March 2018. Risk awareness training was noted as being available from March 2018.

The March 2018 Governing Body minutes record the content of what would have been in the Board Assurance framework being discussed within the Accountable Officer's report along with several detailed power-point presentations. These indicate that assurance will be monitored and reported guided by NHS England's Integrated Assurance Framework.

Internal Audit has undertaken a review of the CCGs governance arrangements during 2017-2018. This review provided Significant Assurance.

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

The 2017/18 Internal Audit Plan was approved by the Audit Committee on 26 April 2017. The work of Internal Audit continues to focus on the design and embedding of core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

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

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

Opinion Level	Opinion Definition	Guidance on Consistency
HIGH (STRONG)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.	The system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. Controls are operating effectively and consistently across the whole system. There are likely to be core controls fundamental to the effective operation of the system. A High opinion can only be given when the controls are working well across all core areas of the system. For example with 'Debtors' the controls over identifying income, raising debt, recording debt, managing debt, receiving debt, etc. are all working effectively – there are no serious concerns. Note this does not mean 100% compliance. There could be some minor issues relating to either systems design or operation which need to be addressed (and hence the report may include some recommendations) – however these issues do not have an impact on the overall effectiveness of the control system and the delivery of the system's objectives.
SIGNIFICANT (GOOD)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.	The system is generally well designed - but there may be weaknesses in the design of the system that need to be addressed. In addition most core system controls are operating effectively – but some may not be. Whilst any weaknesses may be significant they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.
LIMITED (IMPROVEMENT REQUIRED)	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the	The system is operating in part but there are notable control weaknesses. There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved.

Opinion Level	Opinion Definition	Guidance on Consistency
	system's design and/or operation in core areas to effectively meet the system's objectives.	In terms of what differentiates a borderline Significant Opinion to a borderline Limited opinion – the main factors are the scale and potential impact of weaknesses found. Multiple weaknesses across a range of core areas would suggest a Limited Opinion level is applicable. However it also true that ONE weakness can suggest a Limited Opinion if it is fundamental enough to mean that a number of core system objectives will not be achieved.
LOW (WEAK)	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives.	The audit has found that there are serious weaknesses in either design or operation that may mean that the overall system objectives will not be achieved and there are fundamental control weaknesses that need to be addressed. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses. The report will clearly state if 'No Assurance' is actually more applicable than low assurance.

An action plan is agreed with management. In order to ensure significant progress is being made in the implementation of agreed actions, an Audit Recommendations Follow Up Section is included within our Progress Report presented to every Audit Committee.

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level. Two advisory audits have been completed during 2017/18 to date; these related to; The Vale of York Clinical Network and Repeat Prescribing Policy.

The outcome of the assurance audit reports as at 15 May 2018 from the 2017/2018 audit plan are summarised below.

Audit Area	Assurance Level
Governance Arrangements	Significant
Business Continuity	Significant
Performance Management	Significant
Quality Assurance	Significant
Commissioning Plan / QIPP	Significant
Contract Management	Significant
Continuing Healthcare – Financial data	Limited (draft)
Stakeholder Engagement	Significant
Budgetary Control, Financial Reporting and Key Financial Systems	Significant
PCU Transition	Significant (draft)
Information Governance Toolkit	Significant

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

- Insufficient evidence to support Continuing Healthcare decisions
- Up to date information is not always reflected in QA which therefore impacts on the forecasting information reporting higher or lower costs due to packages changing or ending or where start dates differ to what was originally expected.
- Untimely review of Fast Track packages
- Incorrect responsible commissioner / responsible commissioner not recorded.

However, it is recognised that the CCGs have identified these as areas of control weakness and have put in place a CHC Transformation programme to address. Progress against these areas will be subject to audit in 2018/19.

Looking Ahead

The final year-end position is reported against a planned deficit of £6.3m. The Month 12 position reported to the April 2018 Governing Body was a deficit of £20.1m following the release of the 0.5% national risk reserve (£2.0m) and the Category M benefit (£443k) as required by NHS England, both of which improved the previous forecast deficit of £ 22.5m. Of the QIPP target of £14.4m the CCG had delivered £7.9m at Month 12, leaving a QIPP gap of £6.5m (included in the overall deficit).

The financial plan for 2018/19 includes a QIPP target of £14.5m with £15.6m QIPP savings identified.

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
15 May 2018

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

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

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

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

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

The control issues identified in Section 2.5 are the subject of detailed action plans on which the CCG is continuing to work, and the CCG remains under Legal Directions.

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

Section 3

Remuneration and Staff Report

2. Remuneration Report

This section of the Annual Report is subject to audit.

3.1 Remuneration Committee

Details of the Remuneration Committee membership and meetings are outlined in the Members' report on page 80.

3.1.1 Policy on the remuneration of senior managers

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

3.1.2 Remuneration of Very Senior Managers

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

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

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

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

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

3.2 Senior manager remuneration (including salary and pension entitlements) 2017-18

Name and Title	2017-18					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
K Ramsay - Chair	15-20	0			0	15-20
P Mettam - Accountable Officer	120-125	0			20-22.5	145-150
T Preece - Chief Finance Officer	95-100	0			17.5-20	115-120
R Potts - Executive Director of Planning and Governance (to 30 September 2017)	35-40	0			0	35-40
M Carrington - Executive Director of Quality and Nursing	80-85	0			47.5-50	130-135
D Nightingale - Executive Director of Transformation and Delivery (from 10 July 2017)	50-55	0			45-47.5	95-100
Dr K Smith - Executive Director of Primary Care and Population Health (from 1 October 2017) (c)	5-10	0			0	5-10
E Wyllie - Interim Executive Director of Joint Commissioning (to 5 April 2017) - see (a)	0-5	0			0	0-5
Dr S O'Connell - Joint Medical Director	130-135	0			45-47.5	180-185
Dr A Phillips - Joint Medical Director	130-135	0			25-27.5	155-160
Dr T Maycock - Clinical Director (to 31 August 2017)	25-30	0			5-7.5	30-35
Dr E Broughton - Clinical Director	60-65	0			12.5-15	70-75
Dr L Barker - Clinical Director	65-70	0			25-27.5	90-95
S Powell - Lay Member and Audit Committee Chair	10-15	400			0	10-15
D Booker - Lay Member and Chair of Finance and Performance Committee	10-15	200			0	10-15
Dr P Evans - GP, Council of Representatives Member	10-15	0			42.5-45	55-60
Dr A Calder - GP, Council of Representatives Member	5-10	0			0	5-10
Dr A Kuppuswamy - Secondary Care Doctor Governing Body Member – see (d)	10-15	0			2.5-5	10-15
Dr J Lethem - Local Medical Committee Liaison Officer, Selby and York (Co-opted) (to 2 September 2017) - see (b)	0	0			0	0
Dr A Brown - Local Medical Committee Liaison Officer, Selby and York (Co-opted) (from 3 September) - see (b)	0	0			0	0
S Stoltz - Director of Public Health, City of York Council (Co-opted) - see (b)	0	0			0	0

NB all senior managers are continuing except where stated.
(a) E Wyllie was engaged through an off payroll arrangement with her remuneration paid through a contract with a corporate body. Remuneration shown above reflects the gross payments to that body and includes unrecoverable VAT.
(b) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.
(c) Dr K Smith is in post on a secondment arrangement from Public Health England on a part time basis, and remuneration shown above reflects the gross payments to that body. The CCG did not receive his closing pension figures in line with the required timescales, and his pension related benefits are currently shown as zero.
(d) A Kuppuswamy was employed by the CCG via a secondment arrangement from another NHS organisation on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer. The CCG did not receive details of his employee pension contributions in line with the required timescales, and therefore his pension related benefits are shown gross of these contributions.

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

Name and Title	2016-17					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Keith Ramsay - Chair	15-20	0			0	15-20
Dr Mark Hayes - Chief Clinical Officer (to 31 January 2017)	60-65	0			0	60-65
Helen Hirst - Interim Accountable Officer (from 25 April 2016 to 2 October 2016)	25-30	0			10-12.5	35-40
Phil Mettam - Accountable Officer (from 3 October 2016)	75-80	0			22.5-25	100-105
Rachel Potts - Executive Director of Planning and Governance (Chief Operating Officer to 31 January 2017)	90-95	0			12.5-15	105-110
Tracey Preece - Chief Finance Officer	95-100	0			22.5-25	120-125
Michelle Carrington - Executive Director of Quality and Nursing (Chief Nurse to 31 January 2017)	75-80	200			42.5-45	120-125
Jim Hayburn - Interim Executive Director of System Resources (from 31 October 2016 to 31 March 2017) - see (a)	85-90	0			0	85-90
Elaine Wyllie - Strategic Programme Consultant (1 January 2017 to 5 April 2017) -see (a)	35-40	0			0	35-40
Dr S O'Connell - Joint Medical Director (GP Governing Body Member to 31 January 2017)	130-135	0			32.5-35	165-170
Dr A Phillips - Joint Medical Director (GP Governing Body Member to 31 January 2017)	130-135	0			17.5-20	150-155
Dr T Maycock - Clinical Director (GP Governing Body Member to 31 January 2017)	65-70	0			17.5-20	85-90
Dr E Broughton - Clinical Director (GP Governing Body Member to 31 January 2017)	60-65	0			7.5-10	65-70
Dr L Barker - Clinical Director (GP Governing Body Member to 31 January 2017)	65-70	0			15-17.5	80-85
Sheenagh Powell - Lay Member and Audit Committee Chair	10-15	400			0	10-15
David Booker - Lay Member	10-15	100			0	10-15
Dr P Evans - Council of Representatives Member	10-15	0			2.5-5	15-20
Dr A Calder - Council of Representatives Member (from 21 April 2016)	10-15	0			0	10-15
Dr A Kuppuswamy - Secondary Care Doctor	5-10	0			2.5-5	10-15
Louise Johnston - Practice Manager Representative (to 15 December 2016)	5-10	0			0	5-10
Sian Balsom - Director, Healthwatch York (Co-opted) (to 19 January 2017) - see (b)	0	0			0	0
Dr J Lethem - Local Medical Committee Liaison Officer, Selby and York (Co-opted) - see (b)	0	0			0	0
Sharon Stoltz - Director of Public Health, City of York Council (Co-opted) - see (b)	0	0			0	0

NB all senior managers are continuing except where stated.

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

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

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

3.4 Pension benefits as at 31 March 2018

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

(a) E Wyllie was engaged through an off payroll arrangement and is not a current member of the NHS Pension scheme.
(b) A Kuppuswamy was employed by the CCG via a secondment arrangement from another NHS organisation on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer.
(c) Dr K Smith is in post on a secondment arrangement from Public Health England on a part time basis, and remuneration shown above reflects the gross payments to that body. The CCG did not receive his closing pension figures in line with the required timescales, and his pension related benefits are currently shown as zero.
(d) R Potts retired on 30 September 2017 and claimed pension benefits. There is no closing Cash Equivalent Transfer Value to disclose.

3.5 Pension benefits as at 31 March 2017

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

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

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

(c) H Hirst and A Kuppuswamy were employed by the CCG via secondment arrangements from other NHS organisations. These secondments were both on a part time basis, however the pension benefits shown in the table above relate to the total employment contract with the host employer.

3.6 Cash equivalent transfer values

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

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

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

3.6.1 Real increase in cash equivalent transfer values

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

3.6.2 Compensation on early retirement of for loss of office

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

3.6.3 Payments to past members

There have been no payments to past members in 2017-18.

3.6.4 Pay multiples

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

The banded remuneration of the highest paid director/Member in NHS Vale of York CCG in the financial year 2017-18 was £165k - £170k (2016-17: £175k – 180k). This was 5.28 times

(2016-17: 5.16) the median remuneration of the workforce, which was £31,697 (2016-17: £34,393).

The movement in median salary 2017-18 was due to transfer of the service from the Partnership Commissioning Unit to the Clinical Commissioning Group.

In 2017-18, no employees received remuneration in excess of the highest-paid director-Member. Remuneration ranged from £10k - £15k to £130k - £135k (2016-17: £5k - £10k to £130k - £135k).

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

3.7 Staff Report

3.7.1 Number of senior managers

Pay band	Total
Band 8a	8
Band 8b	9
Band 8c	2
Band 8d	3
Band 9	0
VSM	0
Governing body	12
Any other Spot Salary	2

Table 25: Number of senior managers

3.7.2 Staff numbers and costs

	2017-18			2016-17
	Total number	Number permanently employed	Other	Total
	116	111	5	107
Number of whole time equivalents engaged on capital projects	0	0	0	0

Table 26: Staff numbers and costs

The above number represents whole-time equivalents excluding staff recharged to other organisations.

3.7.3 Salaries and wages

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

Table 27: Salaries and wages

3.7.4 Staff composition

Gender	Total (Female)	Total (Male)
Band 8a-d	15	7
Band 9	0	0
VSM	0	0
Governing body	6	6
All other employees (including apprentice if applicable)	75	17

Table 28: Staff composition

3.7.5 Sickness absence data

Absence	Total
Average sickness %	2.5%
Total number of full time equivalent days lost	835.0

Table 29: Sickness absence data

3.7.6 Staff policies

The CCG promotes equality of opportunity in all it does including the recruitment and selection of its workforce. The CCG is registered with the Disability Confident scheme (which replaces the former “Two Ticks” scheme) as Disability Confident Committed.

The CCG has a robust recruitment and selection policy which explicitly illustrates the steps recruiting managers need to take if an applicant declares themselves as disabled. Reasonable steps are taken to ensure all disabled applicants are treated fairly which includes making adjustments in terms of interviewing venue, selection and aptitude tests.

Occupational health advice and support is offered to all staff and specialist advice is taken for any disabled employee or an employee who becomes disabled at work.

3.7.7 Expenditure on consultancy

The total spend on consultancy in 2017-18 is £393k as per Note 5 Operating Expenses in the accounts.

3.7.8 Facility Time

Under the terms of the Trade Union (Facility Time Publication Requirements) Regulations 2017, public sector bodies employing more than 49 people are expected to publish the amount of time that employees with trade union responsibilities spend on trade union activities (facility time). The tables below reflect the requirements set out in Schedule 2 of the Regulations:

3.7.9 Relevant union officials

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

Table 30: Relevant union officials

3.7.10 Percentage of time spent on facility time

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

Table 31: Percentage of time spent on facility time

3.7.11 Percentage of pay bill spent on facility time

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

Table 32: Percentage of pay bill spent on facility time

3.7.12 Paid trade union activities

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

Table 33: Paid trade union activities

3.8 Off-payroll engagements

3.8.1 Off-payroll engagements longer than six months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 34: Off-payroll engagements longer than six months

3.8.2 New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	3
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency - assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 35: New off-payroll engagements

3.8.3 Off-payroll engagements - senior official engagements

For any off-payroll engagements of Board members and - or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and-or senior officers with significant financial responsibility, during the financial year - see (a)	1
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and-or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	18

Table 36: Off-payroll engagements - senior official engagements

(a) This relates to the final three days of work between 1 and the 5 April 2018 in relation to the end of 2016-17 arrangements.

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

Exit package cost band (inc. 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
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	1	2,085	1	1,027				
£10,000 - £25,000	1	23,246						
£25,001 - £50,000	1	46,841						
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 –£200,000								
>£200,000								
Totals	3	72,172	1	1,027				

Redundancy and other departure cost have been paid in accordance with the provisions of section 16 of the NHS Terms and Conditions of Service Handbook (Agenda for Change) for compulsory redundancies. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Vale of York CCG has agreed early retirements, the additional costs are met by NHS Vale of York CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 37: Exit packages

3.8.5 Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice*		
Exit payments following Employment Tribunals or court orders	1	1,027
Non-contractual payments requiring HMT approval**		
Total	1	1,027

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Table 38: Analysis of Other Departures

Compensation payments relate to a payment made by the Partnership Commissioning Unit in relation to an Employment Tribunal. An employee of NHS Scarborough and Ryedale CCG employed within the Partnership Commissioning Unit was dismissed for gross misconduct. The employee took the case to an Employment Tribunal which found in the employee's favour. The payment was accrued in the 2016-17 accounts but the actual payment was slightly higher which resulted in the additional expenditure in 2017-18.

3.9 Parliamentary Accountability and Audit Report

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

Part 2

Annual accounts 2017-18

Phil Mettam
Accountable Officer
24 May 2018

24/5/18

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

Opinion

We have audited the financial statements of NHS Vale of York Clinical Commissioning Group ('the CCG') for the year ended 31 March 2018. 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 notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England ("the Accounts Direction").

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its net operating expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Basis for opinion

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

Use of the audit report

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

Conclusions relating to going concern

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

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

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

Qualified Opinion on Regularity

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

Basis for the Qualified Opinion on Regularity

The CCG reported a deficit of £20.1m in note 19 of its financial statements for the financial year ended 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of the Health and Social Care Act 2012, to ensure revenue resource use does not exceed the amount specified in the Direction.

Other information

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

The parts of the Remuneration and Staff Report subject to audit are:

- the single total figure of remuneration for each Director;
- CETV disclosures for each Director;
- fair pay (pay multiples) disclosures;

- exit packages; and
- analysis of staff numbers and costs.

Matters on which we are required to report by exception

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014
We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 31 January 2018, we issued a report to the Secretary of State for Health under section 30(a) of the Local Audit and Accountability Act 2014, for the breach of financial duties under:

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

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

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, we are not satisfied that, in all significant respects, NHS Vale of York put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion
The CCG reported a deficit of £20.1 million in its financial statements for the year ending 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

The CCG is in special measures, operating under legal directions and subject to the capped expenditure process. NHS England's inspection and assessment framework has identified that the CCG is inadequate.

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

Other matters on which we are required to report by exception

We are required to report to you if:

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

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we

considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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.

Certificate

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

Mark Kirkham
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

25 May 2018

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The Primary Statements

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(1,924)	(1,137)
Other operating income	2	(447)	(498)
Total operating income		**(2,371)**	**(1,635)**
Staff costs	4	6,088	6,109
Purchase of goods and services	5	471,067	459,120
Depreciation	5	76	75
Provision expense	5	124	73
Other operating expenditure	5	87	1,154
Total operating expenditure		**477,442**	**466,531**
Net operating expenditure		**475,071**	**464,896**
Total net expenditure for the year ended 31 March 2018		**475,071**	**464,896**
Of which:			
Administration income and expenditure			
Employee benefits	5	4,466	4,823
Operating expenses	5	2,512	2,587
Other operating revenue	2	(668)	(204)
Net administration expenditure		**6,310**	**7,206**
Programme income and expenditure			
Employee benefits	5	1,622	1,286
Operating expenses	5	468,842	457,835
Other operating revenue	2	(1,703)	(1,431)
Net programme expenditure		**468,761**	**457,690**
Comprehensive expenditure for the year ended 31 March 2018		**475,071**	**464,896**

The notes on pages 5 to 27 form part of this statement.

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets			
Property, plant and equipment	8	378	454
Total non-current assets		**378**	**454**
Current assets			
Trade and other receivables	9	2,371	2,918
Cash and cash equivalents	10	95	163
Total current assets		**2,466**	**3,081**
Total assets		**2,844**	**3,535**
Current liabilities			
Trade and other payables	11	(23,787)	(18,429)
Provisions	12	(124)	(73)
Total current liabilities		**(23,911)**	**(18,502)**
Assets less liabilities		**(21,067)**	**(14,967)**
Financed by taxpayers' equity			
General fund		(21,067)	(14,967)
Total taxpayers' equity		**(21,067)**	**(14,967)**

The notes on pages 5 to 27 form part of this statement.

The financial statements on pages 1 to 27 were approved by the Audit Committee on behalf of the Governing Body on 23 May 2018 and signed on its behalf by:

Philip Mettam
Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2018

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

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

The notes on pages 5 to 27 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(475,071)	(464,896)
Depreciation	5	76	75
(Increase)/decrease in trade and other receivables	9	547	513
Increase/(decrease) in trade and other payables	11	5,358	(3,056)
Provisions utilised	12	(73)	(117)
Increase/(decrease) in provisions	12	124	73
Net cash outflow from operating activities		**(469,039)**	**(467,408)**
Net cash outflow before financing		**(469,039)**	**(467,408)**
Cash flows from financing activities			
Grant in aid funding received		468,971	467,523
Net cash outflow from financing activities		**468,971**	**467,523**
Net increase/(decrease) in cash and cash equivalents	10	**(68)**	**115**
Cash and cash equivalents at the beginning of the financial year		**163**	48
Cash and cash equivalents at the end of the financial year		**95**	163

The notes on pages 5 to 27 form part of this statement.

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group (CCG) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014 for the anticipated or actual breach of financial duties.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by the inclusion of financial provision for that service in published documents.
Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.
Although Note 19 shows that in 2017-18 the Clinical Commissioning Group breached its financial duty to break even under Section 30 of the Local Audit and Accountability Act 2014, the going concern status is not called into doubt because it has not been informed of an intention for dissolution without transfer of services to another body. Accordingly, whilst the financial performance and review of economy, efficiency and effectiveness of the use of resources sections of the annual report highlight significant risks to delivering the scale of savings required to break even in 2018-19 there is no material uncertainty regarding the Clinical Commissioning Group's continuing operational stability for the year ahead.

1.2 **Accounting Convention**

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

1.3 **Pooled Budgets**

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.

Each year the Clinical Commissioning Group enters into pooled budgets with North Yorkshire County Council, City of York Council, East Riding of Yorkshire Council and the following Clinical Commissioning Groups for the Better Care Fund (Note 16):
NHS Airedale, Wharfedale and Craven CCG
NHS East Riding of Yorkshire CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Cumbria CCG
Consideration has been given as to whether 'IFRS 10 - Consolidated Financial Statements' applies to this pooled budget arrangement, but has been deemed irrelevant as no individual organisation has sole control over the fund.
Consideration has been given as to whether 'IFRS 11 - Joint Arrangements' applies to this pooled budget arrangement, and as a consequence it has been deemed a 'jointly controlled operation'. These accounts have therefore been produced in accordance with this as set out above.
Consideration has been given as to whether 'IFRS 12 - Disclosure of Involvement with Other Entities' applies to this pooled budget arrangement. The majority of this standard is deemed irrelevant on the basis that no individual organisation has sole control over the fund, and no individual organisation has full or joint control over another entity, or significant influence over another entity. However, as IFRS 11 applies, we have considered disclosure requirements for joint arrangements and these have been met through this policy note and note 16 of the accounts.

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

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

Notes to the Financial Statements

1.4.1 **Critical Judgements in Applying Accounting Policies**

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

- **Secondary Care Activity**

Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the Clinical Commissioning Group with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as block contract arrangements. Although the counting and coding of secondary care is not finalised, this only potentially affects the following organisations where there is no year-end agreement in place: Leeds Teaching Hospitals NHS Trust, Harrogate and District NHS Foundation Trust, North Lincolnshire and Goole Hospitals NHS Foundation Trust, Ramsay Health Care UK and Nuffield Health.

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

There are four Clinical Commissioning Groups in the North Yorkshire region: NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG. Collaborative arrangements exist whereby one of the Clinical Commissioning Groups hosts certain services on behalf of the other Clinical Commissioning Groups. Details of these hosted services are provided below. IAS 18 determines that the nature of these hosted arrangements constitutes an agency relationship and therefore "net" accounting principles are applicable. Therefore only the NHS Vale of York CCG's share of costs and staff numbers are represented in these accounts.

Referral Support Service and Referral Management Service

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

NHS Hambleton, Richmondshire and Whitby CCG 8% £41,750 (2016-17 7% £38,563)
NHS Harrogate and Rural District CCG* 8% £41,750 (2016-17 28% £155,680)
NHS Vale of York CCG 49% £241,507 (2016-17 37% £205,673)
NHS Scarborough and Ryedale CCG 35% £173,192 (2016-17 28% £155,913)

*Note that the recharge to NHS Harrogate and Rural District CCG reduced in 2017-18 as they no longer use the Referral Support Service.

Serious Incidents

The serious incidents service is a new service in 2017-18 hosted by NHS Vale of York Clinical Commissioning Group on behalf of the NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and NHS Harrogate and Rural District CCG. All payments relating to this service are transacted through NHS Vale of York CCG's ledger and expenditure is apportioned between the Clinical Commissioning Groups on a weighted basis as follows.

NHS Harrogate and Rural District CCG 25% £23,753
NHS Vale of York CCG 50% £47,506
NHS Scarborough and Ryedale CCG 25% £23,753

Medicines Management

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

NHS Hambleton, Richmondshire and Whitby CCG 15% £112,152 (2016-17 15% £123,752)
NHS Harrogate and Rural District CCG 18% £140,831 (2016-17 18% £155,797)
NHS Vale of York CCG* 10% £78,053 (2016-17 21% £180,144)
NHS Scarborough and Ryedale CCG** 28% £216,205 (2016-17 18% £153,560)
NHS Airedale, Wharfedale and Craven CCG 29% £218,849 (2016-17 28% £241,194)

*Note that NHS Vale of York CCG created an in-house medicines management team in 2017-18 hence the reduction in recharge. However some medicines management services are still provided by NHS Harrogate and Rural District CCG.
**Additional staff were allocated to the service on behalf of NHS Scarborough and Ryedale CCG in 2017-18.

Children's Safeguarding

NHS Scarborough and Ryedale CCG host the children's safeguarding service on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Hambleton, Richmondshire and Whitby CCG 20% £74,373 (2016-17 20% £63,693)
NHS Harrogate and Rural District CCG 24% £88,491 (2016-17 24% £75,810)
NHS Vale of York CCG 37% £140,084 (2016-17 37% £118,454)
NHS Scarborough and Ryedale CCG 19% £69,568 (2016-17 19% £58,901)

Primary Care Safeguarding

NHS Scarborough and Ryedale CCG host primary care safeguarding services on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Hambleton, Richmondshire and Whitby CCG 19% £14,522 (2016-17 19% £14,029)
NHS Harrogate and Rural District CCG 20% £15,609 (2016-17 20% £15,079)
NHS Vale of York CCG 46% £34,794 (2016-17 46% £33,613)
NHS Scarborough and Ryedale CCG 15% £11,629 (2016-17 15% £11,234)

Strategic Clinical Networks

Strategic Clinical Networks are hosted by NHS Scarborough and Ryedale CCG on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Vale of York CCG, NHS East Riding of Yorkshire CCG and NHS North Lincolnshire CCG. All payments relating to this service are transacted through NHS Scarborough and Ryedale CCG's ledger and expenditure is recharged on an a risk share basis as follows.

NHS Hambleton, Richmondshire and Whitby CCG 11% £23,806 (2016-17 11% £23,459)
NHS Harrogate and Rural District CCG 13% £26,857 (2016-17 13% £26,493)
NHS Vale of York CCG 28% £58,375 (2016-17 28% £57,844)
NHS Scarborough and Ryedale CCG 10% £19,805 (2016-17 10% £19,430)
NHS East Riding of Yorkshire CCG 24% £50,037 (2016-17 24% £49,417)
NHS North Lincolnshire CCG 14% £28,669 (2016-17 14% £28,142)

Notes to the Financial Statements

Partnership Commissioning Unit
Throughout 2016-17, NHS Scarborough and Ryedale CCG hosted the Partnership Commissioning Unit. The Partnership Commissioning Unit hosted the provision of Continuing Healthcare services and the commissioning of Mental Health, Legal Services, Estates services, Adult Safeguarding and Children's services, on behalf of NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Vale of York CCG.
In 2017-18, the Partnership Commissioning Unit ceased to exist and services previously provided by the Partnership Commissioning Unit were in-housed and hosted by the four North Yorkshire Clinical Commissioning Groups. Details of these hosting arrangements is given below.

Continuing Healthcare and Funded Nursing Care
The commissioning of Continuing Healthcare and Funded Nursing Care services for NHS Vale of York CCG were in-housed by NHS Vale of York CCG from 1 February 2018. Payments relating to these services from 1 February onwards have been transacted through the NHS Vale of York CCG's ledger. Services prior to this date were commissioned and paid for by NHS Scarborough and Ryedale CCG on behalf of NHS Vale of York CCG. NHS Scarborough and Ryedale CCG has hosted Continuing Healthcare and Funded Nursing Care on behalf of NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG throughout 2017-18. Expenditure is recharged on an actual basis. The value of service recharged by NHS Scarborough and Ryedale CCG is set out below.
NHS Hambleton, Richmondshire and Whitby CCG 20% £14,699,849 (2016-17 20% £14,173,431)
NHS Harrogate and Rural District CCG 23% £16,969,457 (2016-17 21% £15,256,986)
NHS Vale of York CCG* 36% £25,900,205 (2016-17 40% £29,254,842)
NHS Scarborough and Ryedale CCG 21% £14,927,448 (2016-17 19% £14,073,874)
*Note this is 10 months of service in 2017/18. To aid comparison the full year cost is £30,081,919.

Other Mental Health
From 1 February 2018, other mental health services for NHS Vale of York CCG were in-housed by NHS Vale of York CCG and all payments relating to this service from this date onwards have been transacted through the NHS Vale of York CCG's ledger. NHS Scarborough and Ryedale CCG hosted this service on behalf of NHS Vale of York CCG prior to this date and payments relating to services prior to 1 February 2018 have been transacted through their ledger. NHS Scarborough and Ryedale CCG has hosted other mental health on behalf of NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural Districts CCG throughout 2017-18. Expenditure is recharged on an actual basis. The value of the service hosted by NHS Scarborough and Ryedale CCG is set out below.
NHS Hambleton, Richmondshire and Whitby CCG 29% £4,049,108 (2016-17 27% £3,022,354)
NHS Harrogate and Rural District CCG 21% £2,875,450 (2016-17 23% £2,655,602)
NHS Vale of York CCG* 34% £4,739,256 (2016-17 35% £4,029,380)
NHS Scarborough and Ryedale CCG 16% £2,280,892 (2016-17 15% £1,650,409)
*Note this is 10 months of service in 2017/18. To aid comparison the full year cost is £5,687,108.

Specialist Neurological Rehabilitation Payments
NHS Scarborough and Ryedale CCG host the specialist neurological rehabilitation payments service on behalf of NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Vale of York CCG and NHS Harrogate and Rural District CCG. NHS Hambleton, Richmondshire and Whitby CCG are charged their actual costs incurred whilst all remaining costs are risk shared between NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG and NHS Vale of York CCG based on the following apportionment.
NHS Hambleton, Richmondshire and Whitby CCG actual basis £350,850 (2016-17 actual basis £268,695)
NHS Harrogate and Rural District CCG risk share 26% £762,803 (2016-17 risk share 26% £567,399)
NHS Vale of York CCG risk share 54% £1,594,140 (2016-17 risk share 53% £1,185,775)
NHS Scarborough and Ryedale CCG risk share 21% £622,757 (2016-17 risk share 21% £463,228)
From 1 April 2018, specialist neurological rehabilitation payments will be hosted by NHS Vale of York CCG on behalf of NHS Vale of Yorks CCG, NHS Scarborough and Ryedale CCG, NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG.

Specialist Neurological Rehabilitation Commissioning
During 2017/18, the commissioning of specialist neurological rehabilitation was transferred to NHS Vale of York CCG who hosted the service on behalf of NHS Vale of York CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG and NHS Harrogate and Rural District CCG. All payments relating to these services have been transacted through the NHS Vale of York CCG's ledger from this date onwards. NHS Scarborough and Ryedale CCG hosted this service on behalf of the four North Yorkshire CCGs prior to this date. Expenditure is recharged on a weighted capitation basis. The value of the service hosted by NHS Vale of York CCG is set out below. The value of the service hosted by NHS Scarborough and Ryedale CCG is included within the Partnership Commissioning Unit staff section later in the note.
NHS Hambleton, Richmondshire and Whitby CCG 19% £5,383
NHS Harrogate and Rural District CCG 21% £6,074
NHS Vale of York CCG 45% £13,201
NHS Scarborough and Ryedale CCG 15% £4,479
Note that charges in relation to specialist neurological rehabilitation were previously recharged to NHS Vale of York CCG within Partnership Commissioning Unit.

Estates
Estates services are hosted by NHS Hambleton, Richmondshire and Whitby CCG on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural Districts CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Hambleton, Richmondshire and Whitby CCG's ledger and expenditure is recharged based upon an actual basis.
NHS Hambleton, Richmondshire and Whitby CCG 42% £38,263
NHS Harrogate and Rural District CCG 11% £9,666
NHS Vale of York CCG 45% £41,114
NHS Scarborough and Ryedale CCG 2% £2,000
Note that charges in relation to estates services were previously recharged to NHS Vale of York CCG within Partnership Commissioning Unit.

Children's Continuing Healthcare Team
The children's continuing healthcare team is hosted by NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG. All payments relating to this service are transacted through NHS Hambleton, Richmondshire and Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows.
NHS Hambleton, Richmondshire and Whitby CCG 19% £22,707
NHS Harrogate and Rural District CCG 21% £25,621
NHS Vale of York CCG 45% £55,682
NHS Scarborough and Ryedale CCG 15% £18,891
Note that charges in relation to the children's continuing healthcare team were previously recharged to NHS Vale of York CCG within Partnership Commissioning Unit.

Notes to the Financial Statements

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

NHS Hambleton, Richmondshire and Whitby CCG 26% £31,782
NHS Harrogate and Rural District CCG 30% £35,861
NHS Vale of York CCG 22% £26,537
NHS Scarborough and Ryedale CCG 22% £26,442

Note that charges in relation to children and young people's commissioning were previously recharged to NHS Vale of York CCG within Partnership Commissioning Unit.

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

NHS Harrogate and Rural District CCG - 33% £56,076
NHS Hambleton, Richmondshire and Whitby CCG - 31% £53,268
NHS Scarborough and Ryedale CCG - 29% £49,546
NHS Vale of York CCG - 7% £12,465

Note that charges in relation to mental health (adults) commissioning were previously recharged to NHS Vale of York CCG within Partnership Commissioning Unit.

Partnership Commissioning Unit
During 2017-18, the Partnership Commissioning Unit continued to provide services until they were in-housed by one of the four North Yorkshire Clinical Commissioning Groups. Partnership Commissioning Unit staff were employed by NHS Scarborough and Ryedale CCG and all costs relating to these staff were transacted through NHS Scarborough and Ryedale CCG's ledger. The costs of these staff are apportioned between the Clinical Commissioning Groups on a weighted capitation basis, dependent on the services each Clinical Commissioning Group received and have changed between years due to the various services being in-housed across the CCGs. There will be no further recharges relating to the Partnership Commissioning Unit in 2018-19.

NHS Hambleton, Richmondshire and Whitby CCG 22% £689,300 (2016-17 19% £763,050)
NHS Harrogate and Rural District CCG 25% £759,294 (2016-17 20% £779,171)
NHS Vale of York CCG 35% £1,089,782 (2016-17 46% £1,827,022)
NHS Scarborough and Ryedale CCG 18% £566,623 (2016-17 15% £580,561)
NHS East Riding of Yorkshire CCG 0% £3,319 (2016-17 0% £0)

1.4.2 **Key Sources of Estimation Uncertainty**
The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

· Accruals

There are a number of estimated figures within the accounts. The main areas where estimates are included are:
• Prescribing - the full year figure is estimated on the spend for the first 10 months of the year based upon historic prescribing patterns.
• Purchase of Healthcare - the full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner, based on Clinical Commissioning Group predicted forecast outturns.
• General Medical Services (GMS) and Personal Medical Services (PMS) - the full year figure for the Quality and Outcomes Framework (QOF) is estimated based on GP practice achievement in 2016-17. Payment for 2017-18 will be reconciled and paid to GP practices in June 2018.
The Clinical Commissioning Group has achieved the following level of accuracy in estimation during 2017-18:
Prescribing > 94%
Purchase of Healthcare >98% (based on our main provider)

· Provisions

A number of key assumptions have been included within the accounts concerning the future:
• Continuing Healthcare Provision - the Clinical Commissioning Group has made a provision for the backlog of cases that has arisen during the financial year in respect of Continuing Healthcare. Data is available regarding the number of patients currently awaiting a full Continuing Healthcare assessment. Assumptions around the number of patients ultimately requiring a package and the anticipated price of such packages are derived from information in the patient database, or from information provided by the clinical team where data is not available. Progress is being made to reduce the backlog.
• Redundancy Provision - the Clinical Commissioning Group has made a provision for redundancy costs as a result of restructuring changes to the Governing Body. The amounts included are based upon latest information from Human Resources however work on the agreements is still on-going and the amounts are not expected to be finalised until 2018-19.

1.5 **Revenue**
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.
The Clinical Commissioning Group receives most of its income from Parliament and does not have any other material income sources.

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

1.6.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pensions Schemes. The schemes are unfunded, defined benefit schemes that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in the schemes is taken as equal to the contributions payable to the schemes for the accounting period. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Notes to the Financial Statements

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.8 **Property, Plant and Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.8.2 **Valuation**

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

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

1.8.3 **Subsequent Expenditure**

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

1.9 **Depreciation and Impairments**

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

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

1.10 **Leases**

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

1.10.1 **The Clinical Commissioning Group as Lessee**

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

1.11 **Cash and Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Cash and bank balances are recorded at current values.

1.12 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.42% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

All percentages are in real terms.

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

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

1.14 **Non-Clinical Risk Pooling**

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

Notes to the Financial Statements

1.15 **Continuing Healthcare Risk Pooling**

In 2014-15 a risk pool scheme was introduced by NHS England for Continuing Healthcare claims, for claim periods prior to 31st March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims. This annual contribution ceased on the 31st March 2017.

The Clinical Commissioning Group has recently been advised that HMRC has conducted a review of the Continuing Healthcare redress guidance issued initially by the Department of Health and Social Care and more recently by NHS England and has asserted that the indexation element of these redress payments constitutes yearly interest for income tax purposes. For this type of interest there is a requirement for the paying organisation (the Clinical Commissioning Group) to deduct 20% income tax before making the payment. HMRC intend to seek retrospective tax settlements from Clinical Commissioning Groups for tax amounts not deducted, starting with the tax year 2013-14.

NHS England intend to dispute this assessment on behalf of Clinical Commissioning Groups and in 2017-18 NHS England will account for any potential liability associated with previously unassessed periods of care (PUPoC) claims.

The Clinical Commissioning Group has considered whether any post PUPoC claims would give rise to a liability in 2017-18 and has determined, using the NHS England methodology that any potential non PUPoC liability would be immaterial in nature.

1.16 **Contingent Liabilities and Contingent Assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

1.17 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The Clinical Commissioning Group's financial assets are classified as loans and receivables.

1.17.1 **Loans and Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.18 **Financial Liabilities**

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

1.18.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 **Value Added Tax**

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

1.20 **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.

1.21 **Losses and Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

The Department of Health and Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The impact of IFRS16 is not yet estimable due to the standard being introduced in 2019-20 and detailed guidance not yet being available. The application of the other Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2. Other Operating Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	0	0	0	18
Prescription fees and charges	298	0	298	14
Education, training and research	0	0	0	1
Charitable and other contributions to revenue expenditure: non-NHS	21	21	0	15
Non-patient care services to other bodies	1,924	640	1,284	1,137
Non cash apprenticeship training grants revenue	3	3	0	0
Other revenue	125	4	121	450
Total other operating revenue	**2,371**	**668**	**1,703**	**1,635**

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

3. Revenue

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

4. Employee Benefits and Staff Numbers

4.1.1 Employee Benefits

	2017-18 Total £'000	2017-18 Permanent £'000	2017-18 Other £'000
Salaries and wages	5,007	4,479	528
Social security costs	441	441	0
Employer contributions to NHS Pension scheme	564	564	0
Apprenticeship Levy	4	4	0
Termination benefits	72	72	0
Gross employee benefits expenditure	**6,088**	**5,560**	**528**
Less recoveries in respect of employee benefits (Note 4.1.2)	0	0	0
Total net employee benefits	**6,088**	**5,560**	**528**

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

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

4.1.2 Recoveries in Respect of Employee Benefits

	2017-18 Total £'000	2017-18 Permanent employees £'000	2017-18 Other £'000	2016-17 Total £'000
Employee benefits - revenue				
Salaries and wages	0	0	0	(14)
Social security costs	0	0	0	(2)
Employer contributions to the NHS Pension Scheme	0	0	0	(2)
Total recoveries in respect of employee benefits	**0**	**0**	**0**	**(18)**

4.2 Average Number of People Employed

	2017-18 Total Number	2017-18 Permanently employed Number	2017-18 Other Number	2016-17 Total Number
Total	**116**	**111**	**5**	**111**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Exit Packages Agreed in the Financial Year

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

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
£25,001 to £50,000	0	0	1	32,379	1	32,379
Total	**0**	**0**	**1**	**32,379**	**1**	**32,379**

The are no departures where special payments have been made in 2017-18 (2016-17 nil).

Analysis of Other Agreed Departures

	2017-18 Other agreed departures		2016-17 Other agreed departures	
	Number	**£**	Number	£
Exit payments following Employment Tribunals or court orders	1	1,027	1	32,379
Total	**1**	**1,027**	**1**	**32,379**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of section 16 of the NHS Terms and Conditions of Service Handbook (Agenda for Change) for compulsory redundancies.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

Compulsory redundancies relate to the Clinical Commissioning Group's share of the Partnership Commissioning Unit redundancies, made during 2017-18 as a result of the closure of the Partnership Commissioning Unit.

4.4 Pension Costs

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

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

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

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

4.4.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full Actuarial (Funding) Valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £503,811 were payable to the NHS Pensions Scheme (2016-17: £374,011) at the rate of 14.38% of pensionable pay. In 2017-18, a further £45,395 employers contributions were payable to the NHS Pensions Scheme by the Partnership Commissioning Unit on behalf of NHS Vale of York CCG (2016-17: £137,771). The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating Expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding Governing Body members	5,028	3,406	1,622	4,706
Executive Governing Body members	1,060	1,060	0	1,403
Total gross employee benefits	**6,088**	**4,466**	**1,622**	**6,109**
Other costs				
Purchase of healthcare from NHS bodies:				
· Services from other CCGs and NHS England	681	278	403	517
· Services from foundation trusts	270,882	0	270,882	265,600
· Services from other NHS trusts	31,291	0	31,291	32,213
Purchase of healthcare from non-NHS bodies	60,092	0	60,092	47,594
Chair and Non-Executive Members	44	44	0	44
Supplies and services – clinical	85	0	85	381
Supplies and services – general	11,190	720	10,470	19,577
Consultancy services	393	380	13	384
Establishment	489	280	209	520
Transport	8	7	1	12
Premises	2,206	475	1,731	1,439
Depreciation	76	76	0	75
Audit fees*	52	52	0	72
Other non statutory audit expenditure				
· Internal audit services	41	41	0	37
Prescribing costs	49,508	0	49,508	49,055
General ophthalmic services	145	0	145	122
GMS and PMS	43,950	0	43,950	41,139
Other professional fees excluding audit	0	0	0	145
Legal fees	22	5	17	0
Grants to other bodies	0	0	0	1,068
Education and training	29	27	2	59
Provisions	124	82	42	73
CHC risk pool contributions	0	0	0	254
Non cash apprenticeship training grants	3	3	0	0
Other expenditure	43	42	1	42
Total other costs	**471,354**	**2,512**	**468,842**	**460,422**
Total operating expenses	**477,442**	**6,978**	**470,464**	**466,531**

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

6. Better Payment Practice Code

6.1 Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	4,629	81,753	4,536	85,188
Total non-NHS trade invoices paid within target	4,481	80,951	4,447	84,909
Percentage of non-NHS trade invoices paid within target	**96.80%**	**99.02%**	**98.04%**	**99.67%**
NHS Payables				
Total NHS trade invoices paid in the year	3,263	339,588	3,553	336,726
Total NHS trade invoices paid within target	3,215	338,343	3,534	336,368
Percentage of NHS trade Invoices paid within target	**98.53%**	**99.63%**	**99.47%**	**99.89%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2017-18 £'000	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Operating Leases

In 2017-18, the Clinical Commissioning Group leased its corporate offices (West Offices) from the City of York Council. The tenancy agreement for this space has been finalised and is now awaiting signature.

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

In 2017-18, the Clinical Commissioning Group paid £1,955,197 (2016-17: £1,181,428) for rent, subsidy and void costs. In addition £104,073 was charged to the Clinical Commissioning Group from the Partnership Commissioning Unit for hosted services (2016-17: £137,503). The subsidy and void charges will continue in 2018-19 subject to the new NHS Property Service Vacant Space Policy and will be subject to a six or twelve month transition arrangement after which NHS Property Services will be liable for the cost of these buildings.

7.1 As Lessee

7.1.1 Payments recognised as an Expense

	2017-18			2016-17		
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payments recognised as an expense						
Minimum lease payments	2,059	(1)	**2,058**	1,318	(1)	**1,317**
Total	**2,059**	**(1)**	**2,058**	**1,318**	**(1)**	**1,317**

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

7.1.2 Future Minimum Lease Payments

The Clinical Commissioning Group does not recognise any future minimum lease payments as lease agreements have not been signed.

8. Property, Plant and Equipment

	Plant and machinery £'000	**2017-18 Information technology £'000**	**Total £'000**	Plant and machinery £'000	2016-17 Information technology £'000	Total £'000
Cost or valuation at 01 April	756	5	761	756	5	761
Cost or valuation at 31 March	**756**	**5**	**761**	**756**	**5**	**761**
Depreciation 01 April	302	5	307	227	5	232
Charged during the year	76	0	76	75	0	75
Depreciation at 31 March	**378**	**5**	**383**	**302**	**5**	**307**
Net book value at 31 March	**378**	**0**	**378**	**454**	**0**	**454**
Purchased	378	0	378	454	0	454
Total at 31 March	**378**	**0**	**378**	**454**	**0**	**454**
Asset financing:						
Owned	378	0	378	454	0	454
Total at 31 March	**378**	**0**	**378**	**454**	**0**	**454**

8.1 Economic Lives

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

9. Trade and Other Receivables

	Current 2017-18 £'000	Current 2016-17 £'000
NHS receivables: revenue	700	1,353
NHS prepayments	866	866
NHS accrued income	85	128
Non-NHS and other WGA* receivables: revenue	374	72
Non-NHS and other WGA prepayments	111	152
Non-NHS and other WGA accrued income	154	261
VAT	79	85
Other receivables and accruals	2	1
Total trade and other receivables	**2,371**	**2,918**
Included above:		
Prepaid pensions contributions	0	0

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

The vast majority of trade is with NHS England. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

*Whole of Government Accounts

9.1 Receivables Past their Due Date but Not Impaired

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	153	31	4
By three to six months	0	2	0
By more than six months	28	32	8
Total	**181**	**65**	**12**

£87,123 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 2018 (31 March 2017: nil).

9.2 Provision for Impairment of Receivables

The Clinical Commissioning Group has not made a provision for impairment of receivables as at 31 March 2018 (31 March 2017: nil).

10. Cash and Cash Equivalents

	2017-18 £'000	2016-17 £'000
Balance at 1 April	163	48
Net change in year	(68)	115
Balance at 31 March	**95**	**163**
Made up of:		
Cash with the Government Banking Service	95	163
Cash and cash equivalents in statement of financial position	**95**	**163**
Balance at 31 March	**95**	**163**

11. Trade and Other Payables

	Current 2017-18 £'000	Current 2016-17 £'000
NHS payables: revenue	1,808	3,269
NHS accruals	2,407	2,406
Non-NHS and other WGA payables: revenue	5,891	1,318
Non-NHS and other WGA accruals	12,822	10,721
Social security costs	58	43
Tax	51	40
Other payables and accruals	750	632
Total trade and other payables	**23,787**	**18,429**

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

Other payables include £76,685 outstanding pension contributions at 31 March 2018 (31 March 2017: £57,080).

12. Provisions

	Current 2017-18 £'000	Current 2016-17 £'000
Redundancy	82	0
Continuing care	42	73
Total	**124**	**73**

The Clinical Commissioning Group has no non-current provisions.

	Redundancy £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2017	**0**	**73**	**73**
Arising during the year	82	42	124
Utilised during the year	0	(73)	(73)
Balance at 31 March 2018	**82**	**42**	**124**
Expected timing of cash flows:			
Within one year	82	42	124
Balance at 31 March 2018	**82**	**42**	**124**

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

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group.

The provision for redundancy is as a result of restructuring changes to the Clinical Commissioning Group's Governing Body.

13. Contingencies

	2017-18 £'000	2016-17 £'000
13.1 Contingent Liabilities		
NHS Resolution Legal Claims	38	271
Net value of contingent liabilities	**38**	**271**

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

In March 2012, the Department of Health announced deadlines for individuals who wished to request an assessment for NHS Continuing Healthcare for the period 1 April 2004 and 31 March 2012.

The deadline for submitting all such requests for previously unassessed periods of care (PuPOCs) was 31 March 2013, and as a result the CCG inherited a large number of retrospective claims from the former North Yorkshire & York Primary Care Trust.

The majority of PuPOC claims were processed during 2016 and any financial liability relating to these claims is recharged to NHS England who hold a provision for this. However, it became evident during this process that a number of applicants had also requested a current assessment (for the period going forward), which has been termed the post PuPOC period.

The Clinical Commissioning Group has considered recording a provision for cases where a post PuPOC assessment has been requested, but assessment has not been carried out. There are now 86 cases requiring assessment across the four North Yorkshire CCGs with 15 having been assessed during 2017-18. Of these 15 cases none were found to be eligible although they do have the right to appeal. A number of uncertainties impact upon the CCG's ability to assess a reasonable provision:
- following assessment; patients may be deemed to be not eligible for care, fully eligible or eligible for only part of the assessed period,
- eligibility is only for costs actually incurred by the individual,
- CCGs are only eligible for costs from April 2013,
- a number of patients may have subsequently been accepted for continuing care, and therefore have already had care funded,
- claim periods can vary significantly, from a few days to several years,
- reimbursements can vary significantly from a few pounds to several thousand pounds per week depending on the level of care that the patient has sourced privately. No information has been received on assessed cases to determine the likely liability,
- eligible individuals may choose not to pursue a claim.

Consequently the CCG is identifying a contingent liability relating to these cases, but is not able to reasonably assess the value of the liability.

13.2 Contingent Assets

The Clinical Commissioning Group had no contingent assets as at 31 March 2018 (31 March 2017: nil).

14. Financial Instruments

14.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the Clinical Commissioning Group Detailed Financial Policies and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

14.1.1 Currency Risk

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

14.1.2 Interest Rate Risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit Risk

The majority of the Clinical Commissioning Group revenue comes from parliamentary funding and the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity Risk

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

14.2 Financial Assets

	Loans and Receivables 2017-18 £'000	Total 2017-18 £'000
Receivables:		
· NHS	785	785
· Non-NHS	528	528
Cash at bank and in hand	95	95
Other financial assets	2	2
Total at 31 March 2018	**1,410**	**1,410**

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

14.3 Financial Liabilities

	Other 2017-18 £'000	Total 2017-18 £'000
Payables:		
· NHS	4,215	4,215
· Non-NHS	19,463	19,463
Total at 31 March 2018	**23,678**	**23,678**

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

15. Operating Segments

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

16. Pooled Budgets

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

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

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

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

	2017-18 £'000	2016-17 £'000
Income	**0**	0
Expenditure	**19,968**	19,618

Details of the total pooled commissioning budgets for 2017-18 are set out below:

	Health and Wellbeing Board 2017-18				
	City of York £'000	**North Yorkshire £'000**	**East Riding of Yorkshire £'000**	**Total BCF pooled budgets £'000**	2016-17 Total BCF pooled budgets £'000
Contributing organisation					
NHS Vale of York CCG	11,400	7,303	1,265	**19,968**	19,618
NHS Airedale, Wharfedale and Craven CCG	0	3,134	0	**3,134**	3,079
NHS Scarborough and Ryedale CCG	0	7,601	0	**7,601**	7,468
NHS Hambleton, Richmondshire and Whitby CCG	0	9,284	0	**9,284**	9,121
NHS Harrogate and Rural District CCG	0	9,584	0	**9,584**	9,415
NHS Cumbria CCG	0	416	0	**416**	408
NHS East Riding of Yorkshire CCG	0	0	19,454	**19,454**	19,112
City of York Council	3,948	0	0	**3,948**	1,003
North Yorkshire County Council	0	13,166	0	**13,166**	3,538
East Riding of Yorkshire County Council	0	0	8,410	**8,410**	2,127
Total Better Care Fund (pooled budget)	**15,348**	**50,488**	**29,129**	**94,965**	**74,889**

Details of the utilisation of NHS Vale of York CCG contributions in 2017-18 are set out below:

	Health and Wellbeing Board 2017-18				
	City of York £'000	**North Yorkshire £'000**	**East Riding of Yorkshire £'000**	**Total NHS Vale of York CCG contributions £'000**	2016-17 Total NHS Vale of York CCG contributions £'000
Supporting Social Care commissioned schemes	3,828	2,861	436	**7,125**	8,202
Supporting Health commissioned schemes	7,572	4,442	829	**12,843**	11,105
Total utilisation of NHS Vale of York CCG contributions	**11,400**	**7,303**	**1,265**	**19,968**	**19,307**

All the Better Care Funds were fully utilised in year.

17. Related Party Transactions

Details of related party transactions with individuals are as follows:

	Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
Dr Louise Barker - Clinical Director - Partner works as Consultant Psychiatrist in Tees, Esk and Wear Valleys Foundation Trust	43,349	0	174	0
Dr Louise Barker - Clinical Director- Salaried GP at Haxby Group Practice	4,013	0	9	(1)
Dr Emma Broughton - Clinical Director - Partner at Priory Medical Group	6,784	(2)	30	(1)
Dr Emma Broughton - Clinical Director - Partner at Priory Medical Group which is a member of the Nimbuscare Ltd Alliance of GP Practices	372	(28)	0	(36)
Dr Tim Maycock - Clinical Director (to 30 September 2017) - Partner at Pocklington Group Practice	2,905	0	3	0
Dr Shaun O'Connell - Joint Medical Director - Salaried GP at South Milford Surgery	1,858	0	0	0
Dr Shaun O'Connell - Joint Medical Director - Spouse an anaesthetist at York Teaching Hospital Foundation Trust	221,633	0	1,401	(840)
Dr Andrew Phillips -Joint Medical Director - Private Medical Director to Helmsley Medical Practice	425	0	1	0
Dr Andrew Phillips - Joint Medical Director - Provides Out of Hours sessions for Yorkshire Doctors Urgent Care	7	0	0	0
Dr Andrew Phillips - Joint Medical Director - ex partner with Pickering Medical Practice (on-going financial settlement)	1,745	(1)	8	0
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group	4,450	(3)	8	(3)
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group which is part of the City and Vale Alliance	123	0	0	0
Dr Paula Evans - Council of Representatives Chair - GP Partner at Millfield Surgery (from 1 January 2018)	1,236	0	3	0
Dr John Lethem - Governing Body Member and Local Medical Committee member (to 31 August 2017) - Partner and GP Prinicipal for Unity Health	1,400	(1)	0	0
Dr John Lethem - Governing Body Member and Local Medical Committee member (to 31 August 2017) - Partner and GP Prinicipal for Unity Health which is a member of the Nimbuscare Ltd Alliance of GP Practices	372	(28)	0	(36)
Dr John Lethem - Governing Body Member and Local Medical Committee member (to 31 August 2017) - Local Medical Committee	315	0	0	0
Sheenagh Powell - Governing Body Lay Member and Chair of Audit Committee - Paid member of Harrogate and Rural District CCG Audit Committee	123	(109)	8	(42)
Sharon Stolz Governing Body Member - Interim Director of Public Health, City of York Council	8,518	(211)	1,106	(254)
Dr Arasu Kuppuswamy - Secondary Care Doctor - Consultant at South West Yorkshire Partnership NHS Foundation Trust	20	0	1	0
Elaine Wyllie (to 5 April 2018) - Interim Executive Director of Joint Commissioning - Director Wybeck Associates Limited	28	0	0	0
Elaine Wyllie (to 5 April 2018) - Interim Executive Director of Joint Commissioning - payments made to Hunter Healthcare Ltd	200	0	0	0
Dr Kevin Smith - Director of Primary Care and Population Health - substantive post as Deputy Director Public Health England, Yorkshire and the Humber	0	0	9	0
Keith Ramsay - Chair of the Governing Body - member of Tees, Esk and Wear Valleys Foundation Trust	43,349	0	174	0
Keith Ramsay Chair of the Governing Body - member of Harrogate and District Foundation Trust	4,818	0	421	(18)
Denise Nightingale (from 10 July 2018) - Executive Director of Transformation and Delivery - seconded from NHS Bassetlaw CCG	101	0	8	0
Philip Mettam - Accountable Officer - (until 1 June 2017 seconded from NHS Bassetlaw CCG)	101	0	8	0
David Booker - Lay Chair - volunteer first responder for Yorkshire Ambulance Service NHS Trust	16,325	0	192	0
Dr Aaron Brown - Local Medical Liaison Officer, Selby and York (from 1 September 2017) - GP York Medical Group	4,450	(3)	8	(3)
Dr Aaron Brown - Local Medical Liaison Officer, Selby and York (from 1 September 2017) - RSS Reviewer NHS Scarborough and Ryedale CCG	33,740	(486)	197	(222)

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

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

- NHS England
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Harrogate and Rural District CCG
- NHS Scarborough and Ryedale CCG
- York Teaching Hospital NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust

In addition, the Clinical Commissioning Group has had a number of transactions with other government departments and other central and local government bodies.
Other material transactions have been with City of York Council and North Yorkshire County Council.

18. Events After the End of the Reporting Period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group.

19. Financial Performance Targets

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

	2017-18 Target £'000	**2017-18 Performance £'000**	2016-17 Target £'000	2016-17 Performance £'000
Expenditure not to exceed income	457,370	477,442	449,067	466,531
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	454,999	475,071	447,432	464,896
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	7,618	6,309	7,556	7,208

Note that 2016-17 targets have been restated to exclude the brought forward deficit and report in-year performance in-line with 2017-18.

The Clinical Commissioning Group has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2017-18 expenditure performance is £20.072m over the income received. It has therefore breached its duty under the NHS Act 2006,as amended by paragraph 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012,which sets statutory duties for CCG's to ensure that the capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (the Revenue Resource Limit and Capital Resource Limit). A formal notification of this position was made by the Clinical Commissioning Group's external auditors, Mazars LLP, to the NHS Commissioning Board (NHS England) and also the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 on 31 January 2018.

As set out in the 2017-18 NHS Planning Guidance, CCGs were required to hold a 0.5% national risk reserve uncommitted from the start of the year. In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs to spend this. Therefore, to comply with this requirement, NHS Vale of York CCG has released its 0.5% national risk reserve to the bottom line, resulting in an improvement to the in-year financial position of £2.01m. This improvement has been used to improve the CCG's in-year deficit.

20. Losses and Special Payments

20.1 Losses

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

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £
Administrative write-offs	37	41,101	0	0
Store losses	0	0	1	432
Total	**37**	**41,101**	**1**	**432**

20.2 Special payments

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £
Compensation payments	1	1,027	0	32,379
Total	**1**	**1,027**	**0**	**32,379**

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

Compensation payments relate to a payment made by the Partnership Commissioning Unit in relation to an Employment Tribunal. An employee of NHS Scarborough and Ryedale CCG employed within the Partnership Commissioning Unit was dismissed for gross misconduct. The employee took the case to an Employment Tribunal which found in the employee's favour. The payment was accrued in the 2016-17 accounts but the actual payment was slightly higher which resulted in the additional expenditure in 2017-18.

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Annual Audit Letter

NHS Vale of York Clinical Commissioning Group

Year ending 31 March 2018

MAZARS

CONTENTS

1. EXECUTIVE SUMMARY

Purpose of the Annual Audit Letter

Our Annual Audit Letter summarises the work we have undertaken as the auditor for NHS Vale of York CCG (the CCG) for the year ended 31 March 2018. Although this letter is addressed to the CCG, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 (the 2014 Act) and the Code of Audit Practice issued by the National Audit Office (the NAO). The detailed sections of this letter provide details on those responsibilities, the work we have done to discharge them, and the key findings arising from our work. These are summarised below.

Area of responsibility	Summary
Audit of the financial statements	Our audit report issued on 25 May 2018 included our opinion that: • the financial statements give a true and fair view of the CCG's financial position as at 31 March 2018 and of its financial performance for the year then ended; and • Income and expenditure has, in all material respects, been applied for the purposes intended by Parliament except for the failure to meet the statutory duty for expenditure not to exceed income in year.
Value for Money conclusion	Our audit report stated that we had matters to report in respect of the CCG's arrangements to secure economy, efficiency and effectiveness in its use of resources in relation to understanding and using appropriate and reliable financial and performance information (including, where relevant, information from regulatory/monitoring bodies) to support informed decision making and performance management, managing risks effectively and maintaining a sound system of internal control, planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions and working with third parties effectively to deliver strategic priorities..
Reporting to the group auditor	In line with group audit instructions issued by the NAO, on 25 May 2018 we reported that the CCG's consolidation schedules were consistent with the audited financial statements.
Statutory reporting	Our report also outlined that we made a referral to the Secretary of State under s30 of the 2014 Act, in relation to the breech of financial duties.

2. AUDIT OF THE FINANCIAL STATEMENTS

Opinion on the financial statements	**Unqualified**
Opinion on regularity	**Modified**

The scope of our audit and the results of our work

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the CCG and whether they give a true and fair view of the CCG's financial position as at 31 March 2018 and of its financial performance for the year then ended.

Our audit was conducted in accordance with the requirements of the Code of Audit Practice issued by the NAO, and International Standards on Auditing (ISAs). These require us to consider whether:

- the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management in the preparation of the financial statements are reasonable; and
- the overall presentation of the financial statements provides a true and fair view.

The Code of Audit Practice also requires us to form and express an opinion on whether the CCG's expenditure has been, in all material respects, applied for the purposes intended by Parliament (our regularity opinion).

Our approach to materiality

We apply the concept of materiality when planning and performing our audit, and when evaluating the effect of misstatements identified as part of our work. We consider the concept of materiality at numerous stages throughout the audit process, in particular when determining the nature, timing and extent of our audit procedures, and when evaluating the effect of uncorrected misstatements. An item is considered material if its misstatement or omission could reasonably be expected to influence the economic decisions of users of the financial statements.

Judgements about materiality are made in the light of surrounding circumstances and are affected by both qualitative and quantitative factors. As a result we have set materiality for the financial statements as a whole (financial statement materiality) and a lower level of materiality for specific items of account (specific materiality) because of the nature of these items or because they attract public interest. We also set a threshold for reporting identified misstatements to the Audit Committee. We call this our trivial threshold.

The table below provides details of the levels applied in the audit of the financial statements for the year ended 31 March 2018:

Financial statement materiality	Our financial statement materiality is based on 2% of gross revenue expenditure.	£9.548 million
Trivial threshold	Our trivial threshold is based on 3% of financial statement materiality.	£286,000
Specific materiality	We have applied a lower level of materiality to the following areas of the accounts:	
	- exit packages	£10,000
	- senior officer remuneration	£150,000

2. AUDIT OF THE FINANCIAL STATEMENTS

Our response to significant risks

As part of our continuous planning procedures we considered whether there were risks of material misstatement in the CCG's financial statements that required special audit consideration. We reported significant risks identified at the planning stage to the Audit Committee within our Audit Strategy Memorandum and provided details of how we responded to those risks in our Audit Completion Report. The table below outlines the identified significant risks, the work we carried out on those risks and our conclusions.

Identified significant risk	Our response	Our findings and conclusions
Management override of controls In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Because of the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits.	We addressed this risk by performing audit work in the following areas: • accounting estimates impacting on amounts included in the financial statements; • consideration of identified significant transactions outside the normal course of business; and • journals recorded in the general ledger and other adjustments made in preparation of the financial statements	Our work has provided us with the assurance we sought and did not highlight any material issues to bring to your attention.
Revenue recognition In all entities, there is a risk of fraud in financial reporting relating to revenue recognition as there is potential to inappropriately record income in the wrong period. This is not to imply we suspect actual fraud, but that we approach our audit maintaining due professional scepticism.	We addressed this risk by: • undertaking cut-off testing of receipts around the year-end; • reviewing inter-NHS reconciliations and data matches provided by the NHSE (income and receivables); and • if necessary, seeking direct confirmation from third parties or their external auditors. This work will also inform our conclusion on the regulatory element of our audit opinion.	Our work has provided us with the assurance we sought and did not highlight any material issues to bring to your attention.
Related party transactions GPs are members of the Governing Body and also potential service providers.	We addressed this risk by: • reviewing the CCG's arrangements for identifying and recording potential related party transactions; • reviewing a range of documents including minutes of meetings and declarations of interest for evidence of potential related party transactions; and • testing disclosures in the financial statements.	Our work has provided us with the assurance we sought and did not highlight any material issues to bring to your attention.

3. VALUE FOR MONEY CONCLUSION

Value for Money conclusion	Adverse

Audit approach

We are required to consider whether the CCG made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The NAO issues guidance to auditors that underpins our work and sets out the criterion and sub-criteria that we are required to consider. We are only required to report if we conclude that the CCG has not made proper arrangements..

The overall criterion is that, 'in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.' To assist auditors in reaching a conclusion on this overall criterion, the following sub-criteria are set out by the NAO:

- informed decision making;
- sustainable resource deployment; and
- working with partners and other third parties.

Our audit report, issued to the CCG on 25 May 2018 outlined our qualified conclusion on the CCG's arrangements to secure economy, efficiency and effectiveness in its use of resources.

Sub-criteria	Commentary	Matters to report
Informed decision making	The CCG has governance arrangements in place.. At the beginning of the year, however, there was some conflict between the financial reporting required by NHS England, reporting the capped expenditure process (CEP) forecast outturn, rather than the more likely actual forecast outturn. Additional reporting of detail was subsequently added to fully explain the financial position. In addition, the Constitution has not been publicly updated since October 2015 and arrangements have changed significantly since then.	Yes. While the CCG has taken action to improve financial information reported to members and has submitted an updated Constitution to NHS England, those arrangements were not in place for a significant proportion of the financial year.
Sustainable resource deployment	The CCG has made a deficit for the last three financial years and is operating under legal directions. The CCG has stabilised the underlying deficit position in 2017/18 and is forecasting a further deficit of £14.0 million for 2018/19. Under the new Commissioner Sustainability Fund, however, the £14.0 million deficit may be funded if the CCG meets the control total. The 2018/19 financial plan includes a challenging £14.6 million QIPP programme.	Yes. Deficits are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities.
Working with partners and other third parties	The CCG is in special measures, operating under legal directions. Part of the savings agreed for 2017/18 required the main hospital services provider to let performance against the constitutional targets slip, i.e., allow waiting times to increase. Subsequently NHS Improvement informed the hospital that this was not acceptable. As a consequence, hospital activity increased in order to meet constitutional targets. The CCG's QIPP targets were not met and the deficit increased compared to the forecast position.	Yes. The CCG has attempted to improve arrangements but more work is needed to address over performance by the local hospital trust.

3. VALUE FOR MONEY CONCLUSION

Significant audit risks

The NAO's guidance requires us to carry out work to identify whether or not a risk to the Value for Money conclusion exists. Risk, in the context of our Value for Money work, is the risk that we come to an incorrect conclusion rather than the risk of the arrangements in place at the CCG being inadequate. In our Audit Strategy Memorandum, we reported that we had identified one significant Value for Money risk. The work we carried out in relation to the significant risk is outlined below.

Risk	Work undertaken	Conclusion
Financial position In 2016/17 the CCG reported a cumulative deficit of £23.8 million. The CCG continued to face several financial challenges in 2017/18, including the need to achieve significant QIPP savings in-year. In addition, the CCG was operating under legal directions and within the CEP with York FT and Scarborough and Ryedale CCG. The CCG was forecasting that it would not meet the requirement, under section 223H (1) of the NHS Act 2006 (as amended), to ensure expenditure in a financial year did not exceed income. When a CCG breaches this statutory duty, even if this is agreed with NHS England, we are under a duty to make a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014.	We addressed this risk by monitoring the progress the CCG made in delivering its financial plan as the year progressed and considering the impact on our audit report.	The CCG set a deficit budget of £6.3 million for 2017/18 and recorded an in-year deficit of £20.1 million. We made a referral to the Secretary of State in January 2018 and qualified our statutory value for money conclusion.

4. OTHER REPORTING RESPONSIBILITIES

Exercise of statutory reporting powers	**Matters to report**
Governance Statement	**No matters to report**
Consistency of consolidation data with the audited financial statements	**Consistent**
Other information published alongside the audited financial statements	**Consistent**

The NAO's Code of Audit Practice and the 2014 Act place wider reporting responsibilities on us, as the CCG's external auditor. We set out below, the context of these reporting responsibilities and our findings for each.

Matters which we report by exception

The 2014 Act provides us with specific powers where matters come to our attention that, in our judgement, require reporting action to be taken. We have the power to:

- issue a report in the public interest;
- make a referral to the Secretary of State where we believe that as decision has led to, or would lead to, unlawful expenditure, or an action has been, or would be unlawful and likely to cause a loss or deficiency; and
- make written recommendations to the CCG which must be responded to publically.

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

On 31 January 2018, we issued a report to the Secretary of State for Health under section 30(a) of the Local Audit and Accountability Act 2014, for the breach of financial duties under:

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

We are also required to report if, in our opinion, the governance statement does not comply with the guidance issued by NHS England or is inconsistent with our knowledge and understanding of the CCG. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the CCG has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

Other information published alongside the financial statements

The Code of Audit Practice requires us to consider whether information published alongside the financial statements is consistent with those statements and our knowledge and understanding of the CCG. In our opinion, the information in the Annual Report is consistent with the audited financial statements.

5. OUR FEES

Fees for work as the CCG's auditor

We reported our proposed fees for the delivery of our work in the Audit Strategy Memorandum, presented to Audit Committee in [month] 2017.

Having completed our work for the 2017/18 financial year, we can confirm that our final fees are as follows:

Area of work	2017/18 proposed fee	2017/18 final fee
Delivery of audit work under the NAO Code of Audit Practice	£42,950	£42,950

Fees for other work

We confirm that we have not undertaken any non-audit services for the CCG in the year.

6. FORWARD LOOK

Financial outlook

The CCG has stabilised the underlying deficit position in 2017/18 at £21.7 million, from £22.4 million in 2016/17 and is forecasting a further deficit of £14.0 million for 2018/19. Under the new Commissioner Sustainability Fund, however, the £14.0 million deficit may be funded if the CCG meets the control total.

The 2018/19 financial plan includes a challenging £14.6 million QIPP programme which has been subject to internal confirm and challenge and external scrutiny on behalf of NHS England. The summary outcome of this review is that the majority of schemes have been rated as amber or red, medium to high risk, because they are in early stages of development.

The most recent feedback from NHS England has raised concerns about the CCG's ability to deliver the forecast position in 2018/19 and further work is being undertaken to provide more assurance.

Challenges

In seeking to address over performance by healthcare providers the CCG recognises the need to work collaboratively. Vale of York and Scarborough and Ryedale CCGs have developed a medium-term system financial recovery plan across the Vale and Scarborough system. The plan includes agreeing and implementing acute service transformation to reduce costs while also providing a framework for the local hospital to achieve constitutional targets.

The Vale and Scarborough Health and Care Partnership Board has been established to develop an integrated care system. The Board includes the two CCGs, the main hospital service providers, GP practices, and local authority representatives. To ensure sufficient activity is commissioned to meet population needs while providers have sufficient resources to meet demand, the CCG and providers all need to agree affordable demand and capacity solutions. While overseeing the collaboration needed and setting the direction for financial recovery, the Governing Body will require assurance on the basis and progress of the changes to activity plans and pathways that need to be made to achieve financial sustainability.

Future actions

The CCG continues to face financial pressures and is well aware of the challenges and risks involved in delivering its future plans. Going forward the whole CCG needs to be focussed on systemic change including challenging current behaviours that lead to increased activity and difficult decisions around the range and level of services provided.

How we will work with the CCG

We are grateful to the CCG, its Members and officers for the cooperation and open dialogue during the year and look forward to continuing to work closely with the CCG in delivering our Code of Audit Practice responsibilities.

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