NHS
Vale of York
Clinical Commissioning Group

Annual Report and Accounts

2015-16

The best health and wellbeing for everyone.

Annual Report and Accounts 2015-16

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Annual Report and Accounts 2015-16

Welcome to the Annual Report and Accounts of NHS Vale of York Clinical Commissioning Group (CCG) for 2015-16. All NHS organisations are required to publish an annual report and financial accounts at the end of each financial year.

This report provides an overview of the CCG's work between 1 April 2015 and 31 March 2016. The report is made up of three parts. The first section contains details of the organisation's performance for 2015-16, with the second section covering details of governance and risk. The third is the financial accounts for the year 2015-16.

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

The CCG held six board meetings and a number of Public and Patient Engagement (PPE) events in 2015-16. These events were open to the public. The dates, times and venues of these and future events can be found on the CCG's website:

http://www.valeofyorkccg.nhs.uk/

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

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NOTE: Due to the absence of the Accountable Officer, Dr Mark Hayes, the Annual Report and Accounts have been signed by the Interim Accountable Officer, Helen Hirst.

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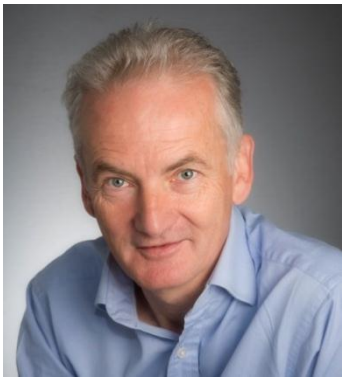
SECTION 1 - Performance Report

1.1 Reports

1.1.1 Report of the Chair of the Governing Body and the Chief Clinical Officer



Dr Mark Hayes

Chief Clinical Officer

Keith Ramsay

Lay Chair

2015-16 has been challenging and, as a whole, the NHS has been under unprecedented financial strain.

Despite the financial challenges in the Vale of York, the CCG has continued to progress its work to improve local health and care services. Regrettably, despite two very successful years of managing tight financial funding, it was not possible to maintain this success into a third year.

Providers and commissioners alike are faced with a very serious financial situation to address but as a health and care system we are working together to resolve local problems. We are working with our partners to develop a system recovery plan for the Vale of York. This plan, which will help the CCG to return to financial balance, is a key outcome required by NHS England.

Transforming and improving health and care

There are many reasons to be optimistic for the future including the development of the System Leaders Board where health and local authority Chief Officers are working on a single plan for the future.

Our transformation work in 2016-17 will focus upon the broader health and care system and include prevention work that will support people to live healthy lives and manage long term conditions. It will help to create sustainability in primary and secondary care through redesigning pathways that will enable health and care to be delivered closer to home. With our partners we will be undertaking a review of urgent care systems across

six CCG areas, including our neighbour NHS Scarborough and Ryedale CCG, where York Teaching Hospital NHS Foundation Trust is the main provider of services.

Innovative health and care

The CCG has developed strong relationships and has benefitted from learning from some of the most effective and efficient systems in the world. This is demonstrated through the launch of the second phase of a randomised controlled trial, Health Navigators. The results to date show very positive outcomes and a significant improvement in the wellbeing of participants.

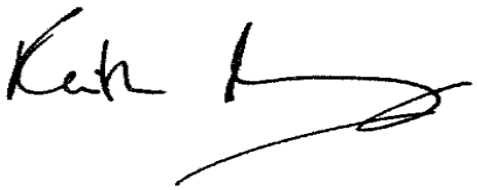
Mental health and learning disabilities services

2015 saw the re-provision of mental health and learning disability services in the Vale of York and the creation of a new service specification that was designed in conjunction with service users. Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) was awarded the contract from 1 October 2015. TEWV's performance in the first few months of its contract is proof that the Vale of York is on course for significant improvements in these services.

The CCG announced its plans for the creation of a new hospital in York for patients with mental health needs and working with our partners, we are moving towards our goal.

Local people are proud of their NHS and they have a passion for the services it provides. Throughout 2016-17 we will continue to work collaboratively with our stakeholders to deliver new and efficient ways of working and stay on course to deliver our five year plan whilst we protect, and where possible, enhance the quality and safety of services.

Dr Mark Hayes
Chief Clinical Officer



Keith Ramsay
Lay Chair

Footnote: Due to the absence of the Chief Clinical Officer, Dr Mark Hayes, the Annual Report and Accounts have been signed by the Interim Accountable Officer, Helen Hirst (see p.44).

1.1.2 Report of the Chair of the Council of Representatives

Dr Paula Evans
Chair - Council of Representatives (Member practices)

In his reflection of 2014-15, my predecessor, Dr Tim Hughes, stated that one of the strongest features of the CCG is the strength of its primary care membership. He highlighted that GPs and practice staff bring their knowledge and understanding of patient experiences, local services and the health needs of the community to help to shape services in the Vale of York. This expertise is a key enabler to help deliver the CCG's commissioning plans.

Throughout 2015-16, the primary care community has worked increasingly collaboratively and cohesively and has both supported the CCG whilst providing appropriate challenge in the consideration of innovative and significantly different delivery models of health and care.

These plans were set out in the CCG's five year strategy – an Integrated Operational Plan for 2014-19 and working closely with member practices and Health and Wellbeing Boards in North Yorkshire, York and East Riding of Yorkshire, the CCG has focussed upon the areas of greatest need, improved service quality, performance and efficiency whilst it embedded its plans for the integration of health and social care.

NHS England announced that, for 2016-17, this plan would become part of a Sustainability and Transformational Plan (STP). For the first time plans will reflect the health and social care needs together as a system, rather than as discrete organisations. This approach will help to accelerate the implementation of the Five Year Forward View.

The STP means that the CCG is part of cluster created for the Humber, Coast and Vale footprint. The aim going forward is to build upon and strengthen our already constructive working relationships and transform the way care is delivered to our community.

Achieving financial balance

Along with the rest of the NHS and the social care delivery across the country, the CCG knew that in spite of achieving financial balance for the previous two years, there would be significant challenges to face in 2015-16.

This has been borne out, resulting in the CCG receiving turnaround support from NHS England. Though having been independently assessed as having the financial capability and capacity, the CCG is now in the invidious position of needing to progress its transformation plans at pace, whilst addressing a deficit. The member practices have taken their responsibilities here seriously, increasing engagement and cognisance through monthly meetings.

Joint commissioning

Co-commissioning is part of a wider strategy to join up care in and out of hospital and aims to provide better access to services by bringing these closer to home and improving patient experience. As one of a series of changes set out in the NHS Five Year Forward View in 2015-16, there was a transfer of commissioning responsibilities with delegated co-commissioning.

Quality and assurance reviews in 2015-16 were very positive and have strengthened the joint commissioning relationship with NHS England.

Engaging and involving the community

Strong relationships and collaboration with our community are vital, helping to shape complex decisions within constrained resources. Throughout its improvement planning and delivery, the CCG has increased this collaboration through its promotion and development of the Provider Alliance Board. The Board, which comprises of representatives from primary and secondary care, local authorities and the voluntary sector, is an essential move towards local providers viewing themselves as part of a health and social care system.

The integration of health and social care

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

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

Better Care Fund schemes have recently been evaluated, and have demonstrated impact and very positive feedback from patients. They will continue to be supported and refined.

Annual evaluation of Membership Body effectiveness

The Membership Body is pleased to report that the CCG has continued with its robust evaluation and governance measures throughout 2015-16.

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

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

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

NHS England's Yorkshire and Humber Area Team - review the CCG on a quarterly basis. The 2015-16 quality and assurance reviews have been very positive and have strengthened the joint co-commissioning relationship with NHS England. There has been a transfer of commissioning responsibilities with delegated co-commissioning this year. This relationship has become increasingly strong and supportive.

This has proved to be a highly challenging year, and the membership wishes to work closely and constructively with the CCG and to empower it to achieve the twin goals of transformation and sustainability.

We congratulate the CCG on its ability to rise and adapt to this challenge, using the feedback it has received and its reflection.

Dr Paula Evans
Chair of the Council of Representatives (Membership Body)

1.2 Context

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

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

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

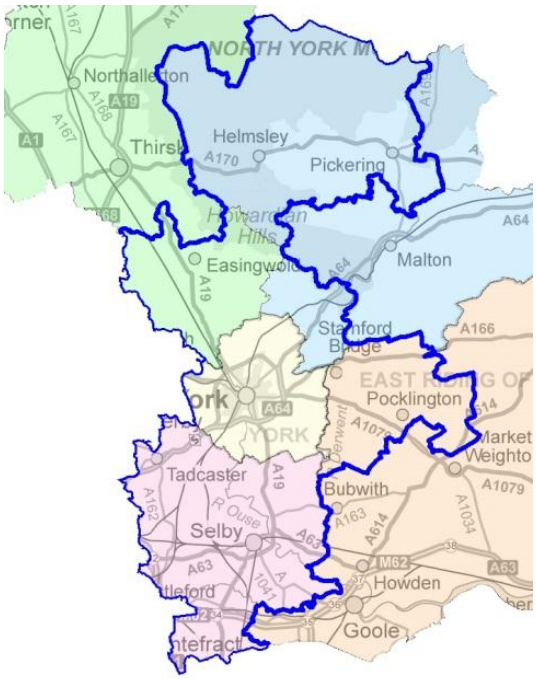


Fig 1 The NHS Vale of York CCG operating area.

CCG footprint

The CCG serves towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of around 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 2015-16, the CCG had 29 member GP practices in its operating area and an annual commissioning budget of £430.5m. The budget is set by central government and based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

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

CCG accountability

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

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

Location of the CCG

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

The CCG's vision

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

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

The CCG's mission

The CCG's mission is to:

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

The CCG's values

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

- Integrity – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.

1.3 Performance for 2015-16

1.3.1 NHS Constitution Targets

The NHS Constitution for England sets out the core values, principles and commitments of the NHS. It states what patients, the public and staff can expect from the NHS - detailing a number of rights, responsibilities and key pledges.

The key measures that the CCG work to uphold are detailed in the tables and descriptions below, along with a view of the CCG's performance against each target.

Throughout this document, Red/Amber/Green (RAG) ratings are applied based on the following standard unless otherwise indicated:

At or above target	
Up to 5% away from meeting target	
More than 5% away from meeting target	

a) Yorkshire Ambulance Service Response Times

The table below shows how the CCG performs against the 8 minute and 19 minute response targets, as well as how this compares to the overall Yorkshire Ambulance Service (YAS).

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% in 8 minutes	>75%	76.5%	75.4%	74.4%	74.1%	73.1%	68.2%	73.9%	73.5%	70.6%	70.4%	71.2%	69.5%
YAS			72.8%	73.5%	70.4%	70.2%	69.9%	70.4%	72.5%	73.3%	70.9%	71.7%	71.2%	69.4%
NHS Vale of York CCG	% in 19 minutes	>95%	94.5%	95.7%	94.3%	92.6%	92.0%	90.8%	93.1%	92.8%	90.8%	92.0%	92.5%	90.6%
YAS			96.2%	96.3%	95.3%	95.3%	95.0%	95.3%	95.3%	95.3%	93.9%	94.7%	95.1%	93.7%

During 2015-16, the CCG have either met or been within 5% of target for both the 8 minute and 19 minute standards, with the exception of a single month. At times throughout the year there have been delays in handover from the ambulance crew to the Emergency Department (ED) staff at York Teaching Hospital NHS Foundation Trust ("YTHFT", or "York Trust"), usually due to patient flow issues within the hospital and ability to staff the ambulance handover area. When delays occur at the hospital, this can have a knock on effect on response times as crews and their vehicles are unable to leave the hospital to respond to calls.

Throughout the year there have been a number of on-going pieces of joint work between the CCG, York Trust and YAS, with the aim of improving ambulance handover times and subsequently response times as more ambulance crews would be available to respond in a timely manner. The CCG is also in the process of a whole system transport review with the aim to procure an improved PTS (patient transport service) by 2017.

b) Emergency Department

A minimum of 95% of patients attending the Emergency Department (ED) should be discharged, admitted or transferred within 4 hours of arrival. This includes attendances at Urgent Care Centres and Minor Injury Units. The CCG figure is weighted accounting for the majority of attendances taking place at York Trust locations, primarily York Hospital, and a small proportion at Harrogate and District NHS Foundation Trust (HDFT).

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% meeting 4 hour target	>95%	87.2%	88.0%	89.4%	93.0%	91.8%	89.8%	87.3%	84.7%	89.3%	86.8%	84.9%	83.5%

York Trust did not meet the 95% 4 hour target in any month during 2015-16. Significant work has been undertaken between the CCG and the Trust to understand the reasons behind the failure to meet target, and there are a number of on-going programmes of work which will continue through 2016-17 with the aim of improving performance against this standard.

The CCG has supported the Trust by funding additional capacity in the ED in the out of hours service (OOH), and is developing a GP front door model in ED due to go live in summer 2016 to ensure only appropriate patients receive care in ED with signposting into other services as directed by the professional team. The Trust has been supported in making improvements to the target by the Emergency Care Improvement Programme (ECIP) who have made recommendations to improve patient flow including considerations on the use of community bed base. The CCG with other partners have signed the ECIP Concordat to ensure improvements are made by strong partnership working. In line with the System Transformation Fund guidance the Trust are required to meet the 4 hour target at 90% by March 2017. The CCG has supported various schemes to decrease the number of ambulatory care conditions being treated in the ED, which include:

- A CQUIN in 2015-16 to increase ambulatory care patients going through the ambulatory care unit at York Trust.
- Introduction of Urgent Care Practitioners (UCPs) – 11 advanced practitioners covering the whole of Vale of York area, providing see-and-treat services with much lower levels of conveyance to the ED with direct access for care homes.
- GP call-back scheme – Ambulance teams can identify patients who are not suitable for ED but can be better managed by their own GP. The

Ambulance crew have discretion to call the GP and subsequently convey the patient to the practice rather than ED.

- York Integrated Care Team - the team now cover a 120,000 population and provide post-discharge support and access for at-risk and vulnerable patients to contact them for support for minor ailments, falls etc. thereby reducing the number of attendances at ED, particularly with non-acute conditions.
- Out of Hours (OOH) services - since their introduction last year, they have worked hard to develop links with the various local teams and are another potential route for ambulatory care type patients to be reviewed by this team rather than ED
- Providing intravenous therapy (IV) care at home has been rolled out successfully in one area over the last year, and is currently being modelled for other areas to avoid patients coming to ambulatory care just for IV antibiotics or similar, when this can be provided in the patients home
- The CCG and York Trust have worked together to review Frailty pathways and provide different routes of access to older patients with risk factors, again to avoid attendance and subsequent admission at ED.

The CCG is also an active partner in reducing Delayed Transfers of Care (DTOC) with a jointly agreed action plan that develops a variety of models to ensure safe discharge of patients from hospital. The CCG continues to work with partners to increase workforce available to deliver home care and increase the number of beds for patients with complex dementia.

c) 12 hour trolley waits

Due to the performance issues described in the above section, there have been a large number of patients waiting 12 hours or more in the ED, mainly in Scarborough Hospital. The CCG provides scrutiny of all cases to gain assurance following root cause analysis investigations and to date no patients were harmed by their waits in ED

d) Diagnostics

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% waiting over 6 weeks	<1%	4.0%	3.0%	2.2%	1.2%	1.4%	0.9%	1.2%	0.7%	1.0%	1.2%	0.4%	0.9%

Performance against the diagnostic target has consistently improved throughout 2015-16 and has met or been within 0.5% of target since July 2015. York Trust has introduced an electronic case management system and the CCG had an agreed Commissioning for Quality and Innovation (CQUIN) indicator for the Trust to improve scan reporting in primary care in 2015-16.

e) Referral to Treatment Time

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% within 18 weeks - Incomplete Pathway	>92%	94.2%	94.1%	94.7%	94.0%	94.3%	94.2%	94.3%	94.8%	94.1%	93.4%	93.4%	92.4%

The CCG has consistently met the Referral to Treatment time target throughout 2015-16, and it is anticipated that this will continue throughout 2016-17.

f) Cancer

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% seen within 14 days - All Tumour Types	>93%	93.3%	93.2%	93.7%	93.0%	91.7%	93.0%	94.5%	95.4%	96.2%	93.8%	96.2%	94.7%
NHS Vale of York CCG	% seen within 14 days - Breast symptomatic	>93%	90.0%	92.4%	94.6%	95.8%	91.5%	96.9%	94.6%	92.8%	95.4%	97.4%	100.0%	94.7%

The CCG has performed consistently well against the key 14 day cancer targets for All Tumour Types and Breast Symptomatic, and has either met or been within 3% of target every month in 2015-16.

In addition to the 14 day targets from referral to being seen, there are a number of 31 and 62 day treatment waiting time targets.

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	% 31 days first treatment	96%	94.5%	98.1%	96.0%	98.2%	99.4%	99.4%	99.4%	98.7%	99.4%	99.5%	99.3%	98.0%
NHS Vale of York CCG	% 31 days subsequent treatment - surgery	94%	100.0%	96.2%	100.0%	97.3%	96.4%	100.0%	95.8%	97.1%	96.2%	97.2%	99.4%	97.0%
NHS Vale of York CCG	% 31 days subsequent treatment - drug	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NHS Vale of York CCG	% 31 days subsequent treatment - radiotherapy	94%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NHS Vale of York CCG	% 62 days GP referral	85%	82.6%	86.1%	89.6%	82.8%	80.2%	84.0%	79.3%	82.3%	91.0%	83.5%	86.9%	90.5%
NHS Vale of York CCG	% 62 days screening referral	90%	100.0%	100.0%	100.0%	90.0%	88.2%	83.3%	100.0%	100.0%	100.0%	100.0%	87.5%	87.5%

The CCG has met all of the 31 day targets throughout 2015-16, with the exception of a single target which was missed by 0.5% in April 2015.

The area which is inconsistent with regards to meeting target is the percentage of patients receiving first definitive treatment within 62 days; however the CCG has performed better than the national average as this target has not been met on a national level in any month throughout 2015-16.

g) Mixed Sex Accommodation Breaches

All breaches of the Mixed Sex Accommodation (MSA) guidance (i.e. occurrences of unjustified mixing) relating to English NHS funded providers of healthcare hospital sleeping accommodation are recorded.

The CCG had 221 MSA breaches during 2015-16.

Level:	Measure:	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Vale of York CCG	Mixed Sex Accommodation Breaches	-	37	36	39	39	37	31	0	0	0	0	2	0

The 219 breaches between April and September 2015 were related to units run by Leeds York Partnership NHS Foundation Trust (LYPFT). Significant building works have taken place over the mental health estate in line with plans to reconfigure services and update Bootham Park Hospital as an interim solution prior to a mental health new inpatient facility in 2019.This building work has contributed to the MSA breaches. A drop in breaches can be seen once the building works were completed in those community units.

The February 2016 breaches occurred in the Vascular Imaging Unit (VIU) at York Trust due to capacity issues. Both the CCG and the Care Quality Commission (CQC) are aware and have taken part in a walk around the unit with the Trust in order to see what could be done differently. Work is planned for 2016 to improve the VIU, enlarging the unit and improving the admission/recovery area to prevent further single sex breaches.

h) Health Care Associated Infections

Health Care Associated Infections (HCAI) remain a major cause of avoidable patient harm. The CCG is committed to a reduction of HCAI's and a robust collaborative approach exists to the review of cases with established pathways for learning is in place.

Work to achieve a whole health economy approach is underway within the Vale of York with a key aim to reduce infections further.

York Trust have faced some significant challenges in relation to Healthcare acquired infections over the last 12 months. Five Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases at Scarborough Hospital (York Trust) gave concern at the beginning of the year. All cases were investigated with a resulting action plan, agreed with the CCG. A further two cases for York Trust resulted later on in the year.

C-Difficile infection continues to be challenging with numbers increasing and exceeding trajectory. The CCG is involved in Post Infection Reviews (PIRs) of all cases of MRSA bacteraemia where the care is comprehensively reviewed using the medical records and the patient journey mapped against the recommended paperwork.

The CCG has supported the lapses in care process in line with national guidance, attending meetings with the Trust clinicians on a regular basis.

Norovirus and diarrhoea and vomiting have resulted in significant bed closures in both York and Scarborough Hospitals (York Trust) which has seriously impacted on performance, patient flow and patient experience.

Following an independent external review of Infection Prevention and Control (IPC) processes York Trust have undertaken a complete review of all IPC governance

arrangements resulting in a Strategic Executive IPC Committee and a workplan which will be monitored by the CCG through contractual processes. The CCG will continue to seek assurance on improvements to staff training, compliance with best practice bundles, improved sharing of actions plans and external visits, more robust post infection reviews with evidence of learning to reduce recurrence and evidence of patient experience being utilised or incorporated into organisation wide learning.

The CCG obtains further assurance on commissioned services by:

- Antimicrobial formulary adherence is reported through provider quality assurance/contract board meetings.
- The Medicine management lead for the CCG monitors and audits primary care compliance with antimicrobial prescribing and formulary adherence.
- Receives and reviews provider's annual HCAI reduction plan and their infection control strategies
- CCG undertakes provider visits as required
- Proactive work with care homes and primary care on strategies to reduce incidents of norovirus.

In terms of HCAI performance for 2015-16, the figures below show the number of infections relating to the Vale of York Patients as a whole (not by commissioned service):

- MRSA – 4 cases
- C-Difficile – 89 cases
- MSSA – 67 cases
- E. coli – 269 cases

The CCG jointly contracts (with other CCGs and commissioners of health and social care) a clinical Infection and Prevention Control (IPC) service that supports providers and independent contractors to comply with the IPC Society/Royal College of Nursing (RCN) toolkit and other national standards and a shared post for a shared specialist infection prevention nurse covering the 4 North Yorkshire CCGs to provide expertise and support longer term assurance and improvement plans.

i) Improving Access to Psychological Therapies

There are two key targets relating to Improving Access to Psychological Therapies (IAPT); the first is regarding the proportion of people entering treatment against the level of need in the general population, which is a local estimate based on the Psychiatric Morbidity Survey. For common mental health conditions treated in IAPT services, it is expected that a minimum of 15% of those in need would willingly enter treatment if available. The second target is that a minimum of 50% of people who complete treatment achieve recovery.

The figures in the table below are based on validated Health and Social Care Information Centre (HSCIC) data, which is produced 3 months in arrears.

Level:	Measure:	Target	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
NHS Vale of York CCG	Prevalance: Monthly prevalance rate	>15%	11.1%	10.6%	11.2%	7.1%	7.0%	13.0%	10.1%	7.4%	7.4%	6.5%	7.2%	11.3%
NHS Vale of York CCG	Recovery: Monthly recovery rate	>50%	57.9%	48.1%	48.0%	44.6%	53.2%	52.9%	44.0%	42.9%	47.9%	34.8%	47.6%	39.3%

Performance for the CCG has been varied in 2015-16, with performance against the prevalence target of 15% ranging from 6.5% to 13.0% across the year, and against the recovery target of 50% from 34.8% to 53.2%.

The lead provider of mental health services for the Vale of York changed part way through the year from LYPFT to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). TEWV are aware of commissioner expectations in relation to performance of IAPT services and have agreed that they will begin to reliably deliver all targets during Quarter 3 2016-17. There have been historic data quality issues which led to a reduction in access and recovery performance, following validation by HSCIC. Recruitment to vacancies is also underway which is anticipated to improve service delivery, along with plans to better engage with GPs and other referrers into the service to encourage broader access to IAPT and better recovery rates.

j) Early Intervention in Psychosis

In 2015-16, a new national access and waiting time standard for Early Intervention in Psychosis (EIP) was introduced. Improvements towards meeting the new standard were being implemented from 1st April 2015, so that by 1st April 2016 more than 50% of people experiencing their first episode of psychosis will begin NICE (National Institute for Health and Clinical Excellence) concordant treatment within two weeks of referral.

The standard is two-pronged and both conditions must be met in order to meet the standard:

- A maximum wait for two weeks from referral to treatment; and
- Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia

The table below provides the current status from NHS England on the CCG's plans to have this standard implemented in 2016-17:

Overall Assessment	Preparing for implementation	MHSDS Dataset Submission	Workforce preparedness
Partially assured	Partially assured	Assured	Partially assured

k) Dementia assessment performance

Currently 54.2% of patients likely to have dementia have received a diagnosis, and TEWV are now implementing the newly specified Cognitive Impairment Pathway. The Partnership Commissioning Unit (PCU) will continue to support CCG colleagues in achieving the national target of 66.8% diagnosis rates, through attendance at regional Strategic Clinical Networks (SCN), York Dementia Action Alliance and contract review of current support service with Dementia Forward.

l) Learning Disability – Building The Right Support

National policy, following the Winterbourne Review, is focused on building the right support for people with learning disabilities in the community rather than in a hospital setting. Therefore, resettlement planning and enhancing the provision of community services need to be scoped and developed. A detailed Building The Right Support (BTRS) project plan is being developed by the Transforming Care Partnership (previously known as the Transforming Care Group).

m) Special Educational Needs and the Local Offer

In November 2014, the four CCGs that commission services through the PCU, together with North Yorkshire County Council and City of York Council commissioned Better Communications CIC to undertake work to support the development of joint commissioning arrangements and a strategic plan for children and young people with Special Educational Needs and Disabilities (SEND). The interim findings were shared with the four CCGs through the PCU Management Board in February 2016. The final report is now complete and a partnership commitment to the report has been drafted and shared with parent and carer forums across the county.

Work has been undertaken to review the health information on each local authority Local offer and to support improvements in partnership with local authority colleagues. Joint commissioning is already undertaken with the local authority for the high cost children.

1.3.2 Other Performance Targets

Serious Incidents and Never Events

The CCG is committed to providing the best possible service to its patients, clients and staff. The CCG recognises that, on occasions, Serious Incidents (SIs) or near misses will occur which require robust, unbiased, systematic review in order to identify any causes or contributing factors and ensure learning occurs to reduce the risk of recurrence.

Promoting patient safety by proactively reducing the risk of error and learning from patient safety incidents is a key priority for the CCG.

The CCG's main focus this year, related to serious incidents is to support and improve the number patients suffering harm from falls and pressure ulcers at York Trust. We continue to work closely with the Trust to ensure improved strategic plans are developed, that evidence of learning is in place to prevent recurrence and closure of the number of serious incidents when action plans are complete. The other area for improvement is to ensure our commissioned services are compliant with Duty of Candour particularly providing evidence of written apology to patients and their families and involvement by them in the investigation of the incident where appropriate. This will remain a key focus in 2016-17.

The CCG also has a responsibility to report and investigate incidents which occur within its own organisation. It also needs to ensure Governing Body is aware of SIs that occur within the CCG and that action plans are monitored by the Quality and Performance Team. The CCG had one serious incident in 2015-16 related to our Referral Support Service which was resolved promptly.

Never Events

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There were three Never Events in our commissioned services in 2015-16, all at York Trust of which, two patients resided in the Vale of York. One Never Event related to the over administration of insulin and two related to wrong site surgery (wrong tooth extraction).

Stroke

In the summer of 2015 a new pathway for patients affected by a stroke at Scarborough was piloted. The aim was to progress an improved service due to capacity issue on the Scarborough Hospital site of York Trust. Once assessed in Scarborough, patients are transported to York Hospital's Hyperacute Stroke Unit for treatment and repatriated to Scarborough in the following days. The external review of the new stroke pathway between York and Scarborough has taken place and endorsed by the reviewers and it was suggested that it may be used as a Beacon site to help support other reconfiguration decisions across Yorkshire and Humber area. This decision will be taken in quarter 1 of 2016-17.

End of Life Care

The CCG has jointly developed an Adult Strategy for End of Life Care 2015 - 2020 with NHS Scarborough and Ryedale CCG. The Strategy details our vision and ambition for commissioning excellent end of life care.

The development of an integrated Hospice at Home service has been invaluable in coordinating and providing a high level of end of life care. Waiting times for Fast Track services remains challenging in line with difficulties in recruitment for home care packages and the CCG remains committed to improve this in 2016-17.

Maternity Services

The North Yorkshire and York maternity network continues to meet and members have helped shape the planned engagement work. The York Maternity Services Liaison Committee has been involved in shaping this work, and four members volunteered to join a virtual task and finish group to develop the engagement tools and approach.

Service user engagement to inform the strategy for commissioning maternity services has been approved by CCGs and launched on 11 January 2016. This includes paper and online surveys as well as some smaller scale Discover! events within localities.

Future in Mind: **Local Transformation Plan**
Following approval by NHS England on 18 November, the Plan has been published on the CCG website http://www.valeofyorkccg.nhs.uk/publications/future-in-mind-n-our-transformation-plan/ and is also published to the local authority websites.

1.3.3 Financial Performance - Our year-end financial position

1.3.3.1 Preparation of the Annual Accounts

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

1.3.3.2 Accounting Policies

The CCG prepares the accounts under International Financial Reporting Standards (IFRS) and in line with the HM Treasury Financial Reporting Manual and approved accounting policies.

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

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

1.3.3.3 Financing Transactions

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

1.3.3.4 Cash

The CCG delivered against all of its cash targets in 2015-16 and plans to do so again in 2016-17.

1.3.3.5 Summary of expenditure

The CCG has two funding streams:

Programme costs

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

Running costs

Payment allocated to CCGs based on £22.07 per head of ONS population to pay for non-clinical management and administrative support, including commissioning support services.

1.3.3.6 Analysis of the programme costs expenditure

Allocation (£'000s) - £430,544 **Spend** (£'000s) - £437,687

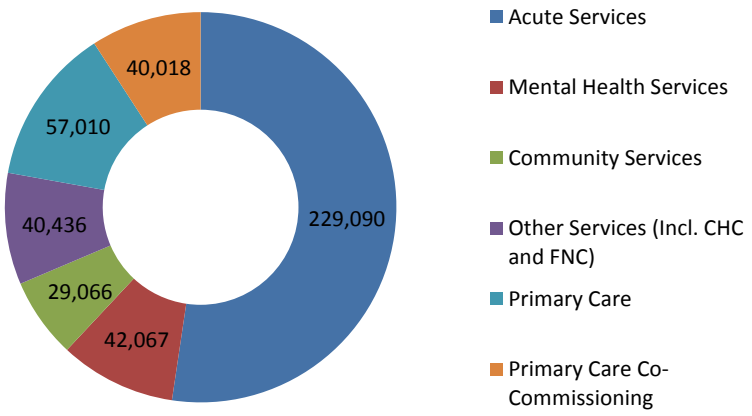


Fig 2 Analysis of the CCG's programme costs 2015-16

1.3.3.7 Analysis of the Running Costs expenditure

Allocation **(£'000s) - £7,602** Spend **(£'000s) - £6,754**

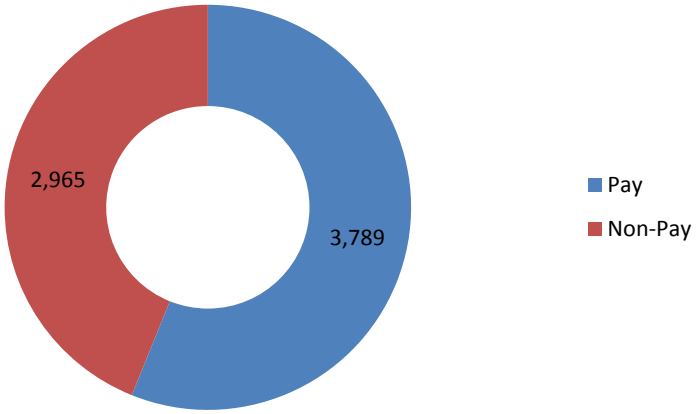


Fig 3 Analysis of the CCG's running costs 2015-16

1.3.3.8 Underlying recurrent position

Excluding the effect of all non-recurrent elements in this year's position, the CCG actually has a significantly poorer financial position with an underlying recurrent deficit of £13.56m moving into 2016-17.

Additionally, there are a number of factors that may further affect the financial position during 2016-17.

Acute services - contract overtrade

The CCG has made a number of growth and activity assumptions that it considers reasonable and has built these into the financial plan for 2016-17. There is a risk though that activity exceeds this or unplanned issues arise in-year. The submitted financial plan as at April 2016 identified a risk of less than 1% of contract value between the main provider's assessment of growth and activity assumptions and the CCG's.

Mental health – Increased costs in 2016-17

The current contract with the new provider of mental health services runs from the 1 October 2015 for five years with the option to extend for a further two. This provides an increased level of certainty as to the costs of the service throughout 2016-17 and beyond as the tender was awarded based on the contract price offered subject to the national inflation impact.

However, further assessment of specific out of contract costs following the move to new provider and updated responsible commissioner guidance is still on-going with potential deterioration in expected costs for 2016-17 onwards.

Quality, Improvement, Performance and Productivity – under delivery

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

QIPP included in plan is £12.2m, initial identification of potential schemes is £11.6m, but all are subject to further development with various degrees of risk ratings with £6.2m rated as red, £2.9m as amber and £2.5m green. The remaining £0.6m is currently unidentified and also therefore classed as red.

Primary Care investment

The CCG recognises that in order to transform the local health and social care economy there will need to be investment within primary care, but this can only be achieved by releasing savings from elsewhere within the health system. The financial plan for 2016-17 is premised on this principle and a key strand of this potential investment is at risk if the providers do not generate savings to offset potential investment of up to £355k.

Better Care Fund contribution

The CCG will contribute the required amount to the three funds it is part of across three local authority areas. This is currently premised on passing over the minimum contribution only to the respective local authorities and there is currently some debate as to whether this does or does not include funding for the Care Act, which may increase costs by up to £197k.

1.3.4 Statement of going concern

The CCG's accounts have been prepared on a going concern basis despite a letter from the CCG's external auditors, Mazars, on 22 January 2016, which was a report to the Secretary of State for Health under Section 30 of the Local Audit & Accountability Act 2014 for the anticipated or actual breach of financial duties.

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 be going concerns where the continuation of the provision of services in the future 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 by itself or another public sector entity.

1.3.5 Data Quality

The quality of data available to the CCG has continued to improve during 2015-16, following a detailed plan of work that took place in 2014-15.

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

Work is also under way to compare the functions of the CCG's existing systems, with the aim of ensuring that data is held in the most appropriate location and form to reduce duplication and encourage accuracy and consistency

The CCG has continued with its close monitoring of the performance of Yorkshire and Humber Commissioning Support (CS), managing potential risks linked to data quality and taking immediate remedial action when required.

1.3.6 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 as follows:

- A programme of staff training in recognising and reporting safeguarding issues is in place with refreshed and approved policies for the CCG and for Primary Care colleagues in year
- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements with quarterly safeguarding reports as part of those arrangements
- Appropriate arrangements are in place to co-operate with local authorities in the operation of Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs), membership on both Boards by the Chief Nurse 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 in addition to appointing in year to a Lead Nurse for Safeguarding for Primary Care
- Expertise in safeguarding adults and a lead for the Mental Capacity Act, supported by the relevant policies and training shared across North Yorkshire CCGs with a Deputy Role within the CCG.

- 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 year the CCG has undergone self-assessment of the NHSE Safeguarding Assurance Framework for Children in Care where verbal feedback was positive and we continue to make preparation for expected CQC visit in 2016. Internal Audit prepared a review of arrangements in advance of the visit and gave significant assurance.

The CCG also received significant assurance in safeguarding through independent audit facilitation and had approval for its Safeguarding Children Strategic Plan at Governing Body.

We completed the section 11 assurance template for our North Yorkshire and City of York Councils and attended the section 11 challenge event in March 2016.

In addition we jointly produced, with local authority and health partners, the Children in Care benchmarking template with associated action plan. This was benchmarked against statutory guidance which was issued in March 2015.

1.4 Patient Experience

One of the key challenges facing commissioners is how to intelligently analyse the wealth of information available from hard and soft intelligence so that it leads to real improvements in patient experience and care. The CCG is committed to ensuring that this information and the patient voice it represents is firmly embedded in all our commissioning activities and the decisions we make, in order to improve the quality of patient care within Vale of York. In 2015-16 the CCG:

- Assessed experience of care by considering elements that matter most to patients such as access, consistency and coordination of care, getting the right information at the right time, being treated with respect and dignity, being listened to, participating in decisions and involvement of family and friends (DH, National Patient Experience Framework, 2011).
- Used patient experience to monitor and assure the quality of services provided.
- Used the intelligence obtained from our patient's experiences of care to inform our business planning, service redesign and procurement decisions
- Looked at themes and trends from patient complaints, concerns and queries to understand where quality improvement is required or where best practice needs to be shared.
- When we recognised poor patient experience, promptly respond to this, supporting providers to make a difference and a real improvement to the quality of patient care and patient experience.

In year the CCG has introduced an electronic soft intelligence tool (YoRInsight) available to primary care and care homes – this enables a mechanism to report issues

and areas of good practice and then be able to subsequently triangulate this information with other intelligence to inform and improve services.

Due to the decommissioning of the CS the CCG in-housed both patient complaints and Patient Advice and Liaison Service (PALs) and has reviewed and implemented new structures to support this.

The CCG awarded its mental health service contract to TEWV which took over from the previous provider LYPFT in October 2015. In September 2015 the CQC took the decision that Bootham Park Hospital (the facility for mental health acute inpatient services, outpatient services, section 136 suite and ECT suite) was not fit for purpose and subsequently could not register TEWV to provide services from that location. Subsequently patients were required to move very quickly to other locations, some out of area. This resulted in a patients and families in the Vale of York seeking answers to the events surrounding the closure, a potential judicial review and extensive media interest. The CCG has cooperated fully with an external, independent lessons learnt review which is due to be published in April 2016.

Friends and Family Test

The way in which the Friends and Family Test (FFT) is measured changed on 1 April 2015. Satisfaction is now being measured by the percentage of patients reporting that they were satisfied with their care (a change from the net promoter score that was used in 2014-15).

Through contractual arrangements with our commissioned services, we monitor the results of the FFT and the actions taken based on patient feedback. We have supported the introduction of FFT in primary care and continue to support the Patient Participation Groups (PPGs).

In line with the national picture it has been challenging for our providers to increase response rates, particularly in ED. Comparison to previous year is difficult as the denominator changed at the start of the year and more services were included in the initiative. Maternity services consistently reported good FFT scores.

Patient Involvement in Commissioning

Engagement plans for projects and initiatives will be assured through the CCG's Programme Delivery Steering Group (a sub-group of the Governing Body's Finance and Quality Committee) to ensure that they meet the needs of local populations. Engagement activity as part of commissioning processes and on-going organisational priority setting and development, will be assured through a tiered prioritisation process. This process will be linked to a reconfiguration matrix as outlined in the CCG's Involving Local Communities engagement strategy (available online).

All engagement plans will be assured through an internal process to be agreed with the Programme Delivery Steering Group. Engagement plans linked to significant service change will be assured directly by the Programme Delivery Steering Group, low-level

impact service change will be assessed and assured through an internal engagement oversight process.

In partnership with the three local authorities, the CCG and health providers will be engaging with local communities as part of a broad based communications and engagement conversation with local people around health and social care priorities. This work will form an essential aspect of the workplan of the local Integrated Transformation Board in shaping and directing commissioning intentions and decisions across the CCG's footprint.
The form of the engagement has yet to be finalised; the CCG will ensure that it engages with a broad base of local communities across the urban, rural and semi-rural populations that it covers. The CCG is committed to ensure that this, and all of its engagement activities, will:

- Give a bigger voice to local people
- Provide an understanding of local need
- Lead to improved, more responsive services
- Improve patient outcomes
- Develop public understanding of health priorities and pressures
- Increase the range of local people engaging with the CCG: Economically; Culturally; Geographically; and Across age ranges

The CCG is working with member practices to create a Patient Group Network with representatives of member practice's PPGs. In addition new mechanisms will be developed to allow the CCG the opportunity to explore practical opportunities to:

- Use pre-existing online resources e.g. MumsNet, PatientsLikeMe
- Broaden use of social media
- Establish online Focus Groups
- Liaise with student populations through links to local Student Unions
- Implement SMS based surveys
- Access major local employers
- Commission social research

1.5 Sustainability Report

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

- Meet the health needs of the local community;
- Provide value for money;
- Are environmentally sound.

To support its ambitions, the CCG has developed and implemented a Sustainability Development Management Plan, available on the CCG website at: http://www.valeofyorkccg.nhs.uk/about-us/delivering-sustainability/ . The plan addresses nine key objectives, which are:

- Governance;
- Travel;
- Procurement;
- Facilities management;
- Workforce;
- Community engagement;
- Buildings;
- Adaptation;
- Models of care.

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

1.5.1 Achievements to date

Over the past 12 months, the CCG's programme to integrate care has gathered pace with service and financial sustainability at the core of the three integration pilots, which aim to test whole system approaches with increased community based support.

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

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

1.5.2 Commissioning intentions for sustainability

In 2015-16 the CCG continued to mandate the use of sustainability assessments for all commissioning projects to ensure that sustainability considerations were included as an integral part of the commissioning process.

1.5.3 Policies supporting sustainability

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

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

1.5.4 Working with our commissioned services

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

1.5.5 Working with health and wellbeing boards

There is widespread agreement across the Vale of York geography that current models of health and social care are not financially sustainable in their current form. During 2015-16 our pilot sites will have tested different approaches leading to an improved understanding of the different care models required to meet the needs of the population well into the future. By bringing care closer to the point of use through establishing care hubs in the community, travel is likely to be reduced, thus reducing carbon emissions. In addition, the York Health and Wellbeing Board is considering the principles of One Planet Living, i.e. using only the resources of one planet rather than three, which is the current situation.

1.5.6 Travel

The CCG plays an active role in encouraging the use of remote communication in place of face to face meetings, and has access to a range of remote working and teleconferencing facilities. The CCG supports opportunities for telephone, web and videoconferencing to reduce the need for travel and will promote other initiatives to reduce car usage e.g. active travel. The CCG is based at West Offices in York, a City of York Council facility with good public transport links and cycle facilities.

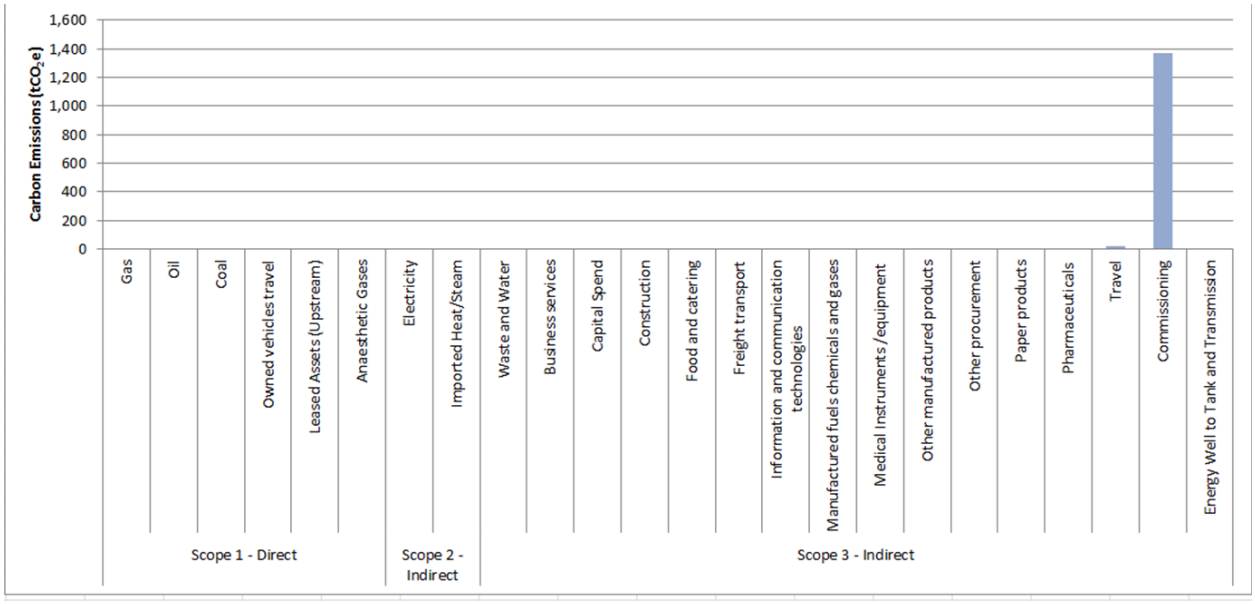


Fig 4 Calculation of the CCG's carbon footprint using the Sustainability Development Unit model and Treasury Scopes

1.5.7 Procurement

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

1.6 Equalities

1.6.1 Health Inequalities

People within the Vale of York have good health overall, and life expectancy at birth is 80.6 for men and 83.8 for women, which are both above the national average. However, life expectancy varies for men and women considerably across this area. The life expectancy gap at birth in York is 7.4 years for males and 5.8 years for females. In Hambleton it is 4.3 years for males and 2.9 years for females. In Selby 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 our approach to service

development. There is well documented evidence of the link between poverty and health inequality, and 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 the rate is significantly higher (70%) compared to the national average (65%). Selby district has a higher proportion portion of children who have excess weight in Reception (23.2%) or Year 6 (33.7%) than in any other district in North Yorkshire and above the national average (Reception - 22.5%, Year 6 – 33.5%).

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.

Although the Vale of York population has a registered prevalence of stroke similar to the England average (2.0%), 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 is 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 the diabetes patients to help prevent hospital admission.

The rate of admission for alcohol-related cancer conditions is also higher in NHS Vale of York CCG 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 & 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 Vale, Coast and Humber 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 other most common co-morbidity was gastro-intestinal 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.

1.6.2 Equality and Diversity

The CCG works to promote equality throughout the planning and development of service commissioning; whilst appreciating and respecting the diversity of our local community and staff.

This year, the equalities strategy has been updated and refreshed to take into account changes in legislation including the Accessible Information Standard, which becomes mandatory from 1 April 2016, and the Workforce Racial Equality Strategy (WRES). The strategy supports our 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's equality objectives are:

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

Objective 1 (Information) – achievements

The CCG's Communications strategy specifically addresses accessible communications and the range of different needs that must be considered by commissioners when communicating with the public and commissioning services. This year we have successfully implemented Browsealoud onto the CCG website to improve access for people with a variety of visual impairments, as well as encouraging GP practices to consider how to make their communications more accessible.

We have worked with our online referral system team to ensure that online referrals take into account the Accessible Information Standard.

Objective 1 (Information) – areas for development

Review current translation and interpreting arrangements in light of changes to commissioning support arrangements.

Objective 2 (Use of Equality Data) - achievements

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

The CCG's Equality Lead works with JSNA teams and public health leads to ensure that insight can be shared more widely with the CCG about health needs and population data, networks can be developed and CCG specific issues and challenges with data can be shared.

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

Objective 2 (Use of Equality Data) - areas for development

Collecting equality data from providers, while improving, still has some inconsistencies. The national data set does not include protected characteristics apart from age and gender, although the mandated collection of sexual orientation data by HSCIC should in future years provide better information. We have agreed with our main providers how to capture disability data and are working jointly to fill in current gaps in data.

Build on the relationships with the Equality and Diversity officers of the main provider organisations to work together to make progress on this objective. The aim is to have sufficiently robust data to meaningfully inform the equality analysis.

Objective 3 (Strengthen stakeholder engagement) - achievements

The Equality Lead has worked collaboratively with equality and diversity leads from York Trust, Scarborough and Ryedale CCG and from TEWV to assess and set goals for the Equality Delivery System 2 (EDS2), with a workshop being held in February 2016. A range of stakeholders participated in the assessment and grading of each organisation, including representatives across most of the protected characteristics. Through the EDS2 process new joint objectives have been identified, which include the development of a directory of local services, further information sharing, increased representation from groups with protected characteristics and additional communications about the EDS process

Healthwatch is part of the CCG's public and patient engagement group and there is regular communication with the CCG. The CCG also receives and responds to Healthwatch reports which deal with health service access issues.

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

Objective 3 (Strengthen stakeholder engagement) - areas for development

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

Objective 4 (Be a Great Employer) – achievements

Following the staff survey, analysis of survey data highlighted that additional investigation into employment opportunities and support for people with disabilities would be required, as this is an under-represented area.

A series of staff engagement activities have been arranged, with a Staff Engagement Week held before Christmas, which provided a wide range of opportunities to provide feedback on current issues.

Objective 4 (Be a Great Employer - areas for development

The WRES is now mandated in the NHS Standard Contract for 2015-16. The Equality Lead will work alongside our contracting team and with our major providers to ensure they have plans in place to meet the standard, aiming for the workforce to be more representative of the population it serves. Further details on the WRES can be found on the CCG website at: http://www.valeofyorkccg.nhs.uk/about-us/equality/

Additional work to become a "Mindful Employer", a form of accreditation for employers who have developed an understanding of how mental health issues affect their employees, and are prepared to provide practical support both to managers and staff to de-stigmatise mental ill-health.

Objective 5 (Ensure Leadership in Equalities) - achievements

The Equality Strategy has been fully endorsed by the Governing Body who oversee equalities delivery.

Joint working with the local authority public health teams is making progress, with work on prevention of some of the major factors of health inequality under way.

Equality and diversity has been embedded into the systems and processes of the CCG.

Objective 5 (Ensure Leadership in Equalities) - areas for development

The CCG's 5 year strategic plan sets clear outcomes and trajectories for improvement in health indicators. Public Health England has been developing a suite of health equity information for use by equalities practitioners.

Further work needs to be undertaken to use available data, including engagement findings, and establishing whether there are any particular groups that experience inequalities particularly relating to their protected characteristic.

1.6.3 Conclusion

This has been a year of consolidation of progress against the original goals, with further advances made in staff engagement and in accessible communications.

Equality Impact Analyses continue to form a key component of commissioning activity, and in particular there has been widespread patient/public engagement in the current procurement exercise for wheelchairs and equipment. The CCG will continue to focus on coaching staff to ensure that equality analysis is an integral part of service improvement and contract management.

Collaboration with local authorities and our major providers is critical. We have made progress this year towards improving the collection of and analysis of equality data whilst working towards joint objectives that will make the most effective use of resources.

1.6.4 Gender breakdown of the Governing Body as at 1 April 2016

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

1.6.5 Gender breakdown of our senior managers

Gender	Male	Female	Transgender
	4 (44.4%)	5 (55.6%)	0

1.6.6 Equalities breakdown of our staff

Total Workforce	86
Gender	
Male	29 (33.72%
Female	57 (66.28%
Ethnicity	
White	72 (83.72%)
BME	11 (12.79%)
Not Stated	3 (3.49%)
Disability	
No	74 (83.72%)
Undefined	6 (6.98%)
Not Declared	5 (5.81%)
Yes	1 (1.15%)

1.7 Emergency Preparedness, Resilience and Response

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

The CCG is a designated Category 2 Responder under the CCA 2004 and its main role in the event of a declared incident, is to support Category 1 responders. The CCG on-Call Director was fully involved in supporting the Gold Command Team from NHSE and the Environment Agency during the flooding which affected the City of York and parts of North Yorkshire over the Christmas period in 2015.

On Saturday, 26 December 2015 the River Wharfe burst its banks and flooded parts of Tadcaster, including the GP surgery and Health Centre. Staff and volunteers worked throughout the weekend to clear the GP surgery and staff were able to operate a reception and dispensing service for patients when it re-opened on Tuesday, 28 December 2015. The GP surgery has extensive internal structural damage and will take 6-12 months to repair. The collapse of the bridge over the River Wharfe has led to further additional changes in community-based services.

On Sunday, 27 December 2016 the Environment Agency made the decision to release the flood gate on the River Foss resulting in approximately 600 homes in the centre of York being flooded. A rest centre was set up at Archbishop Holgate School and the GP out of hours service provided medication and repeat prescriptions for people who had to be evacuated. IT and phone networks at the Trust were also affected by the flooding at the BT sub-station in York and at the Vodafone station in Leeds. At one point there was only a single BT line available into York Hospital which made communications very difficult.

However, none of the GP surgeries in the City of York were affected by the flooding and opened as normal on Tuesday, 29 December 2016.

The CCG operated a 24/7 On-Call Director throughout this period and a 'lessons learnt' session was held on Tuesday, 5 January 2016 to capture the learning and update emergency planning processes following the flooding. The CCG also attended the NHSE flooding de-brief on 12 February 2016 to share feedback and lessons learnt from the flooding over Christmas with colleagues across Yorkshire & the Humber.

I certify that the CCG has incident response plans in place which are fully compliant with the NHS England Core Standards for EPRR and have been fully tested during 2015-16.

1.8 Contribution to Health and Wellbeing Strategy

The CCG, as a member of the York Health and Wellbeing Board, has taken the lead on delivery of the mental health priority of the joint health and wellbeing strategy. A member of the CCG is Chair of the Mental Health and Learning Disabilities Partnership Board, a sub-board of the York Health and Wellbeing Board.

Among the achievements contributing towards the mental health priority in 2015-16 are:

Re-procurement of Mental Health and Learning Disability Services - The re-procurement of mental health and learning disability services for the city is now complete and the contract awarded to TEWV commenced in October 2015. The contract term is for five years (with the potential to extend for up to a further two years).

The specifications for the contract were developed with partners after a series of in-depth discussions with local service users, members of the community, voluntary sector and clinicians through DISCOVER!. This was an extensive engagement programme to collect the views of people from across the footprint of the CCG to help develop high quality mental health and learning disability services.

Learning Disabilities – The Board have worked towards ensuring that learning disabilities work is included within their work programme and now has two meetings focused around learning disabilities per year.

Crisis Response Services - North Yorkshire Police, other emergency services and partner agencies have worked really well with the local health based place of safety,

street triage and psychiatric liaison functions - demonstrably improving outcomes for service users.

Pathways Together – This collaborative project is working with an identified group of service users with multiple needs and complex demands on a range of agencies to address their issues in a structured, person centred manner. This project has also tackled some of the issues related to information sharing.

Mental Health Directory - Partners worked closely with Healthwatch York on the development of the local support services directory which was well received.

Children & Young People - A nationally driven 'Futures in Mind' programme has been established in York which will provide school based specialist mental health support workers to support early intervention and identification.

Signature of Accountable Officer

Helen Hirst
Interim Accountable Officer
NHS Vale of York CCG
Dated: 26 May 2016

SECTION 2 - Accountability Report

2.1 Members' Report

The CCG represents 29 practices in the Vale of York area.

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

Practice	Website
Beech Grove Medical Practice	www.beechgrovemedicalpractice.co.uk
Beech Tree Surgery	www.beechtreesurgery.co.uk
Clifton Medical Practice	www.cliftonhealthcentre.co.uk
Dalton Terrace Surgery	www.daltonterracesurgery.nhs.uk
East Parade Surgery	www.eastparademedical.co.uk
Elvington Medical Practice	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
Petergate Surgery	www.petergatesurgery.co.uk
Pickering Medical Practice	www.pickeringmedicalpractice.co.uk
Pocklington Group Practice	www.pocklingtongps.nhs.uk
Posterngate Surgery	www.posterngatesurgery.nhs.uk
Priory Medical Group	www.priorymedical.com
Scott Road Medical Centre	www.scottroad.org.uk

Sherburn Group Practice	www.sherburnsurgery.nhs.uk
South Milford Surgery	www.southmilfordsurgery.co.uk
Stillington Surgery	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

Meeting attendances

Key:
m = male, f = female.

Y = Attended
A = Apologies
N = Neither attended nor sent apologies
PM = Practice Manager represented Practice / attended with member

Practice	21 May	23 July	17 Sept	15 Oct	19 Nov	17 Dec	21 Jan	25 Feb	24 Mar
Beech Grove Medical Practice	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	A	A
Beech Tree Surgery	Y(m)	Y(m)	Y(m)	Y(f) and PM(m)	Y(m) and PM(m)	Y(m)	Y(m)	Y(m)	PM(m)
Clifton Medical Practice	A	A	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)
Dalton Terrace Surgery	Y(m)	Y(m)	Y(f) and PM(m)	Y(m)	Y(m)	Y(m)	Y(m)	PM(m)	A
East Parade Medical Practice	N	N	N	A	A	Y(m)	N	N	A
Elvington Medical Practice	N	Y(f)	Y(m) and PM(m)	Y(m) and PM(m)	Y(m)	Y(m) and PM(m)	Y(m) and PM(m)	Y(m)	Y(m)
Escrick Surgery	Y(f)	Y(f)	Y(f)	Y(f) and PM(f)	Y(f)	PM(f)	Y(f)	Y(f)	PM(f)
Front Street Surgery	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(m)
Haxby Group Practice	Y(m)	Y(m)	Y(f) and PM(f)	Y(m)	A	Y(m)x2	Y(m)	Y(m)x2	Y(m)

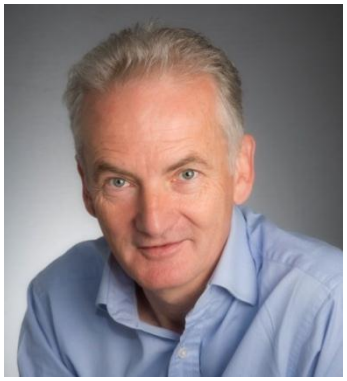
Helmsley and Terrington Surgeries	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Jorvik Gillygate Practice	Y(m)	A	Y(m)	Y(m)	Y(m)	A	Y(m)	Y(m)	Y(m)
Kirbymoorside Surgery	Y(m)	A	Y(m)	Y(m)x2	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Millfield Surgery	Y(f)	Y(m)	Y(f) and PM(m)	Y(f) and PM(m)	Y(f) and PM (m)	Y(f)	Y(m) and PM(m)	Y(f) and PM(m)	Y(f) and PM(m)
MyHealth	Y(m) and PM(f)	Y(m)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m)	Y(m)	Y(m) and PM(f)	Y(m)	Y(m)
Old School Medical Practice	Y(m)	Y(m)	PM(m)	Y(m) and PM(m)	Y(m) and PM(m)	PM(m)	Y(m)	PM(m)	A
Petergate Surgery	A	A	Y(f)	Y(f)	Y(f)	Y(f)	A	Y(f)	A
Pickering Medical Practice	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Pocklington Group Practice	A	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	A
Posterngate Surgery	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)	Y(m)
Priory Medical Group	Y(f)	Y(f)	Y(f) and PM(m)	Y(f) and PM(m)	Y(f) and PM(m)	Y(f)	Y(f)	Y(f)	Y(f)
Scott Road Medical Centre	Y(f)	Y(f)	Y(f)	Y(f) and PM(m)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)
Sherburn Practice	Y(f)	Y(m)	Y(m)	Y(m) and PM(f)	Y(m) and PM(f)	PM(f)	Y(m) and PM(f)	Y(m)	Y(m)
South Milford Surgery	Y(f)	N	PM(f)	Y(f) and PM(f)	Y(f)	Y(f)	PM(f)	A	N
Stillington Surgery	Y(m)	N	Y(m)	Y(m)	Y(f) and PM(f)	PM(f)	Y(m)	Y(m)	Y(m)
Tadcaster Medical Centre	Y(m)	Y(m)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m)	Y(m)	Y(m)	Y(m)
Tollerton Surgery	Y(m)	Y(f)	Y(f)	Y(f) and PM(f)	Y(f)	Y(f) and PM(f)	Y(f) and PM(f)	Y(f)	PM(f)
Unity Health	PM(f)	Y(m) and PM(f)	Y(f) and PM(f)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m) and PM(f)	Y(m) and PM(f)	PM(f)
York Medical Group	Y(f)	Y(m)	Y(f)	Yx2 (f)(m)	Y(f)	Y(f)	Y(f)	Y(f)	Y(f)

The work of the CCG is led by the Governing Body, and the members of the Governing Body as at 31 March 2016 are set out below:

Keith Ramsay,

Governing Body Lay Chair

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



Dr Mark Hayes,

Chief Clinical Officer

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

Helen Hirst

Interim Accountable Officer

From 25 April 2016, Helen is Interim Accountable Officer of the CCG. Helen is also Accountable Officer of Bradford City and Bradford Districts CCGs. Prior to this she was programme director for primary care with the Department of Health/NHS Commissioning Board Authority. Previously, Helen also worked in a part-time capacity for NHS England as director of CCG development. From 2006 to 2010 Helen was deputy chief executive and director of primary care at NHS Bradford & Airedale and has worked in the NHS in Bradford since 1992.

Dr Andrew Phillips,

GP Member and Interim Deputy Chief Clinical Officer

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

Rachel Potts,

Chief Operating Officer

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

Tracey Preece,

Chief Finance Officer

Tracey joined the CCG as Chief Finance Officer in November 2013. She has almost 17 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.

Michelle Carrington,

Chief Nurse

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

Dr Tim Maycock,

GP Member

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

Dr Shaun O'Connell,

GP Member

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

Dr Louise Barker,

GP Member

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

Dr Emma Broughton,

GP Member

Emma 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.

David Booker,

Lay Member, Chair of the Quality and Finance Committee and Deputy Chair of the Audit 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 and Chair of the Quality and Finance Committee, David helps to ensure the CCG is efficient and responsive and listens to the views of local stakeholders.

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.

Sheenagh Powell

Lay member and Chair of 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.

In attendance

Dr John Lethem
Local Medical Committee(LMC) Liaison Officer

John 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.

In attendance

Louise Johnston

Practice Manager representative

Louise is Managing Partner at Unity Health in York. She is an experienced and innovative leader who has previously worked in the education sector. Louise was voted into her CCG Governing Body role by GP Practice Managers in the Vale of York, acting as their representative and giving them a voice. Her role is to engage with Practice Managers and support their professional development whilst increasing recognition of the importance of the Practice Manager role.

In attendance

Sharon Stoltz

Interim Director of Public Health, CYC

Sharon is the Interim 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.

In attendance

Siân Balsom,

Lay Member Healthwatch York

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

In addition, the following were members or in attendance during the year:
Kersten England (to 30 April 2015)
Dr. Guy Porter (to 30 September 2015).
Richard Webb (to 31 August 2015)
Guy van Dichele (1 May 2015 to 6 August 2015)
Michael Ash-McMahon (to 20 April 2015)

Declarations of Interest Report (Governing Body)

Name	Interest Declared	Date Completed/Last reviewed
Dr Andrew Phillips GP Clinical Lead for Unplanned Care	No longer locum with York Medical Group as of 01.04.16 Employed with YDUC OOH service in contract with SRCCG, Lead Clinician for YDUC OOH Contract for the CCG.	05.04.16
David Booker Lay Member and Chair of the Quality and Finance Committee	No interests to declare	07.04.16
Dr Paula Evans Council of Representatives Chair	Profit sharing GP Partner of York Medical Group, a member of the CAVA alliance of practices, and also participate in research through the Primary Care Clinical Research Network, including commercial studies. (Self) from Nov 1997 Director and Material shareholder of Acomb Medical LTD	11.04.16

Name	Interest Declared	Date Completed/Last reviewed
	(pharmacy) member of the CAVA federation (Self) from Dec 2012. Additional work with Out of Hours HDFT (10 Hours/month). YHHEE GP training (Approx. 6 hours per quarter). (Self)	
Dr Emma Broughton GP Clinical Lead for Children's Services and Women's health	Partner at Priory Medical Group (PMG), a member of the Nimbus alliance of practices, additional responsibilities in member practices including acting Safeguarding lead at Heworth Green Surgery. PMG are part of the regional research network since 01.02.11 (Self) Additional work with Yorkshire Skin Clinic undertaking one surgery per month 01.02.11	12.04.16
John Lethem Governing Body Member Local Medical Committee Liaison Officer	GP Principal Partner of Unity Health York, a member of the Nimbus alliance. Spouse Peggy Lethem is a pharmaceutical Sales representative working for Zambon ProPharma. Local Medical Committee Officer (Medico-Political)	19.11.15
Keith Ramsay Governing Body Lay Chair	Director of Thackary Medical Museum (Self), Jigsaw consultancy LTD (Self & Spouse). ABE UK LTD (Self), Incommunities Ltd (Self). Member of Governance Group, Altogether better (Self).	07.04.16
Dr Louise Barker GP Clinical Lead for Mental Health	A salaried GP of Haxby Group, a member of Nimbus federation that may seek contracts with the CCG. Since Sep 2010. Spouse is a TEWV employee (Spouse) In addition works with an Aesthetic practice 4 hours monthly on average (Self) Since Apr 2014.	07.04.16
Mrs Louise Johnston Practice Manager Representative (Unity Health) Non-voting member	Managing Director, Partner and shareholder at Unity Health Trading Limited which are also a part of a group of practices in receipt of cluster funding from the research network. (Self) Director and shareholder of Nimbuscare Limited. (Self) Involved in establishing the Vale of York Clinical Network which is possibly seeking to enter into contracts with the CCG.	18.04.16

Name	Interest Declared	Date Completed/Last reviewed
Dr Mark Hayes Chief Clinical Officer	No interests to declare	23.03.16
Michelle Carrington Chief Nurse	No interests to declare	08.04.16
Rachael Potts Chief Operating Officer	No Interests to declare	05.04.16
Sharon Stoltz Co-Opted member	Director of SFS (Public Health) Consultancy Ltd. (Self)	08.04.16
Dr Shaun O'Connell GP Prescribing Lead	Employee of South Milford Surgery with interest in South Milford Pharmacy, working one day per week as clinical GP Surgeries, home visits and associated admin (Self). Spouse is an employee of YTHFT (Spouse). Shares in GSK	19.02.16
Sheenagh Powell Lay member and Chair of Audit Committee	Independent member of Harrogate and Rural District CCG audit committee. Short term contract as Financial Consultant to Barnsley CCG. (29.02.16 – 23.05.16) Registered with NHS Interim Management and Support. (From 29.02.16)	19.04.16

Name	Interest Declared	Date Completed/Last reviewed
Siân Balsom Healthwatch	Manager of Healthwatch York (Self) since 02.03.16 Chair of Scarborough and Ryedale carers resource (Self) since 13.01.10 Shareholder Golden Ball Co-Operative Public House (Self and Spouse) since October 2013	15.04.16
Dr Tim Maycock GP Clinical Lead for Primary Care	Director of Beckside developments. Partner at Pocklington Group Practice (pecuniary)	23.02.16
Tracey Preece Chief Finance Officer	Spouse Senior Manager with Ernst & Young LLP since June 2014	05.04.16
Helen Hirst Interim Accountable Officer	Director of Bradford and Airedale Lift Co Chief Accountable Officer of Bradford City CCG and Bradford Districts CCG	25.05.16
Dr Guy Porter Secondary Care Doctor	No interests to declare	02.07.15
Richard Webb Corporate Director, North Yorkshire County Council	Trustee, Association of Directors of Adult Social Services (Self) Darley Consulting – Y&H lead on personal health budgets (Spouse)	06.07.15
Kersten England Chief Executive, City of York Council	Trustee of Nesta (Self) Director of Make It York (Self) Member of Company of Merchant Adventurers (Self)	20.04.15

Name	Interest Declared	Date Completed/Last reviewed
Guy van Dichele Interim Director of Adult Social Care, City of York Council	No interests to declare	19.03.2015
Michael Ash-McMahon Deputy Chief Finance Officer	Spouse is an employee of Priory Medical Group (Spouse)	10.02.16

Signature of Accountable Officer

Helen Hirst
Interim Accountable Officer
NHS Vale of York CCG
Dated: 26 May 2016

2.2 Statement of Accounting Officer's Responsibilities

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG 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 CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

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

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity'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 entity'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

Signature of Accountable Officer

Helen Hirst
Interim Accountable Officer
NHS Vale of York CCG
Dated: 26 May 2016

2.3 Annual Governance Statement

2.3.1 Introduction and Context

The Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2015, the Clinical Commissioning Group was licensed without conditions.

2.3.2 Scope of Responsibility

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

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

2.3.3 Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group and best practice.

For the financial year ended 31 March 2016, and up to the date of signing this statement, the CCG complied with the provisions set out in the Code, and applied the principles of the Code except in areas where the CCG is committed to working towards the UK Corporate Governance Code, as outlined below:

Leadership	The CCG is a membership organisation and is led by the Council of Representatives. This includes a representative from each member practice. The strategic and operational management of the CCG is led by the Governing Body. There is clear division between the Council of Representatives, the Governing Body and the Chief Officers Senior Management Team, with the Governing Body chaired by an independent Lay Chair. The Chair of the Council of Representatives is selected by the Council through a vote. The Governing Body met formally six times during the past 12 months with regular attendance from Governing Body members. The Governing Body includes an independent Chairman and Lay Member for governance, additional Lay member, as well as the Chief Clinical Officer, Chief Operating Officer, Chief Finance Officer,

	Chief Nurse, Secondary Care Doctor, six CCG clinical leads, two Council of Representative members, Director of Public Health, Healthwatch, a Practice Manager and a Local Medical Committee representative. The CCG has been categorised as 'not assured' for the well led domain of the national CCG Assurance Framework following concern from the Council of Representatives in the ability of the CCG management team to improve the financial position following the financial deterioration of the CCG. The CCG implemented an action plan to promote clinical engagement with Council of Representatives. The CCG conducted an independent 'capability and capacity' review in November 2015 to identify areas for improvement and recommendation to be implemented within the Turnaround Action Plan.
Effectiveness	The Governing Body had a broad skill mix, supported by officers within the CCG. The CCG appointed an Audit Committee Chair in April 2015 who commenced from June 2015. All new appointments have a role description and induction from the Chair. The tenure of the Chair and the Lay Member is three years. The Governing Body is supported by an Executive Assistant. The Governing Body members undertook statutory and mandatory training and induction. Performance management arrangements were in place for the Chair, clinical leads and lay members and Chief Officer members. The Constitution was refreshed and approved in October 2015 to provided additional information on roles and responsibilities and procedures for replacing key roles. The CCG developed an induction pack for the Governing Body members in July 2015 to support their roles. The Governing Body undertook a self-assessment in July 2015 and again in March 2016. The CCG has undertaken a review of Organisational Development (OD) during 2015 and the supporting OD Plan is under review as part of the Turnaround Action Plan. The Turnaround Action Plan is under regular review and has been published as part of the public Governing Body papers.
Accountability	The CCG's Audit Committee was chaired by the Lay Member lead for finance and governance, who was appointed in June 2015. The CCG has a series of financial controls in place, including the Prime Financial Policies and Scheme of Delegation set out in the Constitution, the Detailed Financial Policies and the Detailed Scheme of Delegation. The Detailed Financial Policies and Scheme of Delegation were reviewed and updated in 2015-16. The CCG implemented a revised set of financial delegated authority in September 2015 as part of the internal control mechanism as the CCG's financial position deteriorated.

	The Risk Management Framework was in place through 2015-16, with a refresh of the policy in December 2015. The CCG has fully implemented risk software to support the internal control framework. Risk reports are sent to each Quality and Finance Committee and Governing Body and bi-annually to the Audit Committee. However in 2015-16 the CCG was not able to effectively mitigate the financial risks identified resulting in the CCG's deficit position at end 2015-16. The CCG had policies in place regarding conflicts of interest and business conduct, and published the declarations of interest for Governing Body members. The CCG has implemented the Conflicts of Interest Policy effectively and has received an internal audit opinion of Significant Assurance. The CCG's Information Governance Steering Group, reporting into the Audit Committee, has overseen the improvements required to ensure the CCG achieves its governance goals. The CCG instructed internal audit (North Yorkshire Audit Services) and external auditors (Mazars LLP) to report to Audit Committee.
Remuneration	The Remuneration Committee has approved new Terms of Reference in October 2015.
Relations with Stakeholders	The Chairman of the Governing Body was the lead for engagement within the CCG. The CCG reviewed the Engagement Strategy in 2016, with a revised strategy approved in April 2016. The CCG has been actively engaged with three Health and Wellbeing Boards (North Yorkshire, York and East Riding) and had Governing Body representation at each one. The Health and Wellbeing Boards were underpinned by key strategic partnerships, including children's trusts and the Mental Health/Learning Disability Partnership Board, a local delivery board leading on joint commissioning across health and the local authority. The CCG has been working collaboratively with Scarborough and Ryedale and East Riding CCGs, local authorities, and health providers through the Systems Resilience Group (SRG). The Collaborative Improvement Board was refocused and the formal SRG was approved in July 2015 to deliver the Performance Recovery Plan on Constitutional Targets. The CCG worked closely with neighboring CCGs to help plan across the health system and manage collaborative commissioning arrangements. This was managed through the North Yorkshire and Humber CCG Collaboratives. This has included joint work on the re-procurement of the Commissioning Support Services across Yorkshire and Humber and appointment of the new provider, who

	commenced on 1 April 2016. The CCG is scheduling an AGM and annual meeting of the Council of Representatives to be held later in the year (late summer 2016).

2.3.4 The Clinical Commissioning Group Governance Framework

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

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

The Governing Body works to the CCG Constitution to discharge its functions and apply the principles of good governance. The Constitution sets out the roles and responsibilities between the Governing Body and Council of Representatives (the membership body of the CCG).

2.3.4.1 The Constitution

The CCG has set its vision of 'achieving the best health and wellbeing for everyone in our community'. To deliver this vision it is committed to developing a strong, transparent and effective organisation to deliver excellent local commissioning. The CCG's constitution provides the framework for the organisation. It is signed up to by all member practices and is embedded across the organisation. The Constitution was revised in October 2015, to take account of changes to Committees, the Scheme of Delegation in light of delegated commissioning responsibilities and to provide additional detail on the roles and responsibilities of each Governing Body Member.

The Constitution is available on the CCG's website at:
http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/governance/voyccg-constitution-version-4-final-october-15.pdf

The Constitution covers:

- The CCG's geographic area;
- Membership;
- Vision, mission and values;
- Functions and general duties;
- The governing structure (decision-making);
- Roles and responsibilities;
- Standards of business conduct and managing conflicts of interest;
- The CCG as an employer;
- Transparency, ways of working and standing orders.

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

The Constitution sets the framework for decision making through the scheme of delegation, which sets out the split of responsibilities and decision making between the membership body (Council of Representatives), the Governing Body and the committees of the CCG. This was in place for authorisation and has been implemented throughout 2015-16.

During 2015-16 the Council of Representatives has continued to develop and strengthen, with monthly meetings established from December 2015. During 2015-16 the Council of Representatives elected a new chair and are in the process of appointing a new deputy chair.

The Constitution is supported by a range of underpinning documents, which were reviewed and where necessary refreshed through 2015-16. These included the detailed financial policies and the detailed scheme of financial and operational delegation (refreshed in December 2015), Risk Management Strategy (December 2015), Equalities Strategy (January 2016) and Sustainability Management Plan.

2.3.4.2 Governing body and committee structure

The CCG has made amendments to the Committee Structure in 2015-16, with the separation of the 'Part 2' Quality and Finance Committee (Primary Care Commissioning) to a separate meeting. An additional sub-committee of the Quality and Finance Committee, the 'Clinical Research and Effectiveness Committee' was approved in May 2015. The CCG has bi-monthly formal Governing Body meetings, alternating formal meetings with Governing Body workshops, monthly Quality and Finance Committee meetings, quarterly Audit Committee meetings, quarterly Primary Care Commissioning Committee meetings and ad-hoc Remuneration Committee meetings. The Senior Management Team continues to meet weekly and has been reviewed to increase clinical membership from two Clinical Leads and the Chief Officers, to five Clinical Leads and the Chief Officers.

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

management of financial risk and controls from the PCU as a result of the 2015-16 financial position.

The CCG works collaboratively across the Health and Care system through the System Resilience Group. The System Resilience Group is supported by the Urgent Care Working Group and Planned Care Working Group, focussed on a return to NHS Constitution performance. The System Resilience Group approved a performance recovery plan in July 2015, which resulted in a return or improvement towards NHS Constitution performance for planned care, cancer and diagnostics. This was revised in March 2016 to maintain focus on Urgent Care recovery and implementation of the Emergency Care Improvement Programme recommendations.

The CCG has worked with local system partners to establish the System Leaders Board in 2015-16. This comprises the Accountable Officers and Chief Executives of the CCG, NHS Scarborough and Ryedale CCG, York Trust, TEWV, City of York Council and North Yorkshire County Council to oversee system recovery on performance and finance across the geographical areas of the two CCGs. The Board provides oversight and challenge for operational resilience through the SRG and transformational plans through the Vale of York Integration and Transformation Board. The System Leaders' Group established in February 2016 provides the local feed into the Humber, Coast and Vale Sustainability and Transformation Footprint, established in spring 2016.

2.3.4.3 Committee Structure

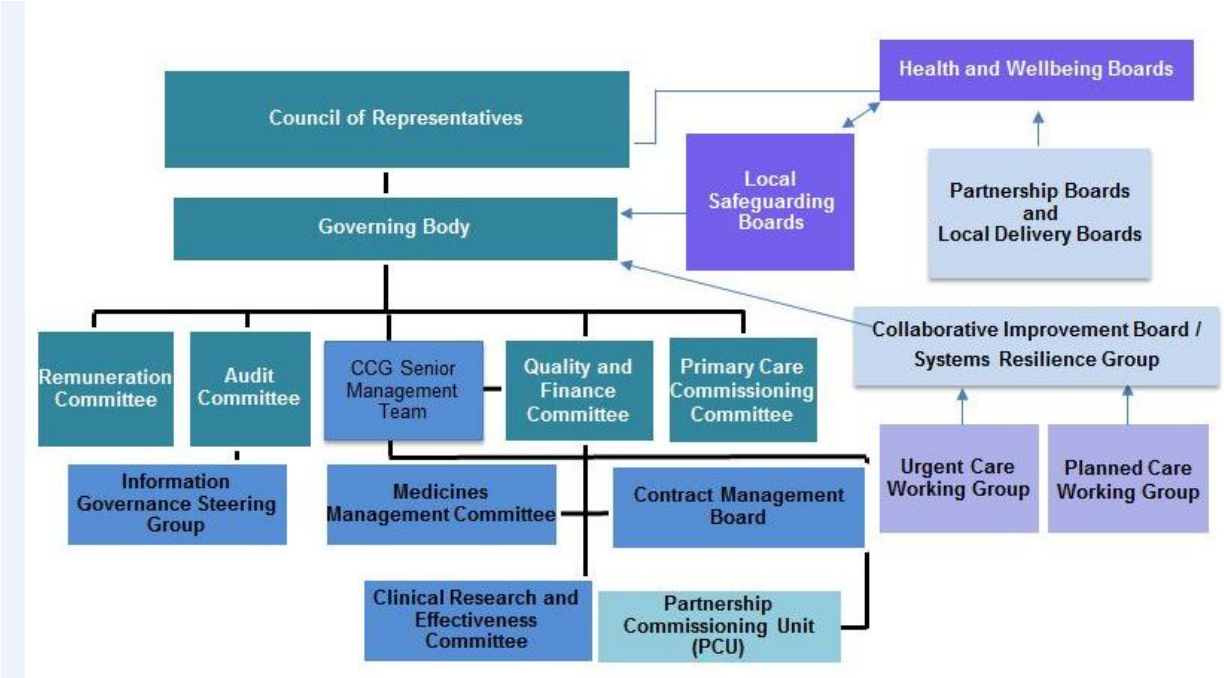


Fig 5 - The CCG's Committee Structure

2.3.4.4 Governing Body meetings

The Governing Body met six times in public and was quorate on each occasion. Additionally six workshop sessions were held when discussion included the CCG's strategic and financial planning, patient and public engagement, integration and new models of care including presentations from the three integration pilots, risk management and conflicts of interest, Governing Body self-assessment against maturity matrix, briefing on the role of external audit, financial turnaround and the Sustainability and Transformation Plan.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Mr Keith Ramsay	CCG Chair	6/6
Mr Michael Ash-McMahon To 20 April	Interim Chief Finance Officer	1/1
Dr Louise Barker	GP Member	6/6
Mr David Booker	Lay Member, Quality and Finance Committee Chair	5/6
Dr Emma Broughton	GP Member	5/6
Mrs Michelle Carrington	Chief Nurse	6/6
Dr Paula Evans	GP, Council of Representatives Member	5/6
Dr Mark Hayes	Chief Clinical Officer	4/6
Dr Tim Maycock	GP Member	5/6
Dr Shaun O'Connell	GP Member	2/6
Dr Andrew Phillips	GP Member	5/6
Dr Guy Porter To 30 September	Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member	1/3
Mrs Rachel Potts	Chief Operating Officer	5/6
Mrs Sheenagh Powell From 1 June 2015	Lay Member and Audit Committee Chair	5/5
Mrs Tracey Preece From 20 April 2015	Chief Finance Officer	4/5 (Representative attended 1)
Attendees		
Miss Siân Balsom	Manager, Healthwatch York	6/6
Mr Guy van Dichele 1 May to 6 August	Interim Director Adult Social Care, City of York Council	2/2
Ms Kersten England To 30 April	Chief Executive, City of York Council	0/1
Mrs Louise Johnston	Practice Manager Representative	6/6
Dr John Lethem	Local Medical Committee Liaison Officer, Selby and York	6/6
Mrs Sharon Stoltz From 1 September	Interim Director of Public Health, City of York Council	1/3
Mr Richard Webb To 31 August	Corporate Director, Health and Adult Services, North Yorkshire County Council	1/3 (Representative attended 2)

The table above covers the period from 1 April 2015 to 31 March 2016. From 25 April 2016 the Interim Accountable Officer, Helen Hirst, attended Governing Body meetings.

2.3.4.5 Committee attendances

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

Committee	Role and performance highlights
Strategic Committees	
Audit Committee	Chaired by the Lay Member with the lead role in governance and conflict of interest, the Audit Committee has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and security management, and financial reporting. The Committee met five times in 2015-16 and was quorate on each occasion. There is a schedule of preceding private meetings of members with internal and/or external audit. The terms of reference were revised in October 2015. Membership April to October: Sheenagh Powell (Committee Chair), Lay Member with the lead role in governance from 1 June David Booker, Lay Member and Chair of Quality and Finance Committee Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member, to 30 September Dr Shaun O'Connell, GP Governing Body Member, to 31 August Dr Tim Maycock, GP Governing Body Member, from 1 September Membership October to March: Sheenagh Powell (Committee Chair), Lay Member with the lead role in governance David Booker, Lay Member and Chair of Quality and Finance Committee Dr Tim Maycock, GP Governing Body Member Performance/Highlights: • Review of terms of reference and work plan • Regular updates on Detailed Financial Policies and Procedures and Scheme of Delegation • Receiving 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 • Receiving regular assurance on clinical governance processes • Review of Assurance Framework and Risk Register processes • Review of Information Governance Assurance • Regular updates on Counter Fraud • Review of Commissioning Support Unit assurance • Review of Partnership Commissioning Unit assurance • Review of Committee effectiveness through Chair's self-assessment

Committee	Role and performance highlights
	and members' and attendees' self-assessment • Review of Internal Audit and Counter Fraud effectiveness • Review of External Audit effectiveness
Remuneration Committee	Chaired by the CCG Chairman, the Remuneration Committee has delegated authority from the Governing Body to determine pay and remuneration for employees of the CCG including development pay, the use of Recruitment and Retention Premiums, annual salary awards where applicable, allowances under any pension scheme it might establish as an alternative to the NHS pension scheme, severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money', and receipt and review of new policies and instructions relating to remuneration. The Committee met five times in 2015-16 and was quorate on each occasion. Members: Keith Ramsay, CCG and Remuneration Committee Chair David Booker, Lay Member and Chair of Quality and Finance Committee Sheenagh Powell, Lay Member with the lead role in governance and Audit Committee Chair, from 1 June Performance / highlights: • Review of Committee terms of reference • Consideration of Living Wage Employer • Revision to Chief Clinical Officer's hours • Review of Senior Leadership Team remuneration • Consideration of Clinical Leadership Strategy
Quality and Finance Committee	Chaired by a Lay Member of the Governing Body the Quality and Finance Committee met 11 times and was quorate on each occasion. The overall objectives of the Quality and Finance Committee are to ensure that the CCG has strong contractual and quality performance, clinically appropriate and safe services, and to ensure that this is delivered within the financial plan. Where the Committee deems necessary, matters of concern would be escalated to the Governing Body. The terms of reference were reviewed in December 2015 when the Primary Care Commissioning Committee was established as separate from the Quality and Finance Committee. Members: David Booker (Committee Chair), Lay Member Michael Ash-McMahon, Interim Chief Finance Officer to 20 April and Deputy Chief Finance Officer thereafter Fiona Bell, Deputy Chief Operating Officer/Innovation Lead Michelle Carrington, Chief Nurse Dr Mark Hayes, Chief Clinical Officer Dr Tim Maycock, Governing Body GP, Clinical Lead for Primary Care

Committee	Role and performance highlights
	Dr Shaun O'Connell, Governing Body GP, Clinical Lead for Planned Care and Prescribing Dr Andrew Phillips, Governing Body GP, Clinical Lead for Urgent Care/Interim Deputy Chief Clinical Officer Dr Guy Porter, Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member (Chair for one meeting) to 30 September Rachel Potts, Chief Operating Officer Tracey Preece, Chief Finance Officer, from 20 April Paul Howatson, Senior Innovation and Improvement Manager, attends each meeting and a representative of NHS England Assurance and Delivery Team is invited. The CCG Chair and Audit Committee Chair are invited to attend when procurement is an agenda item. Performance / highlights: • Monthly detailed consideration of the Integrated Quality and Performance Exception Report and the Finance, Activity and Quality, Improvement, Performance and Productivity Report (renamed the Financial Performance Report in October) • Regular Safeguarding reports • Monthly Corporate Risk Register update • Procurement reports • Revised terms of reference following full delegation of primary (medical) care co-commissioning • Infection Control Annual Report • CCG Strategic Estates Plan The February Committee focused on consideration of the Turnaround Work Plan and the Operational Plan and, following review of agenda planning, a new format agenda was introduced at the March meeting to focus on the financial recovery plan and provide assurance on the priority to deliver.
Primary Care Commissioning Committee	Established as the Part II Quality and Finance Committee the Primary Care Co-Commissioning Committee met in public on one occasion in its original format. Following review by the Quality and Finance Committee and subsequent approval by the Governing Body, the primary care co-commissioning function was separated from that of the Quality and Finance Committee. The Primary Care Commissioning Committee was established as a committee of the Governing Body with the Governing Body Chairman as its Chair. It met in public on one occasion. The meetings were both quorate. Membership to February and unless otherwise stated from the CCG: David Booker (Committee Chair), Lay Member Michael Ash-McMahon, Interim Chief Finance Officer to 20 April and Deputy Chief Finance Officer thereafter Fiona Bell, Deputy Chief Operating Officer/Innovation Lead Dr Emma Broughton, Governing Body GP, Clinical Lead for Women and

Committee	Role and performance highlights
	Children and Joint Clinical Lead for Primary Care Michelle Carrington, Chief Nurse Dr Mark Hayes, Chief Clinical Officer Dr Tim Maycock, Governing Body GP, Clinical Lead for Primary Care Dr Shaun O'Connell, Governing Body GP, Clinical Lead for Planned Care and Prescribing Dr Andrew Phillips, Governing Body GP, Clinical Lead for Urgent Care/Interim Deputy Chief Clinical Officer Constance Pillar, Assistant Head of Primary Care, NHS England – North (Yorkshire and Humber) Rachel Potts, Chief Operating Officer Tracey Preece, Chief Finance Officer, from 20 April In Attendance (Non Voting): Holly Bainbridge, Lay Member, Healthwatch North Yorkshire Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York Shaun Macey, Senior Innovation and Improvement Manager Philippa Press, Health Improvement Manager – Health Inequalities, City of York Council on behalf of Sharon Stoltz, Interim Director of Public Health, City of York Council Performance / highlights: • GP Practice boundary changes • Primary Medical Services uplift • Primary Care Infrastructure Fund • Primary Care Update from NHS England North Membership from February and unless otherwise stated from the CCG: Keith Ramsay, CCG Chair and Committee Chair Michael Ash-McMahon, Interim Chief Finance Officer to 20 April and Deputy Chief Finance Officer thereafter Fiona Bell, Deputy Chief Operating Officer/Innovation Lead Dr Lorraine Boyd, GP, Council of Representatives Member Dr Emma Broughton, Governing Body GP, Clinical Lead for Women and Children and Joint Clinical Lead for Primary Care Michelle Carrington, Chief Nurse Dr Mark Hayes, Chief Clinical Officer Dr Tim Maycock, Governing Body GP, Clinical Lead for Primary Care Dr Shaun O'Connell, Governing Body GP, Clinical Lead for Planned Care and Prescribing Dr Andrew Phillips, Governing Body GP, Clinical Lead for Urgent Care/Interim Deputy Chief Clinical Officer Constance Pillar, Assistant Head of Primary Care, NHS England – North (Yorkshire and Humber) Rachel Potts, Chief Operating Officer Sheenagh Powell, Lay member and Audit Committee Chair Tracey Preece, Chief Finance Officer, from 20 April Vacant, GP Council of Representatives Member Vacant, Secondary Care Doctor (Vice-Chair)

Committee	Role and performance highlights
	In Attendance (Non-Voting): Mrs Kathleen Briers, Healthwatch Representative Dr John Lethem, Local Medical Committee Liaison Officer, Selby and York Shaun Macey, Senior Innovation and Improvement Manager Sharon Stoltz, Interim Director of Public Health, City of York Council Performance / highlights: • Update on Primary Care Delivery Group • York Medical Group Merger • NHS Vale of York CCG Interim Estates Strategy and Primary Care Transformation Fund • Personal Medical Services Update • Primary Care Update from NHS England North • City of York Sexual Health Services

Remuneration Committee

Name	Role	Membership from	Attendance
Mr Keith Ramsay	CCG and Remuneration Committee Chair	April 2015	5/5
David Booker	Lay Member and Chair of Quality and Finance Committee	April 2015	5/5
Sheenagh Powell	Lay Member with a lead role in governance and Audit Committee Chair	June 2015	4/4

Non Remuneration Committee member attendances

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

Mrs Amanda Wilcock, Director of Human Resources and Organisational Development, Yorkshire and Humber Commissioning Support, attended four meetings of the Remuneration Committee in the capacity of external advisor;

Miss Kerry Ryan, HR Business Partner for Yorkshire and Humber Commissioning Support, attended three meetings – in addition to Amanda Wilcock on one occasion and in addition to Janet Thacker on one occasion (in the capacity of external advisor).

Mrs Janet Thacker, Head of Workforce for Yorkshire and Humber Commissioning Support, attended two meetings – in addition to Amanda Wilcock on one occasion and in addition to Kerry Ryan on one occasion (in the capacity of external advisor).

Mrs Wilcock, Miss Ryan and Mrs Thacker also provided a range of general HR advice to the CCG during the 2015-16 financial year. They were employed by Yorkshire and Humber Commissioning Support 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 Yorkshire and Humber Commissioning Support through the Service Level Agreement (SLA).

Dr Mark Hayes attended one meeting for a specific item and Mrs Rachel Potts attended a single item meeting.

2.3.4.6 The Performance of the Governing Body, including their own assessment of their effectiveness.

The Governing Body has undertaken two self-assessments in 2015-16 and was involved in an independent Capability and Capacity review in November 2015. The Governing Body uses the national CCG Maturity Matrix to self-assess performance and inform the work-plan for the Governing Body. This was conducted in the July 2015 Governing Body Workshop. The primary outcome of the self-assessment was to improve engagement with the wider clinical community and Council of Representatives. The CCG implemented a Council of Representatives Action Plan to improve clinical engagement and input.

Following the first self-assessment, the financial position of the CCG deteriorated. The Governing Body received financial reports at each meeting and the papers of the Governing Body can be found at: http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/

The Governing Body also considered the financial position in Part 2 meetings in September, November, December, January and February.

Following the continued deterioration of the financial position in October, an independent review of the Capacity and Capability of the CCG was undertaken. The report can be found at: http://www.valeofyorkccg.nhs.uk/current-work/facing-financial-challenges-and-transforming-services/

The Capacity and Capability Review recommended that the Governing Body provided further challenge on the financial plan and associated risks and mitigations. The report noted that the meetings were effective and well-administered. The report recommended the refresh of the Organisational Development (OD) plan, including succession planning for the CCG and additional independent challenge. A turnaround action plan was put in place. This will be complete in spring 2016.

The self-assessment in March 2016 was conducted against the key lines of enquiry in the ‘well-led’ domain of the CCG Assurance Framework to inform the self-assessment submission. The Governing Body self-assessment their performance as offering ‘limited assurance’ and identified the improvements made in year to communicate the vision and focus on financial recovery. Areas for improvement in 2016-17 included the implementation of OD reforms, review of performance appraisal processes for Governing Body members and consideration of the forward plan to give sufficient time to debate within Governing Body workshops.

2.3.5 The Clinical Commissioning Group Risk Management Framework

2.3.5.1 The CCG's Risk Management Framework

The CCG has an agreed Risk Management Strategy, which was refreshed in December 2015. The update to the strategy reflected:

- implementation of a Covalent Steering Group with responsibility for developing risk management operational processes;
- clarification of the risk escalation process; and
- updates to committee names and job titles.

The strategy sets out our definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management. The Risk Management Strategy/Policy is published on the CCG's website: http://www.valeofyorkccg.nhs.uk/publications/policies/

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

The Board Assurance Framework developed in 2014-15 was revised in summer 2015 to take account of the revised national CCG Assurance Framework and was approved by Governing Body in June 2015.

The CCG Assurance Framework: Critical Success Factors June 2015 onwards

- Well led organisation with the skills and capacity to deliver statutory functions
- Effective Clinical and quality assurance improving the quality and safety of commissioned services
- Resilient health care system, improving health outcomes for the local population
- Financial sustainability supported by effective financial management
- Transforming local healthcare services

All risks were aligned to the revised critical success factors, with significant corporate risks reported to Governing Body at each session.

2.3.5.2 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

All corporate risks are assigned a risk lead at Director level and a risk owner who will monitor 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 management. Risk briefings have been presented to the senior management team and risk reports are presented monthly to the Quality and Finance Committee, (sub-committee of the Governing Body) bi-monthly to the Audit Committee, (sub-committee of the Governing Body) and quarterly to Governing Body.

In addition to the on-going review of risks, of which many are on-going relating to the financial and performance positions of the CCG, the CCG has implemented a 'horizon scanning' process across the CCG to identify emerging risks and opportunities for the CCG. This is reviewed fortnightly by the Senior Management Team and action taken as appropriate. The Chief Clinical Officer report to the Governing Body provides a forum for future risks to be reported and signalled to the Governing Body. The future risks to the CCG include achievement of the planned efficiencies and delivery of the Financial Plan. New significant ("red") risks have been reported to Governing Body as a result of Turnaround, including financial governance processes, planning for 2016-17 to meet

NHS England requirements and cost pressures from the CS transition. Actions are being developed in response to the planning risk." These risks are being closely monitored.

A copy of the risk report presented to the March 2016 Governing Body is provided at Appendix A.

2.3.5.3 Risk Reduction

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

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

The CCG had 8 counter fraud days in its plan for 2015-16 allocated in accordance with the generic counter fraud areas of action as noted below:

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

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

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

Stakeholder Engagement

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

The engagement and involvement of patients, partners and other stakeholders is intrinsic to the commissioning and procurement of services. This work is led by the Deputy Chief Operating Officer who has the Senior Management Team responsibility for engagement and the Lay Chair who is the Governing Body lead for this work. The CCG has approved the appointment of an Engagement Officer, following the in-housing of the engagement function from the Yorkshire and Humber Commissioning Support Service in November 2015. The CCG has embedded a culture of stakeholder involvement and engagement in all roles, with every staff member being part of the process.

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

2.3.5.4 Capacity to Handle Risk

The CCG's approach to risk management is outlined in its Constitution and documented in the CCG Risk Management Policy and Strategy which was reviewed during 2015-16, (final approval pending). The Risk Management Policy/Strategy is published on the CCG's website.

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

- Project/Programme Risks
- Team Risk
- Corporate Risks

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

The CCG has implemented clear roles and responsibilities in relation to risk management as detailed in the CCG's Risk Management Policy and Strategy. The CCG has accepted that during 2015-16, the risk mitigations reported against financial risk were not sufficient to control the risk. To address this, the CCG has revised the structure of financial risk assessment and reporting. The risk reports have also been amended to include mitigation actions at Governing Body for red risks and additional

training for the CCG on risk in scheduled for spring 2016. The CCG has also revised the process for reviewing and challenging project risk, including procurements, ensuring a member of the corporate team is included on programme boards to challenge and champion risk identification and mitigation.

Risk is a standing item on the Quality and Finance Committee agenda with a significant risk report being received at each meeting.

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

The CCG considered the organisational risk appetite at the Governing Body workshop in July 2015 and the Governing Body were satisfied with the escalation and scoring framework in place.

Risk Roles and Responsibilities

The CCG Governing Body

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

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

The Chief Operating Officer

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

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

Senior Managers

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

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

Head of Corporate Assurance and Strategy

The Head of Corporate Assurance and Strategy has responsibility for:

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

All staff

All staff working for the CCG are responsible for:

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

The CCG has implemented the Covalent system to support the consistent assessment, monitoring and management of risk. All teams have a designated Covalent risk lead.

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

See Appendix A for an example of the risk reporting format.

2.3.5.5 Current Significant Risks and Mitigations

The CCG's current significant risks can be found in the Governing Body meeting papers at: http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/

The risks of greatest financial significance reported to the April 2016 meeting were:

- Failure to deliver QIPP Plans
- Main providers overtrading
- Prescribing overspend
- Better Care Fund

http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/7-march-2016/item-7-risk-report-april-16.pdf

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

The CCG has significant and realised risks in relation to performance against NHS Constitution targets, including A&E waiting times, Ambulance response times Ambulance Turn-around times and Healthcare Acquired Infections. The CCG has proactively managed these risks through the establishment of the multi-agency Urgent Care and Planned Care system resilience groups and the implementation of the System Resilience Group performance recovery plan. Urgent care performance remains a high risk in 2016-17. Mitigation actions include the revised SRG performance recovery plan, the introduction of a new model of triage (Emergency Department Front Door) and implementation of the ECIP priorities. Controls include the York Teaching Hospital NHS Foundation Trust Contract management board and Quality and Performance contract management board sub-group and the SRG.

Internal Control

See section 2.3.6. The CCG has maintained the systems and process in place in the previous year during 2015-16 and enhanced the reporting mechanisms, achieving significant assurance opinions on area including Risk, Conflicts of Interest, Training and Development, Information Governance.

There are significant risks to the CCG's licence due to the CCG being classified as an organisation in Turnaround and the financial forecast for 2016-17. The CCG has identified a significant risk to developing a credible plan for 2016-17. The CCG is working to mitigate the risks as follows:

- Implementation of the System performance recovery plan under the System Resilience Group, which has seen a return to NHS Constitutional performance for 18 week waits, diagnostic and cancer targets.
- Engagement in the Emergency Care Improvement Programme (ECIP) for Urgent Care

- Implementation of temporary controls to the detailed scheme of delegation
- Capability and Capacity review and associated Turnaround Action Plan
- Additional senior support capacity
- Increased internal capacity within the finance team
- Refresh of all financial risks
- Confirm and challenge on QIPP schemes and confidence ratings on delivery
- Alignment of incentives (e.g. CQUIN) to programmes critical to the delivery of the financial recovery plan
- Council of Representatives action plan and re-establishment of clinical network 'artist' groups
- Review of Project Management Office (PMO) documentation and processes to better identify project risk and slippage
- Review of Partnership Commissioning Unit processes and financial reporting to the CCG
- Review of governance arrangements and Governing Body annual work plan
- Refresh of the Organisational Development Plan for the Governing Body and Clinical Team
- Staff engagement group and implementation of the staff engagement action plan
- Extended quarterly meetings of the Quality and Finance Committee in 2016-17 to provide an in-depth review of quality issues.

2.3.6 The CCG's Internal Control Framework

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

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

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

The CCG has continued the system for internal control including arrangements for internal audit, external audit and counter fraud support during 2015-16. Underpinning the Prime Financial Policies, the CCG has detailed financial policies and a supporting detailed scheme of delegation. The detailed scheme of delegation is aligned to the CCG

financial systems to ensure appropriate level approvals. The CCG has implemented an annual review of the detailed financial policies and detailed scheme of delegation. The financial system the CCG operates is kept up to date in line with these documents. This is then subject to internal audit for which, as part of its financial governance review, the CCG received a high level of assurance.

However, the risk and control mechanisms have not prevented the CCG from classification of 'Not Assured' under the 2015-16 NHS England CCG Assurance Framework in respect of a failure to meet the constitutional targets, financial risk and year end position and the failure to effectively mitigate the financial risk.

In addition the response to the identified need for greater engagement with the clinical members (identified in July 2015 through the Governing Body self-assessment) was not sufficient to mitigate the concern from the Council of Representatives on the ability of the CCG management team to deliver the financial plan in September 2015. The collective impact of this and the financial risk and impact, performance challenges has been to move the CCG into an organisation in 'Turnaround'. The CCG is in a process of reviewing its internal controls for 2016-17 to take account of the issues experienced in 2015-16.

Assurance framework

The CCG Assurance Framework was refreshed during 2015-16, with the risks assessed against critical success factors for the organisation from April 2015 - June 2015:

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

The CCG corporate risk register reported on risks to the following critical success factors from June 2015 onwards, with all existing risks re-aligned and refreshed.

Critical factor	
1	Well led organisation with the skills and capacity to deliver statutory functions
2	Effective Clinical and quality assurance improving the quality and safety of commissioned services
3	Resilient health care system, improving health outcomes for the local population
4	Financial sustainability supported by effective financial management
5	Transforming local healthcare services

Internal Controls to support the Board Assurance Framework during 2015-16

Assurance Framework Domain (Internal)	Controls
Well led organisation with the skills and capacity to deliver statutory functions	Corporate governance, including the constitution, committees and decision making bodies and associated procedures Internal Audit External Audit Monthly risk review Recruitment processes, induction, including security measures and workforce reporting Information Governance & security and Incident reporting Risk & Programme management system Freedom of Information processes Sustainability and Equalities assessments Conflicts of interest processes Emergency preparedness and business continuity plans Stakeholder engagement processes
Effective clinical and quality assurance improving the quality and safety of commissioned services	As above Serious Incident management Clinical audit Contract Management Board Safeguarding protocols and mandatory training
Resilient health care system, improving health outcomes for the local population	Quality and Finance performance reporting and dashboards System Resilience Groups Contract Management Board System-wide structures and recovery programme
Financial sustainability supported by effective financial management	Internal Audit External Audit Prime Financial Policies Detailed Financial Policies

	Detailed Scheme of Delegation Financial control assessment Annual reports and self-assessment Financial and budgetary management system
Transforming local healthcare services	IVA and Business Case templates and approval process – revised PMO established during 2015-16 Detailed scheme of delegation for managed approval of programmes Procurement strategy and regulations Conflicts of Interest management

Each risk on the Assurance Framework is embedded into the relevant departmental risk register. The risk registers and overall Assurance Framework are reviewed and updated monthly and reported to each Quality and Finance Committee, with the significant risks reported to Governing Body.

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

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

2.3.7 Information Governance

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

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG and other organisations that the CCG adequately discharges its duties.

The CCG's Information Governance Steering Group oversees compliance and delivery of the CCG's Information Governance Toolkit and is accountable to the Audit Committee for discharging this duty. The Audit Committee is responsible for providing the Governing Body with assurance regarding Information Governance systems, including the management of information risk.

The CCG has published a Privacy or Fair Processing Notice on its website http://www.valeofyorkccg.nhs.uk/privacy which informs what personal information the CCG holds and processes, the legal basis for doing so and the purposes. This notice was reviewed within year to ensure its accuracy.

All staff working for the CCG are required to undertake Information Governance training annually. Reminders and updates on information governance good practice and principles were also circulated throughout the year.

Risks to data security are managed by the CCG with advice, support and guidance from externally procured Information Governance and IT specialists provided by Yorkshire and Humber Commissioning Support. Data maps documenting flows of personal data and security arrangements for information assets were formally reviewed in year. The risks were evaluated and where a need to mitigate and/or manage risk was identified, clear plans were included in Information Governance action plans.

2.3.7.1 Incident reporting

The CCG operates an incident reporting system to ensure that incidents are managed in an appropriate way and that lessons are learned. Information security or data protection incidents are reported via the CCG's incident reporting system. All incidents logged are reviewed and investigated and reported to the CCG Audit Committee. If an incident meets the criteria for classification as a "Serious Incident," the CCG's Senior Information Risk Owner (SIRO) and Caldicott Guardian are immediately notified and notification made to external regulator(s), as appropriate. The CCG's risk registers are reviewed and updated as a result of incidents, along with a note of actions to be taken to minimise the chances of occurrence and reduce impact.

The CCG has experienced two information breaches during the year. The assessed level of incident breach was level 1 in both cases and as such did not require reporting

to the Information Commissioner's Office (ICO). A summary of information incidents, as required by Annual Accounts reporting guidance, is provided below.

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

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

2.3.7.2 Access to Information

The CCG also has processes in place for ensuring compliance with the Freedom of Information Act 2000, (FOIA). It has published a Freedom of Information Act Publication Scheme on the CCG's website, http://www.valeofyorkccg.nhs.uk/publications/freedom-of-information-new/

During the period 1 April 2015 to 31 March 2016, the number of requests under the Freedom of Information (FOI) Act 2000 received are detailed in the table below. A small increase (6%) in the number of requests was noted and Section 10, notification of additional days was applied in seven instances in order for the public interest test to be undertaken.

	2015-16
Number of FOI requests processed	260
Percentage of requests responded to within 20 working days	97%
Average number of days taken to respond to an FOI request	16.3

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

2.3.8 Review of Economy, Efficiency and Effectiveness of the Use of Resources

2.3.8.1 2015-16 Financial Performance

During 2015-16 the CCG's overall financial performance was monitored and managed on a regular basis by the Senior Management Team and by a formal committee of the Governing Body at the Quality and Finance Committee. The Governing Body also receives a finance report at each meeting which covers all aspects of financial performance. Monthly briefings and additional reports have been provided in-year to the NHS England regional team due to the deterioration in the CCG's financial position described below.

The CCG began the year planning to maintain the 2014-15 level of surplus at the full 1%. However, the CCG, as with the NHS as a whole, has experienced a range of financial and operational challenges. This has impacted on the organisation's ability to deliver its financial position and in combination with growth in health services over and above that which was planned for has resulted in the CCG reporting a deficit position of £6.3m at the end of 2015-16. This represents a significant deterioration of £10.25m from the planned surplus of £3.95m and means the CCG has failed to deliver this key business rule for the first time since it came into existence three years ago.

Consequently, the CCG is currently classed as an organisation in turnaround as a result of the deterioration in the financial position. A review of the CCG's capability and capacity was completed in December 2015 by PricewaterhouseCoopers (PwC) and this has informed the development of a Turnaround Plan and revised financial plan. Whilst the commitment to the vision set out in 2014 remains there will need to be a focus on in-year financial sustainability in 2016-17 to provide greater assurance of delivery on our mandate within the Constitutional requirements.

The CCG did not overspend its administrative costs (Running costs), as per the business rules, which were underspent by £848k against the administrative cost allocation.

2.3.8.2 Financial Recovery Plan

The CCG has undertaken a refresh of the original five year plan so that it now covers 2016-17 to 2020-21. This includes a detailed refresh of the 2016-17 financial plan, year three of the original five year plan, including an assessment of the underlying, recurrent financial position from 2015-16.. The plan also includes the CCG's firm notified allocations for the first three years, with indicative allocations for the final two in order to allow for longer-term planning. . The plan clearly articulated the scale of the financial

challenge the CCG will face and the fact that the CCG is therefore proposing a four year recovery period before it can fully meet all the business rules on a recurrent basis.

The Financial Recovery Plan is based on the following principles and parameters:

- Plans must be realistic & deliverable
- 3-4% savings per annum maximum
- Outline strategy backed by detailed plans
- No short term measures that result in long term pressure
- Transformational and transactional plans both required
- Multi-year recovery timeframe
- Flexibility on NHS England business rules during recovery period
- Must support & enable the operational plan & vision
- Aim to reduce overall cost in the system & with providers
- Stabilisation leading to financial sustainability
- System focus – work in partnership & with stakeholders
- Accountability for delivery

The recovery plan proposed is based on a substantial level of savings over the required period from a review of all investments, transactional efficiencies and further cost reductions from the BCF and QIPP. It is clear that, even with this, there will be further deterioration in the overall financial position in 2016-17 and that considerable financial risks remain in the coming year for the CCG. Both NHS England and the Governing Body have considered this plan and due to the proposed deficit in 2016-17 have not yet assured this plan, although there is recognition of the need for a longer term recovery period.

2.3.8.3 2015-16 Savings Performance

The QIPP target in the 2015-16 Financial Plan was £12.4m with a further £7.1m of savings from the BCF. With regards to the QIPP savings, £9.9m was always unidentified, with a series of contingencies proposed to bridge this gap. However, due to the in-year pressure that arose, these contingencies were instead used to offset this increased cost and could not be used to close the unidentified QIPP gap to the level anticipated. The CCG did deliver £1.8m of QIPP savings against the identified QIPP plans of £2.5m with a further £3.8m saved against the BCF plans to deliver £7.1m.

As outlined above there remains significant risk in the delivery of recurrent savings in order to meet the CCG's part of the national £22bn funding gap outlined in the 'Five Year Forward View published in October 2014. The CCG is responding to this challenge by focussing on transformational change and the collaborative working across the primary, secondary, social and voluntary sector care in order to deliver this.

2.3.8.4 Finance Team Capacity and Capability

Following the recommendations outlined in the PwC report the CCG has temporarily increased the finance and contracting team resource with a six month secondment for a senior finance manager, previously the Deputy Chief finance Officer at NHS Barnsley CCG. During the year an additional Contract Analyst post has been filled on a permanent basis following a successful internal secondment.

2.3.8.5 Commissioning Support

The CCG commissioned a range of support services from Yorkshire and Humber Commissioning Support during 2015-16 and these included:

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

The Yorkshire and Humber Commissioning Support Service closed on the 31 March 2016. The CCG has been working collaboratively with NHS England and the other 22 CCG's across Yorkshire and Humber on a joint procurement for commissioning support services coordinated by NHS England. The CCG conducted an assessment of all commissioned services and brought the following functions in-house:

- Communications and Engagement (from November 2015)
- Corporate Services (from November 2015)
- Service Improvement (From November 2015)
- Referral Support Service (From 1 February 2016)

The CCG is working under shared arrangements with local CCGs on joint services including:

- Medicines Management
- Quality and clinical services
- Research
- Legal
- Specialist Commissioning Networks

The CCG has procured the following services to commence from 1 April 2016.

- Procurement (non-LPF)
- Information Technology and Information Governance (provider: eMBED)
- Business Intelligence (provider: eMBED)
- HR and Workforce support (provider: eMBED)
- Individual Funding Requests (provider: NECS)

2.3.8.6 Better Care Fund

The BCF is a joint initiative between health and local authority services, to integrate health and social care systems, and pooling funds to facilitate this. In 2015-16 this was formally enacted with each of the three local authorities under Section 75 of the Health Care Act 2006. All parties to these agreements contribute to a pooled commissioning budget which is overseen by the relevant Health and Wellbeing Board (HWB). This has strengthened the already effective partnerships the CCG enjoys across the three local authority boundaries the CCG covers in the City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council.

The pooled budget arrangements for each HWB are as follows:

HWB	Host	Pooled Budget £m	NHS Vale of York CCG contribution £m
City of York	NHS Vale of York CCG	12.1	11.2
North Yorkshire	North Yorkshire County Council	46.7	6.9
East Riding of Yorkshire	East Riding of Yorkshire County Council	22.5	1.3
Total		**81.3**	**19.4**

In 2015-16 the pooled budgets funded a number of major new initiatives throughout the year:

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

In 2015-16 the total spent on these schemes across all three BCFs was £3.1m.

2.3.8.7 Primary Care Co-commissioning

The CCG took on delegated responsibility for primary care commissioning in April 2015. Originally established as the Part II Quality and Finance Committee, the Primary Care Co-Commissioning Committee met in public on one occasion in its original format. Following review by the Quality and Finance Committee and subsequent approval by the Governing Body in February 2016, the primary care co-commissioning function was separated from that of the Quality and Finance Committee. The Primary Care Commissioning Committee was established as a committee of the Governing Body with the Governing Body Chairman as its Chair. The committee has met in public in this format on one occasion during 2015-16.

2.3.9 Feedback from Delegation Chains regarding Business, Use of Resources and Responses to Risk

On the 1 April 2015 and in accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England delegated the exercise of certain specified primary care commissioning functions to the CCG. This included the transfer of budgets totalling £40.5m with a corresponding increase in the CCG's overall allocation. The NHS England primary care team retained responsibility for the processing of payments in relation to these budgets, but the CCG accounted for them within its financial position.

The CCG established a Primary Care Commissioning Committee to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act as follows:

- GMS, PMS and APMS contracts
- Newly designed enhanced services
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Approving practice mergers
- Making decisions on "discretionary" payments

The CCG has established the CCG Primary Care Commissioning Committee to function as the corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers. The Committee is a delegated committee of the CCG's Governing Body.

The CCG spent £40m against the allocated budget, an under-spend of £488k, which largely relates to the 0.5% contingency amount that was provided for and a number of smaller underspends in-year.

2.3.10 Review of the Effectiveness of Governance, Risk Management & Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

2.3.10.1 Capacity to Handle Risk

The CCG has reviewed and refreshed the Risk Management Framework and Strategy during 2015-16, including a review of risk thresholds and appetite at the Governing Body workshop in July 2015. In November 2015 the independent Capacity and Capability review recognised the systems and processes the CCG has implemented, but recommended more pro-active responses to emerging risk and a review of mitigating actions to manage financial risks, due to the high risk environment.

Risk reporting was enhanced during 2015-16 with reports to each Governing Body and a review of all team risks at the Senior Management Team. A session on risk and governance was held with the Council of Representatives in January 2015.

The roles and responsibilities in relation to risk management are articulated in the Risk Management Strategy, and staff have been trained on the risk management system. There is a need for additional risk training to ensure effective mitigations are implemented across the CCG. The CCG has established the Covalent Steering Group, comprising representatives from each team to oversee risk procedures and implementation to ensure there is consistency in risk recording and reporting. The CCG continually seeks to learn from best practice and has adopted the recommendations of the Capacity and Capability review through the Turnaround Action Plan.

2.3.10.2 Review of Effectiveness

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and Quality

and Finance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Internal controls are subject to review and have been included in the Internal Audit Plan for 2015-16, with significant assurance opinions provided for Information Governance, Primary Care Co-Commissioning delegation arrangements, Conflicts of Interest, Risk Management and Training and Development.

The terms of reference for each Committee have been reviewed and refreshed during 2015-16, as well as the Constitution to ensure governance arrangements are compliant with the latest recommendations and are effective. The Audit Committee and Governing Body have carried out self-assessments of their effectiveness and compliance with terms of reference. Recommendations from the Capacity and Capacity review in respect of the Quality and Finance Committee have been implemented. Improvements have included the additional Lay and Clinical involvement in Audit Committee, reconfiguration of the Quality and Finance Committee Part 2 (Primary Care Commissioning) and improvements in agenda setting to allow sufficient time for consideration of the financial position.

2.3.10.3 Head of Internal Audit Opinion

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

FINAL 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 2016

Roles and responsibilities

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

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. As such, it is one component that the CCG 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 CCG 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:

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

- An assessment of the range of individual opinions arising from risk-based audit assignments, contained within 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.

Current Financial Position

The CCG is currently classed as an organisation in turnaround, which is due to the deteriorating financial position during 2015-16. Key factors affecting the CCG's position have been; the implementation of and under-delivery against Better Care Fund (BCF) funded schemes resulting in an over-trade against acute contracts; an underlying gap in the financial plan that plans were not identified to meet; under delivery of QIPP schemes; and weaknesses in the risk management process for ensuring mitigating

actions are in place and deliver the required improvement. The CCG's management team have put in place a financial recovery strategy and turnaround action plan, supported by a refreshed accountability and PMO structure and are being supported by NHS England and an independent team of senior NHS colleagues who are providing peer challenge and guidance.

The design and operation of the Assurance Framework and associated processes

During 2015-16 the CCG arrangements for managing risk and providing assurance to the Governing Body have continued to mature.

The Governing Body has agreed an Assurance Framework which is aligned to strategic objectives and has been reviewed twice this financial year by the Audit Committee.

The Audit Committee reviewed the CCG's Risk Management Strategy in December 2015. The Assurance Framework and Corporate Risk Register are underpinned by a portfolio of team, programme and project risk registers. The consideration of risk is a standing agenda item on committee agendas with risk registers regularly being reviewed. Following progress in 2014-15 in embedding these risk registers this progress has continued in 2015-16. The CCG continues to embed the Covalent system for recording and reporting of risk. An escalation process in Covalent has been agreed to escalate risk to the Corporate Risk Register. The Corporate Risk Register is reviewed by the Governing Body at each meeting. They have received and reviewed the Corporate Risk Register six times during the financial year to date. The Governing Body is well sighted on the risks facing the organisation, including the financial risks identified and which materialised during the year. These risks have been highlighted through the Corporate Risk Register and via the Quality and Finance Committee.

Further work is planned to differentiate risk reporting through the CCG's Committee structure, to clarify links between corporate risks and strategic objectives and to improve the identification and monitoring of mitigating actions.

The CCG has strengthened working links between the Quality and Finance Committee and the Audit Committee through the year and this has been evidenced by the Q&F escalating issues which have resulted in the Audit Committee commissioning Internal Audit work.

Internal Audit undertook a detailed review of the CCG's governance arrangements during 2014-15, which incorporated risk management, assurance and reporting processing and was awarded significant assurance. We made a number of recommendations for further improvement which we have followed up this year.

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

The 2015-16 Internal Audit Operational Plan was approved by the Audit Committee on 11 March 2015. 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 (incorporating assurance and risk management)
- Securing Improvements in Quality
- Commissioning and Contract Management
- 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:

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

An action plan is agreed with management. In order to ensure significant progress is being made in the implementation of agreed actions an Audit Recommendations Status Report is presented to every Audit Committee. An automated recommendation tracking system underpins this process with responsible officers being requested to provide updates on a monthly basis.

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

The following table highlights the work completed during 2015-16.

Audit	**Assurance Level**
Preparation for Primary Care Co-Commissioning	Significant

Safeguarding Children	Significant
Management of Conflicts of Interest	Significant
Quality Improvement	Limited
Better Care Fund	CYC – Limited NYCC – Significant ERoY - Significant
Procurement Governance	Significant
Financial Governance	Significant
Information Governance Toolkit	Significant
Training and Staff Development	Significant
Partnership Commissioning Unit* – Mental Health Act Section 117 Children and Families Act Self Billing Funded Nursing Care Information Governance Toolkit Financial Reporting Processes Continuing Healthcare	 Limited Significant Significant Significant Significant - Core Processes Limited - Forecasting for High Cost CHC Packages Limited

* Note: The Partnership Commissioning Unit (PCU) is a hosted organisation established by the CCGs in North Yorkshire to undertake commissioning activities on behalf of all four organisations. This includes Continuing Health Care, Children Services Commissioning, Mental Health Commissioning and Adult Safeguarding. As part of each internal audit plan a number of audit days are allocated to the audit of systems and controls at the PCU in order to provide assurance to all four CCGS. A detailed audit plan for the PCU for 2015/2016 was agreed to provide assurance in relation to the commissioning activities undertaken on behalf of the CCGs.

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

- The BCF was launched to drive the transformation of local services to ensure that people receive better and more integrated care and support. The audit of BCF arrangements with City of York Council (CYC) found that the governance arrangements in place do not provide an adequate control framework for 2015-16. A signed section 75 agreement is now in place and applicable to 2015-16, however this was only signed in March 2016. There is no Partnership Board to provide scrutiny and strategic direction. Whilst performance monitoring is undertaken at a project level there was no aggregate performance monitoring in place.

- There are established governance arrangements in place to manage and review the quality of service delivered by the CCG's main acute provider

organisation, York Trust. There is also no doubt that provider performance is of high priority at the CCG. Improvements could however be made to ensure the transparency of performance monitoring process. Key to this is ensuring that there is evidence of performance issues being followed through from initiation to resolution and subsequent quality improvement.

- Section 117 (s117) of the Mental Health Act 1983 (MHA) imposes a duty on CCGs and local authorities, in co-operation with relevant voluntary agencies, to provide or arrange for the provision of aftercare services for individuals who have left hospital after ceasing to be detained under ss. 3, 37, 45A, 47 or 48 of the MHA. CCGs must, together with relevant local authorities, arrange for the provision of after care for persons previously detained under the Mental Health Act, at the time that they cease to be detained. Such after care should be provided until the CCGs and local social services authority is satisfied that such services are no longer required.

  The PCU undertakes this management function of behalf of the four North Yorkshire CCGs. The audit found that the arrangements to manage the commissioning of s117 aftercare, including effective partnership working with the relevant local authority, were not sufficient to meet the system objectives. The number of agencies and teams involved in the process makes it complex and requires an effective framework of control and accountability. The audit identified a number of gaps in control. The absence of these controls leads to a number of risks including ineffective utilisation of existing / alternative services leading to demand for additionally funded care and a lack of clarity over what health and social care should pay for resulting in the CCGs potentially funding care that is not health related.

  A detailed action plan has been agreed with the responsible officers at the PCU. Work has commenced on addressing the issues but as at 31 March 2016 these actions were not complete. Consequently, until fully addressed these risks remain.

- The PCU administers Continuing Health Care (CHC) on behalf of the four North Yorkshire and York CCGs. In 2014-15 an audit was conducted of the arrangements in place to meet the standards in the National Framework for CHC. This resulted in a Limited Assurance opinion. A significant amount of work has been undertaken in 2015-16 to address the outstanding issues. In particular, significant progress has been made in addressing the backlog of assessments. It is planned to complete the backlog of assessments by 31 May 2016.

The variability in the care needs of patients that are determined as part of the assessment process has in some months resulted in movements in previously forecast spend. The PCU and the CCGs are to work together to agree how best to reflect high cost packages in the financial forecast.

As was the case with the 2014-15 review, the audit completed in 2015-16 has confirmed that the assessment and decision making processes are compliant with the National Framework but further improvements are required in order to comply with the National Framework, particularly in relation to the reviews of patients. There is an outstanding risk that care provision is not effectively managed resulting in care that is not cost effective or meets the needs of clients. An action plan has been agreed with the PCU to address these issues. A strategy has been agreed with all four North Yorkshire CCGs setting out an approach to fully meet all requirements of the national framework.

During the year, Internal Audit issued the following audit reports which identified governance, risk management and/or control issues which were significant to the organisation:

Quality Improvement

The audit of Quality Improvement found that the CCG had established governance arrangements in place to manage and review the quality of service delivered by the CCG's main acute provider organisation, York Trust. There is also no doubt that provider performance is of high priority at the CCG. Improvements could however be made to ensure the transparency of performance monitoring process. Key to this is ensuring that there is evidence of performance issues being followed through from initiation to resolution and subsequent quality improvement.

The CCG has improved the Quality and Performance sub group tracker to improve transparency and linkages with other groups and committees. All quality elements have picked up in the contract negotiations for 2016-17.

BCF

The BCF was launched to drive the transformation of local services to ensure that people receive better and more integrated care and support. The audit of BCF arrangements with City of York Council found that the governance arrangements in place do not provide an adequate control framework for 2015-16. A signed section 75 agreement is now in place and applicable to 2015-16, however this was only signed in March 2016. There is no Partnership Board to provide scrutiny and strategic direction. Whilst performance monitoring is undertaken at a project level there was no aggregate performance monitoring in place.

The CCG now has a signed section 75 agreement in place with City of York Council covering the 2015-16 financial year.

2.3.10.4 Data quality

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

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

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

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

2.3.10.5 Business critical models

The CCG and its key partner (Yorkshire & the Humber Commissioning Support) recognise the principles as reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery. Current quality assurance systems are in place to manage our business risks including:

- Customer feedback (e.g. Patient Complaints)
- Risk Assessment (including risk registers and an assurance framework)
- Internal and External Audit
- Clinical Leads with clear work portfolios supported by programme officers
- Policy control and schedule of review processes
- Public and Patient Involvement and Engagement
- Third Party Assurance mechanisms

We can confirm that all of these quality assurance processes are used across our business critical areas as appropriate.
The CCG received modelling advice and support from Yorkshire and Humber Commissioning Support that included multi-disciplinary expertise for activity, business intelligence, workforce and service re-design services. The CCG has used national modelling tools, including IHAM modelling, ONS information, national activity profiling

and benchmarking, such as RightCare and Commissioning for Value information, and NHS England local benchmarking.

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

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

The CCG's external business environment

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

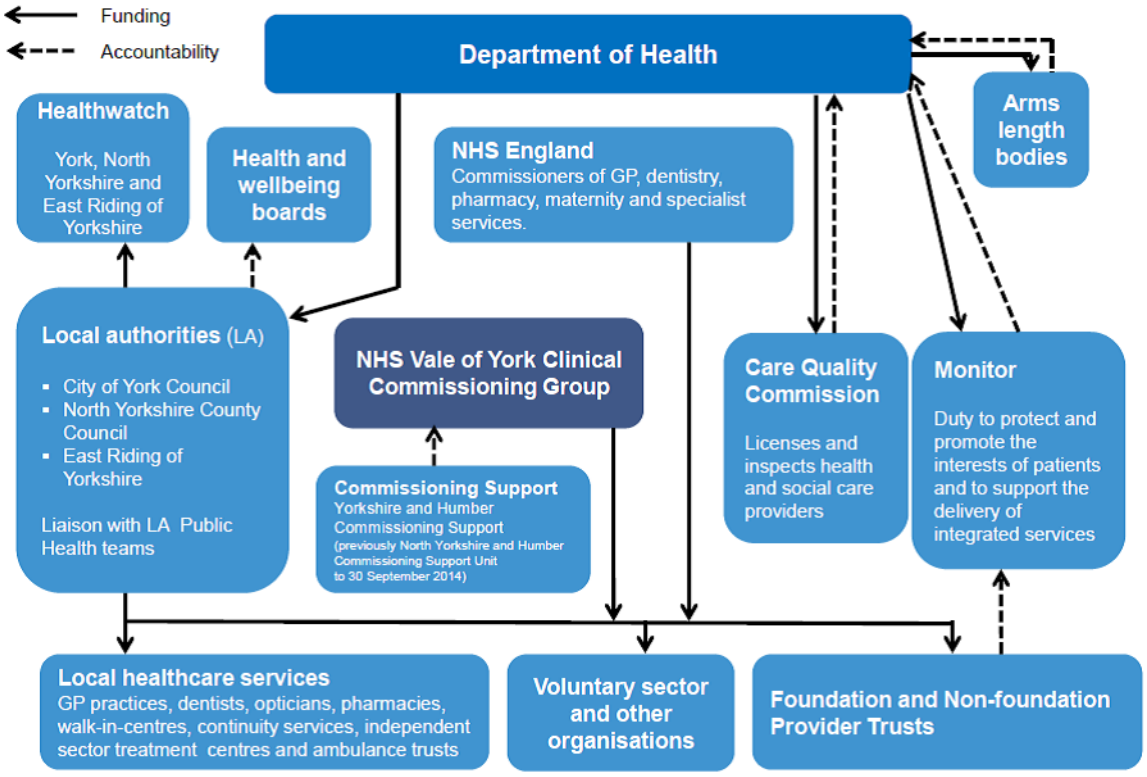


Fig 6 The CCG's external business environment

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

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

- Through contracts with current providers and future contract variations;
- Through enabling patients, when referred to services, to choose from

Any Qualified Provider (AQP) that can provide the service;

- Through tendering for a new or replacement service.

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

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

There was one main acute provider of hospital and community care - York Trust and one main provider of mental health services - LYPFT to 30 September 2015, thereafter TEWV, in the Vale of York area.

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

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

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

Commissioning support

During 2015-16, until 31 March 2016, the CCG was supported by NHS North Yorkshire and Humber Commissioning Support Unit that provided a range of back office functions and clinical policy support to the CCG.

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

2.3.10.6 Data Security

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

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

2.3.10.7 Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the CCG 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 Chief Officer who has confirmed that structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

2.3.10.8 Conclusion

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

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

Signature of Accountable Officer

Helen Hirst
Interim Accountable Officer
NHS Vale of York CCG
Dated: 26 May 2016

2.4 Remuneration and Staff Report

2.4.1 Remuneration Committee Report Summary

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

The Committee met five times in 2015-16, and was quorate on each occasion.

2.4.1.1 Remuneration Committee Highlights

Key work of the Remuneration Committee included:

- Review of Committee terms of reference
- Agreed to implement the principles of the Living Wage across the CCG
- Revision to Chief Clinical Officer's Hours
- Review of Senior Leadership Team remuneration
- Consideration of Clinical Leadership Strategy

2.4.1.2 Details of Membership of Remuneration Committee

Name	Role	Membership from	Attendance
Keith Ramsay	CCG and Remuneration Committee Chair	April 2014	5/5
David Booker	Lay Member and Chair of Quality and Finance Committee	November 2014	5/5
Sheenagh Powell	Lay Member and Chair of Audit Committee	1 June 2015	4/4

2.4.1.3 Non Remuneration Committee Member Attendances

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

Mrs Amanda Wilcock, Director of Human Resources and Organisational Development, Yorkshire and Humber Commissioning Support, attended four meetings of the Remuneration Committee in the capacity of external advisor;

Miss Kerry Ryan, HR Business Partner for Yorkshire and Humber Commissioning Support, attended three meetings – in addition to Amanda Wilcock on one occasion and in addition to Janet Thacker on one occasion (in the capacity of external advisor).

Mrs Janet Thacker, Head of Workforce for Yorkshire and Humber Commissioning Support, attended two meetings – in addition to Amanda Wilcock on one occasion and in addition to Kerry Ryan on one occasion (in the capacity of external advisor).

Mrs Wilcock, Miss Ryan and Mrs Thacker also provided a range of general HR advice to the CCG during the 2015-16 financial year. They were employed by Yorkshire and Humber Commissioning Support 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 Yorkshire and Humber Commissioning Support through the Service Level Agreement (SLA).

Dr Mark Hayes attended one meeting for a specific item and Mrs Rachel Potts attended a single item meeting.

2.4.2 Policy on Remuneration of Senior Managers

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

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

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

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

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.

2.4.3 Senior Managers' Performance Related Pay

There were no Performance Related Pay (PRP) payments made during 2015-16.

2.4.4 Policy on Senior Managers' Contracts

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

2.4.5 Senior Managers' Service Contracts

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

2.4.6 Payments to Senior Managers

There were no payments made to senior managers over and above that contained within section 2.4.7 Salaries and Allowances.

2.4.7 Salaries and Allowances

The tables and narrative provided in this section will be subject to External Audit review that will provide an opinion on these disclosures.

Salaries and allowances 2015-16

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Mr K Ramsay - Chair	15-20				0	15-20
Mrs R Potts - Chief Operating Officer	95-100				2.5-5	95-100
Dr M Hayes - Chief Clinical Officer	90-95				42.5-45	135-140
Mrs T Preece - Chief Finance Officer - see (a)	95-100				17.5-20	115-120
Mr M Ash-McMahon - Interim Chief Finance Officer - see (a)	5-10				0-2.5	5-10
Mrs M Carrington - Chief Nurse	70-75				205-207.5	275-280
Dr S O'Connell - GP Governing Body Member	130-135				20-22.5	150-155
Dr T Maycock - GP Governing Body Member	65-70				12.5-15	80-85
Dr E Broughton - GP Governing Body Member	55-60				0	55-60
Dr A Phillips - GP Governing Body Member	130-135				15-17.5	150-155
Dr L Barker - GP Governing Body Member	65-70				10-12.5	75-80
Mrs S Powell - Lay Member and Audit Committee Chair (from 1 June 2015) - see (b)	5-10				0	5-10
Mr D Booker - Lay Member and Quality and Finance Committee Chair	10-15				0	10-15
Dr P Evans - Council of Representatives Member	5-10				5-7.5	15-20
Dr G Porter - Secondary Care Doctor (to 30 September 2015) - see (c)	5-10				0	5-10
Mrs L Johnston - Practice Manager Representative (Co-opted)	5-10				0	5-10
Miss S Balsom - Manager, Healthwatch York (Co-opted)	0				0	0
Dr J Lethem - Local Medical Committee Liaison Officer, Selby and York (Co-opted)	0				0	0
Ms K England - Chief Executive, City of York Council (Co-opted) (to 30 April)	0				0	0
Mr G van Dichele - Interim Director of Adult Services, City of York Council (Co-opted) (from 1 May to 6 August 2015)	0				0	0
Mrs S Stoltz - Interim Director of Public Health, City of York Council (Co-opted) (from 1 September 2015)	0				0	0
Mr R Webb - North Yorkshire County Council (Co-opted) (to 31 August 2015)	0				0	0

NB all senior managers are continuing except where stated.
(a) Mrs T Preece returned from maternity leave on 20 April, and the Chief Finance Officer role was covered by Mr M Ash-McMahon until this date.
(b) The post of Audit Committee Chair was vacant until Mrs S Powell was appointed with effect from 1 June 2015.
(c) The post of Secondary Care Doctor was vacant from 1 October 2015. Dr G Porter was employed by Airedale NHS Foundation Trust and the CCG was invoiced directly by them for his time.
(d) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.

Salaries and allowances 2014-15

Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Professor A Maynard - Chair	10-15				0	10-15
Mrs R Potts - Chief Operating Officer	95-100				37.5-40	130-135
Dr M Hayes - Chief Clinical Officer	155-160				0-2.5	155-160
Mrs T Preece - Chief Finance Officer - see (a)	85-90				80-82.5	165-170
Mr M Ash-McMahon - Interim Chief Finance Officer (from 17 October 2014) - see (a)	35-40				17.5-20	55-60
Ms L Botting - Chief Nurse (to 5 March 2015)	80-85				30-32.5	115-120
Mrs M Carrington - Deputy Chief Nurse (from 4 December 2014 to 5 March 2015) and Chief Nurse (from 6 March 2015) - see (c)	20-25				-	20-25
Dr S O'Connell - GP Governing Body Member	110-115				20-22.5	130-135
Dr T Maycock - GP Governing Body Member	40-45				0-2.5	40-45
Dr E Broughton - GP Governing Body Member	45-50				15-17.5	65-70
Dr A Phillips - GP Governing Body Member	110-115				17.5-20	125-130
Dr L Barker - GP Governing Body Member	65-70				5-7.5	70-75
Dr C Burgin - GP Governing Body Member (to 31 July 2014)	10-15				0-2.5	10-15
Mr D Booker - Lay Member (from 1 August 2014)	5-10				0	5-10
Mr K Ramsay - Lay Member and Audit Committee Chair	5-10				0	5-10
Dr P Evans - Council of Representatives Member (from 19 September 2014)	0-5				0	0-5
Dr T Hughes - Council of Representatives Member	5-10				0	5-10
Dr J Lloyd - Council of Representatives Member (to 31 July 2014)	0-5				0	0-5
Dr G Porter - Secondary Care Doctor - see (b)	15-20				0	15-20
Mr J McEvoy - Practice Manager Representative (to 4 December 2014)	10-15				0	10-15
Miss S Balsom - Manager, Healthwatch York (Co-opted) (from 1 August 2014) - see (d)	0				0	0
Dr P Edmondson-Jones - Local Authority Director of Public Health and Wellbeing (Co-opted) (to 30 September 2014) - see (d)	0				0	0
Mr G Van Dichele - Interim Director of Adult Services (Co-Opted) (from 4 December 2014) - see (d)	0				0	0
Dr J Lethem - Local Medical Committee Representative (Co-opted) - see (d)	0				0	0
Mr R Webb - Local Authority Corporate Director Health and Adult Services (Co-opted) - see (d)	0				0	0

NB all senior managers are continuing except where stated.
(a) Mrs T Preece was on maternity leave from 17 October and the Chief Finance Officer role was covered by Mr M Ash-McMahon.
(b) Dr G Porter is employed by Airedale NHS Foundation Trust and the CCG is invoiced directly by them for his time.
(c) Mrs M Carrington was on secondment from York Teaching Hospital NHS Foundation Trust as Deputy Chief Nurse, and was the Chief Nurse representative on Governing Body until her permanent appointment to the role of Chief Nurse.
(d) Co-opted members of the governing body do not receive remuneration direct from the CCG for their role.
(e) Dr P Evans, Dr T Hughes and Dr J Lloyd invoice the CCG for their time. Dr Evans and Dr Hughes invoice through their practices (York Medical Group and Kirkbymoorside Surgery respectively).

Pensions 2015-16

Name and Title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employers Contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100
Mr K Ramsay - Chair	0	0	0	0	0	0	0	0
Mrs R Potts - Chief Operating Officer	0-2.5	0-2.5	40-45	120-125	724	21	754	0
Dr M Hayes - Chief Clinical Officer	0-2.5	5-7.5	20-25	65-70	324	-328	0	0
Mrs T Preece - Chief Finance Officer	0-2.5	-	20-25	55-60	263	14	279	0
Mr M Ash-McMahon - Interim Chief Finance Officer (to 20th April)	0-2.5	-	10-15	35-40	155	0	159	0
Mrs M Carrington - Chief Nurse	7.5-10	27.5-30	25-30	75-80	249	154	406	0
Dr S O'Connell - GP Governing Body Member	0-2.5	-	15-20	40-45	233	23	259	0
Dr T Maycock - GP Governing Body Member	0-2.5	0-2.5	10-15	25-30	142	12	156	0
Dr E Broughton - GP Governing Body Member	0-2.5	-	15-20	45-50	202	1	205	0
Dr A Phillips - GP Governing Body Member	0-2.5	2.5-5	10-15	30-35	185	32	220	0
Dr L Barker - GP Governing Body Member	0-2.5	-	5-10	20-25	90	7	97	0

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Pensions 2014-15

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

2.4.8 Payments for Loss of Office

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

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

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

Any payments are subject to External Audit review that will provide an opinion on these disclosures.

2.4.9 Payments to Past Senior Managers

There were no payments to past senior managers.

Any payments are subject to External Audit review that will provide an opinion on these disclosures.

2.4.10 Pay Multiples

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

The banded full time equivalent remuneration of the highest paid member of the Governing Body of the CCG in the financial year 2015-16 was £175k - £180k (2014-15, £185k - £190k). This was 5.02 times (2014-15, 4.70) the median remuneration of the workforce, which was £35,384 (2014-15 £39,899).

The movement in median salary 2015-16 was due to the transfer of the Referral Support Service administration team from employment with Yorkshire and Humber Commissioning Support Unit to the CCG from 1st March 2016.

In 2015-16, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £0k - £5k to £130k - £135k (bands of £5,000). In 2014-15 remuneration ranged from £0k - £5k to £155k - £160k (bands of £5,000).

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

Pay multiples are subject to External Audit review that will provide an opinion on these disclosures.

2.4.11 Off-Payroll Engagements

There were no off-payroll engagements during 2015-16.

2.4.12 Staff Matters – Health and Safety

The Health and Safety Assessment and action plan for 2015-16 is based joint arrangements with City of York Council for premises. A staff survey and a 360 degree review undertaken during 2015-16. Outcomes include actions to manage stress and reduce ill-health. A Staff Engagement Group was set up during the year to increase the involvement of staff in the CCG's organisational development and policies, including equalities, health and safety and other ways to improve the wellbeing of staff. A detailed work plan is in place. A number of staff workshops with the Senior Management Team have been held as part of this action plan.

Performance management arrangements, including objective setting, appraisal and personal development processes and staff team meetings are in place and staffing issues are a standing item on the senior management team's agenda.

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

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

2.4.13 Statement on Disability

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

Policies and processes in place to support this include:

- Managing Performance
- Disciplinary / Conduct
- Grievance
- Staff Induction
- Bullying and Harassment
- Flexible working
- Job descriptions (including statements regarding equality and diversity expectations)
- Annual appraisals with staff

Policies are available at: http://www.valeofyorkccg.nhs.uk/

We actively encourage people with disabilities to apply for positions in our organisation. We have a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job (the "2 ticks" commitment), as well as making reasonable adjustments to avoid any disabled employee being put at a disadvantage compared to non-disabled people in the workplace. Staff who have disabilities have the opportunity to discuss their development through our Personal Development and Review process. An equality impact analysis is undertaken on all newly proposed Human Resources policies to determine whether it has a disproportionate impact on people with a disability and, where identified, action is considered to mitigate this.

2.4.14 Sickness Absence Data

The CCG's 2015-16 sickness absence level for directly employed staff was 7.4%. Details of total staff days lost to sickness are included within the Financial Statements.

2.4.15 Staff Turnover

The annual turnover for directly employed staff of the CCG was 1.4.

Signature of Accountable Officer

Helen Hirst
Interim Accountable Officer
NHS Vale of York CCG
Dated: 26 May 2016

2.5 Better Payments Practice Code

The Better Payment Practice Code (BPPC) requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements and are summarised below for 2015-16.

Non-NHS invoices

Month	Total paid	Invoices paid on time	% paid within target	Value paid (£)	Value paid on time (£)	% paid within target
Apr-15	299	294	98.33	7,311,786.14	7,310,442.79	99.98
May-15	266	259	97.37	3,044,065.55	3,029,439.19	99.52
Jun-15	381	370	97.11	2,837,400.19	2,750,621.31	96.94
Jul-15	490	478	97.55	3,699,503.65	3,679,976.22	99.47
Aug-15	324	313	96.60	2,652,870.30	2,646,220.01	99.75
Sep-15	324	312	96.30	3,454,308.02	3,444,831.97	99.73
Oct-15	286	281	98.25	2,437,100.20	2,432,594.26	99.82
Nov-15	319	308	96.55	2,777,138.46	2,761,978.72	99.45
Dec-15	363	352	96.97	3,364,681.66	3,314,836.50	98.52
Jan-16	289	275	95.16	2,996,066.93	2,988,816.01	99.76
Feb-16	312	303	97.12	3,839,018.93	3,814,401.87	99.36
Mar-16	397	377	94.96	2,960,900.43	2,906,299.96	98.16
	4,050	**3,922**	**96.84**	**41,374,840.46**	**41,080,458.81**	**99.29**

NHS Invoices

Month	Total paid	Invoices paid on time	% paid within target	Value paid (£)	Value paid on time (£)	% paid within target
Apr-15	224	223	99.55	25,531,878.72	25,531,768.72	100.00
May-15	139	138	99.28	27,311,615.22	27,311,598.01	100.00
Jun-15	160	151	94.38	24,530,141.01	24,505,339.39	99.90
Jul-15	202	201	99.50	28,277,799.45	28,276,356.60	99.99
Aug-15	237	223	94.09	26,344,179.72	26,256,700.35	99.67
Sep-15	395	390	98.73	25,145,353.60	25,133,650.80	99.95
Oct-15	146	146	100.00	25,323,141.97	25,323,141.97	100.00
Nov-15	430	409	95.12	26,893,233.10	26,149,152.62	97.23
Dec-15	352	339	96.31	28,116,099.58	28,065,180.67	99.82
Jan-16	352	349	99.15	25,986,426.51	25,984,598.02	99.99
Feb-16	352	351	99.72	26,694,166.80	26,689,201.80	99.98
Mar-16	284	280	98.59	28,368,946.99	28,367,490.97	99.99
	3,273	**3,200**	**97.77**	**318,522,982.67**	**317,594,179.92**	**99.71**

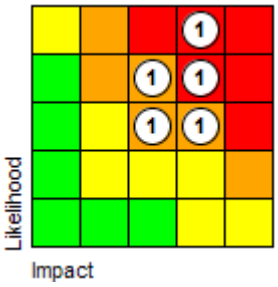
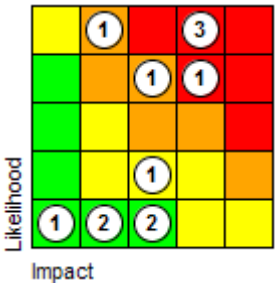
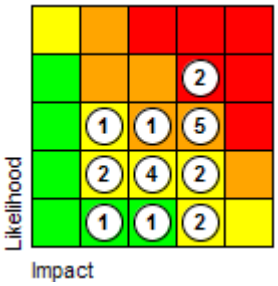
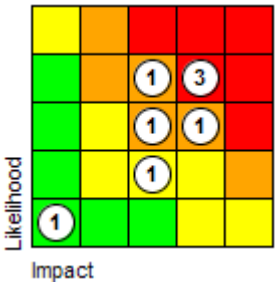
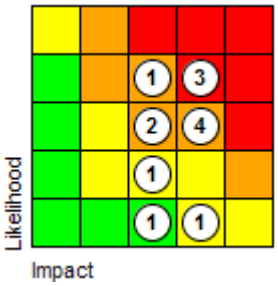
ANNEX A – RISK REPORT March 2016

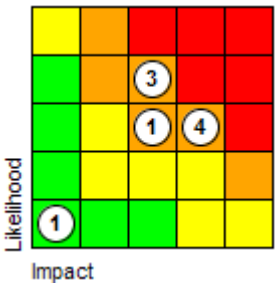
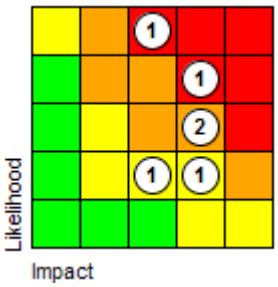
Section A: Events - Risks that have materialised

Risk Summary	Operational Lead	Lead Director	Last Reviewed Date	Latest Note	Latest Note Date
QIPP - Failure to deliver QIPP plans and address financial gap	Michael Ash-McMahon	Tracey Preece	11-Mar-2016	The forecast outturn for M9 now shows no achievement against the unallocated QIPP of £9.91m.	11 Mar 2016
Risk of main providers overtrading	Michael Ash-McMahon	Tracey Preece	11-Mar-2016	Year end deals have now been agreed with our main providers, in particular York Teaching Hospital NHS Foundation Trust, Leeds Teaching Hospital NHS Trust and other some other smaller contracts. Whilst others are in development this has now fixed the bulk of the overtrades	11 Mar 2016
Better Care Fund	Michael Ash-McMahon	Tracey Preece	11-Mar-2016	The planned non-elective reductions have delivered at a significantly reduced level, which has a material impact on the financial position. The CCG has agreed the Section 75 agreement with relevant local authorities. Planning for 2016-17 is underway to seek to reduce risks for future years.	11 Mar 2016
Financial Governance process and procedures are not clearly defined and robust and monitored through the appropriate committees	Natalie Fletcher	Tracey Preece	11-Mar-2016	The PWC report identified areas for improved financial governance, including additional time on financial issues at Quality and Finance Committee and Governing Body. The agenda has been revised in line with the Turnaround Action Plan with the Chair to ensure sufficient time and analysis on financial issues at the Committee. The risk reporting of financial risks continues to be an area for improvement. The organisation is formally in financial turnaround.	11 Mar 2016
The CS arrangements do not represent value for money and may be a cost pressure for 2015-16	Michael Ash-McMahon; Natalie Fletcher	Rachel Potts	11-Mar-2016	The CS changes will be a cost pressure for 2015-16 due to NHS England agreed policy for stranded costs and the CCG cannot pull back the costs for the full service line value of in-housed services. This is reflected in our financial position. The CCG has secured additional resource where required and requested compensating credits for this from the CS.	11 Mar 2016
The CCG is unable to release the anticipated savings from the CS Transition	Lynette Smith	Rachel Potts	11-Mar-2016	The CS changes will be a cost pressure for 2015-16 due to NHS England agreed policy for stranded costs and that the CCG cannot pull back the costs for the full service line value of in-housed services. This is reflected in our financial position.	11 Mar 2016

Risk Summary	Operational Lead	Lead Director	Last Reviewed Date	Latest Note	Latest Note Date
Judicial Review relating to the "closure" of Bootham Park Hospital	Michelle Carrington; Paul Howatson; Stacey Marriott	Mark Hayes; Rachel Potts	10-Mar-2016	The CCG is an 'interested party' in this claim for a judicial review.	10 Mar 2016
CQC do not allow the use of BPH for inpatient services	Paul Howatson	Dr. Louise Barker	10-Mar-2016	Work continues to progress on the conversion of Peppermill Court into the two acute working age adults wards and Section 136 suite and is on schedule for summer 2016 and this will see the completion of the interim plan for fit for purpose accommodation in the Vale of York until the new hospital is completed in 2019.	10 Mar 2016
Constitution target – Urgent Care - CCG failure to meet 4 hour A&E target	Fliss Wood	Michelle Carrington	03-Mar-2016	The Trust are not expected to meet the 95% target until September 2016. Full detail is provided in the March 16 Quality and Performance Intelligence Report. Latest York Trust data shows January performance of 86.8%, performance has been affected by a large number of beds closed due to infection.	03 Mar 2016

Section B: Risk Summary

Teams	Current Risk Matrix
Communications and Engagement	
Finance & Contracting	
Governance	
Innovation and Improvement	
Quality & Performance Register	

Partner Organisation-PCU	
Governance-CSU	

Section C: Profile Report of Red Risks

NHS Vale of York Clinical Commissioning Group

Communications and Engagement

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
CE.02	Twitter-tweets naming the CCG may not be responded to on a timely basis.	Sharron Hegarty	Rachel Potts	16	16	16		11-Mar-2016
CE.04	Proactively managing reputation	Sharron Hegarty	Rachel Potts	8	20	8		11-Mar-2016

Finance & Contracting

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
F.02	QIPP - Failure to deliver QIPP plans and address financial gap	Michael Ash-McMahon	Tracey Preece	8	20	4		11-Mar-2016
F.04	Risk of main providers overtrading	Michael Ash-McMahon	Tracey Preece	9	20	3		11-Mar-2016
F.06	Prescribing overspend	Michael Ash-McMahon	Tracey Preece	6	16	3		11-Mar-2016
F.09	Better Care Fund	Michael Ash-McMahon	Tracey Preece	15	20	8		11-Mar-2016

Governance

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
G.11	Financial Governance process and procedures are not clearly defined and robust and monitored through the appropriate committees	Natalie Fletcher	Tracey Preece	8	16	4		11-Mar-2016
G22.	Failure to achieve an assured position for the 2016-17 operational plan<new risk>	Helena Nowell; Lynette Smith		12	16	12		11-Mar-2016

Innovation and Improvement

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
I&I.01	QIPP - Transformational changes fail to achieve target savings	Paul Howatson	Rachel Potts	16	16	9		10-Mar-2016
I&I.02	Failure to reduce non-elective admissions to planned levels	John Ryan	Rachel Potts	12	16	12		08-Mar-2016
I&I.04	Delivery of BCF targets is dependent on partners and outside the immediate control of the CCG	John Ryan	Rachel Potts	16	16	9		08-Mar-2016

Quality & Performance Register

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
Q&P.02	Constitution target – Urgent Care - CCG failure to meet 4 hour A&E target	Fliss Wood	Michelle Carrington	16	16	8		03-Mar-2016

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
Q&P.07	YTHFT Serious Incident processes may not be effectively managed	Michelle Carrington	Michelle Carrington	16	16	8		03-Mar-2016
Q&P.10	Lack of assurance on quality and performance monitoring in Primary Care.	Michelle Carrington	Michelle Carrington	16	16	8		03-Mar-2016

Governance-CSU

Risk ID	Risk Summary	Operational Lead	Lead Director	Initial Risk Rating	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
G15.2	Business Intelligence capacity is reduced during the transition, impacting on the organisation's ability to effectively plan for 2016-17.	Lynette Smith	Rachel Potts	20	16	9		11-Mar-2016
G15.6	The CCG is unable to release the anticipated savings from the CS Transition	Lynette Smith	Rachel Potts	12	15	9		11-Mar-2016

SECTION 3 – Annual Accounts 2015-16

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

We have audited the financial statements of NHS Vale of York CCG for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 (the 2015-16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described as being subject to audit.

This report is made solely to the members of the Governing Body of NHS Vale of York CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. 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.

Respective responsibilities of the Accountable Officer and auditor

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

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1) (c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5) (b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

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

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

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

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

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

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

November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Vale of York CCG as at 31 March 2016 and of its net expenditure and income for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Opinion on regularity

As disclosed in note 41 of its financial statements, the CCG failed to meet its statutory 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.

Except for the incurrence of expenditure in excess of the specified targets, in our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Annual Report Directions made under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we report by exception

We are required to report to you if:

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

We have nothing to report in these respects.

Exception reports

Referral the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

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

On 22 January 2016, we issued 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 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 are required to report to you if we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Basis for qualified (adverse) conclusion

The CCG reported a deficit of £6.3 million in its financial statements for the year ending 31 March 2016, as a result of this the CCG breached its statutory 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.

The CGG has not yet succeeded in in addressing the underlying deficit in its budget and is forecasting a cumulative deficit of £13.3 million for 2016/17. Current plans identify that the CCG will not return to financial balance until the end of 2018/19.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion (adverse)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, we are not satisfied that, in all significant respects, NHS Vale of York CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

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

Mark Kirkham
For and on behalf of Mazars LLP

Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

May 2016

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	4,863	4,425
Operating Expenses	5	442,769	380,446
Other operating revenue	2	(3,191)	(3,684)
Net operating expenditure before interest		**444,441**	**381,187**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**444,441**	**381,187**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**444,441**	**381,187**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	3,789	3,337
Operating Expenses	5	3,313	3,956
Other operating revenue	2	(347)	(249)
Net administration costs before interest		**6,755**	**7,044**
Programme Income and Expenditure			
Employee benefits	4.1.1	1,074	1,088
Operating Expenses	5	439,456	376,490
Other operating revenue	2	(2,844)	(3,435)
Net programme expenditure before interest		**437,686**	**374,143**

Other Comprehensive Net Expenditure		2015-16 £000	2014-15 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments			
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**444,441**	**381,187**

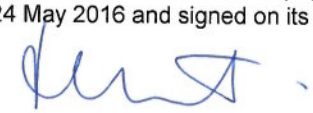
The notes on pages 5 to 48 form part of this statement.

Statement of Financial Position as at 31 March 2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	13	529	605
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**529**	**605**
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	3,431	2,337
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	48	145
Total current assets		**3,479**	**2,482**
Non-current assets held for sale	21	0	0
Total current assets		**3,479**	**2,482**
Total assets		**4,008**	**3,087**
Current liabilities			
Trade and other payables	23	(21,485)	(17,398)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(117)	(935)
Total current liabilities		**(21,602)**	**(18,333)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(17,594)**	**(15,246)**
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	**0**
Assets less Liabilities		**(17,594)**	**(15,246)**
Financed by Taxpayers' Equity			
General fund		(17,594)	(15,246)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(17,594)**	**(15,246)**

The notes on pages 5 to 48 form part of this statement.

The financial statements on pages 1 to 48 were approved by the Audit Committee on behalf of the Governing Body on 24 May 2016 and signed on its behalf by:



Helen Hirst
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(15,246)	0	0	**(15,246)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(15,246)**	**0**	**0**	**(15,246)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(444,441)			(444,441)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(444,441)**	**0**	**0**	**(444,441)**
Net funding	442,093	0	0	442,093
Balance at 31 March 2016	**(17,594)**	**0**	**0**	**(17,594)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(12,446)	0	0	(12,446)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Commissioning Board balance at 1 April 2014	**(12,446)**	**0**	**0**	**(12,446)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs for the financial year	(381,187)			(381,187)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(381,187)**	**0**	**0**	**(381,187)**
Net funding	378,387	0	0	378,387
Balance at 31 March 2015	**(15,246)**	**0**	**0**	**(15,246)**

The notes on pages 5 to 48 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2016

	Note	**2015-16 £000**	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(444,441)	(381,187)
Depreciation and amortisation	5	76	75
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(1,094)	1,418
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	4,087	759
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(408)	0
Increase/(decrease) in provisions	30	(410)	655
Net Cash Inflow (Outflow) from Operating Activities		**(442,190)**	**(378,280)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	**0**
Net Cash Inflow (Outflow) before Financing		**(442,190)**	**(378,280)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		442,093	378,387
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**442,093**	**378,387**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(97)**	**107**
Cash & Cash Equivalents at the Beginning of the Financial Year		**145**	38
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**48**	**145**

The notes on pages 5 to 48 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts. The legacy provision from North Yorkshire & York PCT relating to retrospective continuing healthcare claims is the responsibility of NHS England and is reported within their accounts. The CCG undertakes the administration of these claims on behalf of NHS England.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit & 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 inclusion of financial provision for that service in published documents.
Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

1.4 **Movement of Assets within the Department of Health Group**

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 **Charitable Funds**

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

1.6 **Pooled Budgets**

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

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

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

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

From the 1 April 2015 the Clinical Commissioning Group entered 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 35):

NHS Airedale, Whafedale 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

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 not 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 35 of the accounts.

1.7 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.7.1 **Critical Judgements in Applying Accounting Policies**

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

- 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: Hull and East Yorkshire Hospitals NHS Trust, Ramsay Health Care UK and Nuffield Health.

- Gross/Net Accounting Arrangements for Hosted Services

NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG) host a Partnership Commissioning Unit (PCU) for the provision of Continuing Healthcare services and the commissioning of Mental Health, Adult Safeguarding and Children's services, on behalf of 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 these services are transacted through the NHS Scarborough and Ryedale CCG ledger.

In prior years, expenditure was recharged to the other Clinical Commissioning Group parties on a risk share basis. In 2015/16, although SRCCG continue to host these arrangements, charges to other CCG's for Continuing Healthcare/Funded Nursing Care and Out of Contract Mental Health have been made on an actual costs basis rather than a risk share. Risk share arrangements have remained in place for the PCU management team, Specialist Neurological Rehab and Children's Safeguarding. The terms of these recharges are defined in the Partnership Commissioning Unit Service Level Agreement.

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

Continuing Healthcare/Funded Nursing Care*
NHS Hambleton Richmondshire and Whitby CCG actual basis 19.20% £11,538,616 (2014-15 risk share 20.23% £11,863,370)
NHS Harrogate and Rural District CCG actual basis 19.40% £11,656,160 (2014-15 risk share 24.46% £14,344,613)
NHS Vale of York CCG actual basis 40.66% £24,430,543 (2014-15 risk share 34.64% £20,315,063)
NHS Scarborough and Ryedale CCG actual basis 20.74% £12,458,754 (2014-15 risk share 20.66% £12,114,345)

Mental Health Out of Contract Placements*
NHS Hambleton Richmondshire and Whitby CCG actual basis 21.10% £2,379,198 (2014-15 risk share 8.81% £1,188,510)
NHS Harrogate and Rural District CCG actual basis 16.49% £1,859,429 (2014-15 risk share 12.13% £1,636,349)
NHS Vale of York CCG actual basis 44.20% £4,983,732 (2014-15 risk share 54.23% £7,318,359)
NHS Scarborough and Ryedale CCG actual basis 18.21% £2,053,213 (2014-15 risk share 24.84% £3,351,631)

The Partnership Commissioning Unit staff are employed by NHS Scarborough and Ryedale CCG. The costs of these staff are apportioned between the CCGs on a weighted capitation basis, as follows:

NHS Hambleton Richmondshire and Whitby CCG 19.03% £664,476 (2014-15 18.97% £669,403)
NHS Harrogate and Rural District CCG 19.87% £693,842 (2014-15 20.39% £719,337)
NHS Vale of York CCG 46.30% £1,617,152 (2014-15 45.45% £1,603,353)
NHS Scarborough and Ryedale CCG 14.80% £516,983 (2014-15 15.19% £535,979)

During 2015/16, the Legal Services Team and Specialist Neurological Rehabilitation Commissioning Team transferred from the NHS Yorkshire & Humber Commissioning Support Unit (CSU) to the Partnership Commissioning Unit (PCU) in December 2015 and March 2015, respectively. Although these staff transferred to the CCG payroll in 2015/16, the CSU continued to provide services through the existing Service Level Agreement until 31st March 2016. Therefore, the costs of these staff are included in Gross Employee Benefits (note 4.1.1) and subsequently netted off in Recoveries of Employee Benefits (note 4.1.2) to reflect the reimbursement from the CSU.

Notes to the financial statements

NHS Scarborough and Ryedale CCG also hosts Children's Safeguarding on behalf of the CCGs and the costs of these hosted services are apportioned as follows:

Children's Safeguarding
NHS Hambleton Richmondshire and Whitby CCG 19.57% £61,644 (2014-15 18.15% £58,654)
NHS Harrogate and Rural District CCG 23.30% £73,395 (2014-15 21.60% £69,812)
NHS Vale of York CCG 38.15% £120,188 (2014-15 36.12% £116,720)
NHS Scarborough and Ryedale CCG 18.98% £59,787 (2014-15 24.13% £77,983)

Specialist Neurological Rehab*

In 2015/16 the CCGs have agreed an arrangement to charge NHS Hambleton Richmondshire and Whitby CCG their actual costs incurred whilst all remaining costs are risk shared between NHS Scarborough & 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 £157,202 (2014-15 risk share 5.00% £111,026)
NHS Harrogate and Rural District CCG risk share 25.60% £456,670 (2014-15 risk share 25% £555,129)
NHS Vale of York CCG risk share 53.50% £954,369 (2014-15 risk share 50.00% £1,110,258)
NHS Scarborough and Ryedale CCG risk share 20.90% £372,828 (2014-15 20.00% £444,103)

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 Clinical Commissioning Group's share of costs and staff numbers are represented in these accounts.

* 2015/16 costs relate to 2015/16 expenditure only and exclude costs relating to prior years. Where prior year costs have been incurred in 2015/16 these have been recharged on the risk share basis.

1.7.2 **Key Sources of Estimation Uncertainty**

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

- Accruals

There are a number of estimated figures within the accounts. The main areas where estimates are included are:
• Prescribing - The full year figure is estimated on the spend for the first 10 months of the year.
• Purchase of Healthcare - The full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner, based on CCG predicted forecast outturns.
• GPMS/APMS and PCTMS - The full year figure for the Quality and Outcomes Framework (QOF) is estimated based on GP practice achievement in 2014/15. Payment for 2015/16 will be reconciled and paid to GP practices in June 2016.
The CCG has achieved the following level of accuracy in estimation during 2015/16:
Prescribing > 96%
Purchase of Healthcare >98% (based on our main provider)

- Provisions

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

1.8 **Revenue**

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

1.9.2 **Retirement Benefit Costs**

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

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

Notes to the financial statements

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Clinical Commissioning Group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.11.2 **Valuation**

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

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

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

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;

Notes to the financial statements

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

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

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

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

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

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

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

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

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

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

Notes to the financial statements

1.17.2 **The Clinical Commissioning Group as Lessor**

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

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

1.18 **Private Finance Initiative Transactions**

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

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

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

1.18.1 **Services Received**

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

1.18.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Clinical Commissioning Group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **PFI Liability**

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

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

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

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

1.18.4 **Lifecycle Replacement**

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

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

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

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

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

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the Clinical Commissioning Group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Clinical Commissioning Group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 **Inventories**

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 **Cash & Cash Equivalents**

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group's cash management.

Notes to the financial statements

1.21 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims. It is anticipated that 2016-17 will be the final year of the risk pool scheme.

1.25 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Clinical Commissioning Group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.26 **Contingencies**

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

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

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

1.27 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

The Clinical Commissioning Group does not have any financial assets to disclose.

Notes to the financial statements

1.27.2 **Held to Maturity Assets**
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 **Available For Sale Financial Assets**
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.
The Clinical Commissioning Group does not have any financial assets to disclose.

1.27.4 **Loans & Receivables**
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The Clinical Commissioning Group does not have any loans or receivables to disclose.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.28.1 **Financial Guarantee Contract Liabilities**
Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.
The Clinical Commissioning Group does not have any financial liabilities to disclose.

1.28.3 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

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

1.30 **Foreign Currencies**
The Clinical Commissioning Group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group's surplus/deficit in the period in which they arise.

1.31 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

Notes to the financial statements

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

Material entities over which the Clinical Commissioning Group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Clinical Commissioning Group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Associates**

Material entities over which the Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Clinical Commissioning Group from the entity.
Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **Joint Ventures**

Material entities over which the Clinical Commissioning Group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 **Joint Operations**

Joint operations are activities undertaken by the Clinical Commissioning Group in conjunction with one or more other parties but which are not performed through a separate entity. The Clinical Commissioning Group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 **Research & Development**

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2. Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	44	8	36	21
Patient transport services	0	0	0	0
Prescription fees and charges	228	0	228	123
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,919	339	2,580	3,527
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	0	0	0	13
Total other operating revenue	**3,191**	**347**	**2,844**	**3,684**

Other operating income is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note includes cash received from NHS England of £860,051 for prescribing, £472,273 from North Yorkshire County Council for Better Care Fund, and £364,629 from NHS Property Services in respect of the rental of Clifton Park Treatment Centre at market rent.

3. Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	3,191	347	2,844	3,684
From sale of goods	0	0	0	0
Total	**3,191**	**347**	**2,844**	**3,684**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2015-16	Total		Admin			Programme		
	Total £000	**Permanent Employees £000**	**Other £000**	**Total £000**	**Permanent Employees £000**	**Other £000**	**Total £000**	**Permanent Employees £000**	**Other £000**
Employee Benefits									
Salaries and wages	4,103	3,931	172	3,207	3,073	134	896	858	38
Social security costs	303	303	0	239	239	0	64	64	0
Employer Contributions to NHS Pension scheme	457	457	0	343	343	0	114	114	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**4,863**	**4,691**	**172**	**3,789**	**3,655**	**134**	**1,074**	**1,036**	**38**
Less recoveries in respect of employee benefits (note 4.1.2)	(44)	(44)	0	(8)	(8)	0	(36)	(36)	0
Total - Net admin employee benefits including capitalised costs	**4,819**	**4,647**	**172**	**3,781**	**3,647**	**134**	**1,038**	**1,000**	**38**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,819**	**4,647**	**172**	**3,781**	**3,647**	**134**	**1,038**	**1,000**	**38**

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

4.1.1 Employee benefits	2014-15	Total		Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	3,572	3,424	148	2,757	2,663	94	815	761	54
Social security costs	285	285	0	225	225	0	60	60	0
Employer Contributions to NHS Pension scheme	418	418	0	324	324	0	94	94	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	150	150	0	31	31	0	119	119	0
Gross employee benefits expenditure	**4,425**	**4,277**	**148**	**3,337**	**3,243**	**94**	**1,088**	**1,034**	**54**
Less recoveries in respect of employee benefits (note 4.1.2)	(21)	(21)	0	(4)	(4)	0	(17)	(17)	0
Total - Net admin employee benefits including capitalised costs	**4,404**	**4,256**	**148**	**3,333**	**3,239**	**94**	**1,071**	**1,017**	**54**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,404**	**4,256**	**148**	**3,333**	**3,239**	**94**	**1,071**	**1,017**	**54**

4.1.2 Recoveries in respect of employee benefits	2015-16			2014-15
	Total £000	**Permanent Employees £000**	**Other £000**	Total £000
Employee Benefits - Revenue				
Salaries and wages	(36)	(36)	0	(17)
Social security costs	(4)	(4)	0	(2)
Employer contributions to the NHS Pension Scheme	(4)	(4)	0	(2)
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(44)**	**(44)**	**0**	**(21)**

4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**86**	**85**	**1**	81
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	895	1,318
Total Staff Years	86	81
Average working Days Lost	**10**	**16**

The CCG is required to use staff sick data provided by Health and Social Care Information Centre in 2015-16.An estimate using the same methodology for 2014-15 would result in 12 average working days lost (total days lost 972 total staff years 81)

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	2	149,777	0	0	2	149,777
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**149,777**	**0**	**0**	**2**	**149,777**

	2015-16 Departures where special payments have been made		2014-15 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2015-16 Other agreed departures		2014-15 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**0**	**0**

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

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

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

Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the NHS Pension Scheme.

4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year.

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers' contributions of £319,151 were payable to the NHS Pensions Scheme (2014-15 £300,166) at the rate of 14.3% of pensionable pay. In 2015-16, a further £137,768 employers' contributions were payable to the NHS Pension Scheme by the PCU on behalf of NHS Vale of York CCG (2014-15 £117,929). 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 in June 2014.

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3,707	2,633	1,074	3,303
Executive governing body members	1,156	1,156	0	1,122
Total gross employee benefits	**4,863**	**3,789**	**1,074**	**4,425**
Other costs				
Services from other CCGs and NHS England	3,622	2,195	1,427	7,281
Services from foundation trusts	251,823	17	251,806	242,632
Services from other NHS trusts	29,938	0	29,938	27,543
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	46,596	0	46,596	42,033
Chair and Non Executive Members	0	0	0	0
Supplies and services – clinical	676	0	676	402
Supplies and services – general	14,247	117	14,130	7,162
Consultancy services	185	144	41	187
Establishment	375	205	170	333
Transport	23	19	4	18
Premises	510	311	199	702
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	76	76	0	75
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	72	72	0	97
Other non statutory audit expenditure				
· Internal audit services	37	37	0	38
· Other services	0	0	0	1
General dental services and personal dental services	0	0	0	0
Prescribing costs	50,849	0	50,849	48,316
Pharmaceutical services	0	0	0	0
General ophthalmic services	132	0	132	106
GPMS/APMS and PCTMS	41,509	0	41,509	1,795
Other professional fees excl. audit	54	44	10	7
Grants to other public bodies	1,740	0	1,740	246
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	77	73	4	277
Change in discount rate	0	0	0	0
Provisions	(410)	0	(410)	655
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	635	0	635	540
Other expenditure	3	3	0	0
Total other costs	**442,769**	**3,313**	**439,456**	**380,446**
Total operating expenses	**447,632**	**7,102**	**440,530**	**384,871**

6. Better Payment Practice Code

6.1 Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,050	41,375	3,582	30,743
Total Non-NHS Trade Invoices paid within target	3,922	41,080	3,515	30,496
Percentage of Non-NHS Trade invoices paid within target	**96.84%**	**99.29%**	**98.13%**	**99.20%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,273	318,523	3,263	307,212
Total NHS Trade Invoices Paid within target	3,200	317,594	3,216	306,847
Percentage of NHS Trade Invoices paid within target	**97.77%**	**99.71%**	**98.56%**	**99.88%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2015-16 £000**	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities (2014-15 nil).

8. Investment revenue

The Clinical Commissioning Group had no investment revenue in 2015-16 (2014-15 nil).

9. Other gains and losses

The Clinical Commissioning Group had no other gains or losses in 2015-16 (2014-15 nil).

10. Finance costs

The Clinical Commissioning Group had no finance costs in 2015-16 (2014-15 nil).

11. Net gain/(loss) on transfer by absorption

There is no net gain/loss on transfer by absorption (2014-15 nil).

12. Operating Leases

12.1 As lessee

NHS Property Services, on behalf of the Clinical Commissioning Group, is finalising a tenancy agreement with the City of York Council for space within West Offices, Station Rise, York. The proposed agreement commenced on 1 April 2013 for a period of six years, with a four year break point. The lease will be held by NHS Property Services. The Clinical Commissioning Group was recharged the full cost of the lease under a separate agreement in 2015/16.

For 2015/16, NHS Property Services costs have been calculated and invoiced to the Clinical Commissioning Group based on the actual cost of the buildings. The charge to the Clinical Commissioning Group includes rental cost for properties occupied and subsidy and void charges where properties are unused.

For 2015/16 this equated to a charge of £357,969 (2014/15 £485,334) for the Clinical Commissioning Group. In addition £141,585 rental (2014/15 £94,095) was charged to the Clinical Commissioning Group through the Partnership Commissioning Unit's hosted services. The subsidy and void charges will continue in 2016/17 subject to the new NHS Property Services Vacant Space Policy and will be subject to a six to twelve month transition arrangement after which NHS Property Services will be liable for the cost of these buildings.

12.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Payments recognised as an expense								
Minimum lease payments	0	500	2	**502**	0	579	1	580
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**500**	**2**	**502**	**0**	**579**	**1**	**580**

12.1.2 Future minimum lease payments

	2015-16				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Payable:								
No later than one year	0	276	0	**276**	0	425	12	437
Between one and five years	0	551	0	**551**	0	827	23	850
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**827**	**0**	**827**	**0**	**1,252**	**35**	**1,287**

12.2 As lessor

12.2.1 Rental revenue

	2015-16	2014-15
	£000	£000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value

	2015-16	2014-15
	£000	£000
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

13 Property, plant and equipment

2015-16	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2015	0	0	0	0	756	0	5	0	761
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2016	**0**	**0**	**0**	**0**	**756**	**0**	**5**	**0**	**761**
Depreciation at 1 April 2015	0	0	0	0	151	0	5	0	156
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	76	0	0	0	76
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2016	**0**	**0**	**0**	**0**	**227**	**0**	**5**	**0**	**232**
Net Book Value at 31 March 2016	**0**	**0**	**0**	**0**	**529**	**0**	**0**	**0**	**529**
Purchased	0	0	0	0	529	0	0	0	529
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**0**	**0**	**0**	**0**	**529**	**0**	**0**	**0**	**529**
Asset financing:									
Owned	0	0	0	0	529	0	0	0	529
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**0**	**0**	**0**	**0**	**529**	**0**	**0**	**0**	**529**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000	Buildings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

All assets detailed above transferred from closed NHS bodies as a result of the 1 April 2013 transition and relate to Independent Sector Treatment Centre equipment transferred from North Yorkshire and York PCT.

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	756	0	5	0	761
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**756**	**0**	**5**	**0**	**761**
Depreciation 1 April 2014	0	0	0	0	76	0	5	0	81
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	75	0	0	0	75
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**151**	**0**	**5**	**0**	**156**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**
Purchased	0	0	0	0	605	0	0	0	605
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**
Asset financing:									
Owned	0	0	0	0	605	0	0	0	605
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**605**	**0**	**0**	**0**	**605**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000	Buildings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13. Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group had no additions to assets under construction in 2015-16 (2014-15 nil).

13.2 Donated assets

The Clinical Commissioning Group has not had any assets donated in 2015-16 (2014-15 nil).

13.3 Government granted assets

The Clinical Commissioning Group has not had any government granted assets in 2015-16 (2014-15 nil).

13.4 Property revaluation

There have been no property revaluations performed in 2015-16 (2014-15 nil).

13. Property, plant and equipment cont'd

13.5 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties for assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure (2014-15 nil).

13.6 Write downs to recoverable amount

The Clinical Commissioning Group has had no assets written down to recoverable amounts and no reversals of previous write-downs (2014-15 nil).

13.7 Temporarily idle assets

The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2016 (31 March 2015 nil).

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2015-16 £000	2014-15 £000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery *	0	0
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	0	0
Total	**0**	**0**

*The cost or valuation of fully depreciated assets (Plant & machinery) was shown as £605,000 in the 2014-15 Annual Accounts.This amount represented the "valuation of assets" and not the "cost of fully depreciated assets".The comparative amount has been adjusted in the 2015-16 Annual Accounts to reflect this mis-statement.

13.9 Economic lives

	Minimum Life (years)	**Maximum Life (years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	10	10
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	0	0

14. Intangible non-current assets

The Clinical Commissioning Group had no intangible assets as at 31 March 2016 (31 March 2015 nil).

14. Intangible non-current assets cont'd

14.1 Donated assets

The Clinical Commissioning Group has not had any donated intangible assets in 2015-16 (2014-15 nil).

14.2 Government granted assets

The Clinical Commissioning Group has not had any government granted intangible assets in 2015-16 (2014-15 nil).

14.3 Revaluation

There have been no intangible non-current assets revaluations in 2015-16 (2014-15 nil).

14. Intangible non-current assets cont'd

14.4 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties for intangible assets impaired, lost or given up and consequently there are no amounts included in the Statement of Comprehensive Net Expenditure (2014-15 nil).

14.5 Write downs to recoverable amount

The Clinical Commissioning Group has had no intangible assets written down to recoverable amounts and no reversals of previous write-downs (2014-15 nil).

14.6 Non-capitalised assets

The Clinical Commissioning Group purchased licences and support for specific software during 2015-16 (2014-15 nil). These are under the control of the Clinical Commissioning Group during the period the licence is purchased for but do not meet the recognition criteria of IAS 38 for capitalisation as an intangible asset as the licences are annual and do not allow for the probable flow of future economic benefits.

14.7 Temporarily idle assets

The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2016 (31 March 2015 nil).

14.8 Cost or valuation of fully amortised assets

The Clinical Commissioning Group had no fully amortised assets still in use as at 31 March 2016 (31 March 2015 nil).

14.9 Economic lives

	Minimum Life (years)	**Maximum Life (years)**
Computer software: purchased	0	0
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

15. Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2016 (31 March 2015 nil).

16. Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2016 (31 March 2015 nil).

17. Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	142	0	616	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	863	0	972	0
NHS accrued income	48	0	0	0
Non-NHS receivables: Revenue	825	0	718	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	84	0	37	0
Non-NHS accrued income	1,462	0	0	0
Provision for the impairment of receivables	0	0	(15)	0
VAT	0	0	9	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	7	0	0	0
Total Trade & other receivables	**3,431**	**0**	**2,337**	**0**
Total current and non current	**3,431**		**2,337**	
Included above:				
Prepaid pensions contributions	0		0	

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.

17.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	545	207
By three to six months	39	35
By more than six months	17	10
Total	**601**	**252**

£0 of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any colateral against receivables outstanding at 31 March 2016 (31 March 2015 nil).

17.2 Provision for impairment of receivables	**2015-16 £000**	2014-15 £000
Balance at 1 April 2015	(15)	0
Amounts written off during the year	0	0
Amounts recovered during the year	15	0
(Increase) decrease in receivables impaired	0	(15)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2016	**0**	**(15)**

	2015-16 £000	2014-15 £000
Receivables are provided against at the following rates:		
NHS debt	0	0

18. Other financial assets

The Clinical Commissioning Group had no other financial assets as at 31 March 2016 (31 March 2015 nil)

19. Other current assets

The Clinical Commissioning Group had no other current assets as at 31 March 2016 (31 March 2015 nil).

20. Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	145	38
Net change in year	(97)	107
Balance at 31 March 2016	**48**	**145**
Made up of:		
Cash with the Government Banking Service	48	145
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	**48**	**145**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2016	**48**	**145**
Patients' money held by the Clinical Commissioning Group, not included above	0	0

21. Non-current assets held for sale

The Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2016 (31 March 2015 nil).

22. Analysis of impairments and reversals

The Clinical Commissioning Group had no impairments or reversals of impairments recognised in expenditure during 2015-16 (2014-15 nil).

23. Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	7,205	0	5,690	0
NHS payables: capital	0	0	0	0
NHS accruals	1,927	0	1,873	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	2,655	0	1,248	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	9,374	0	8,379	0
Non-NHS deferred income	0	0	0	0
Social security costs	35	0	32	0
VAT	1	0	0	0
Tax	41	0	39	0
Payments received on account	0	0	0	0
Other payables	247	0	137	0
Total Trade & Other Payables	**21,485**	**0**	**17,398**	**0**
Total current and non-current	**21,485**		**17,398**	

Other payables include £51,964 outstanding pension contributions at 31 March 2016 (£48,947 at 31 March 2015).

24. Other financial liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2016 (31 March 2015 nil).

25. Other liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2016 (31 March 2015 nil).

26. Borrowings

The Clinical Commissioning Group had no borrowings as at 31 March 2016 (31 March 2015 nil).

27. Private Finance Initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group had no Private Finance Initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2016 (31 March 2015 nil).

28. Finance lease obligations

The Clinical Commissioning Group had no finance lease obligations as at 31 March 2016 (31 March 2015 nil).

29. Finance lease receivables

The Clinical Commissioning Group had no finance lease receivables as at 31 March 2016 (31 March 2015 nil).

30. Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	117	0	696	0
Other	0	0	239	0
Total	**117**	**0**	**935**	**0**
Total current and non-current	**117**		**935**	

	Pensions Relating to Former Directors £000	**Pensions Relating to Other Staff £000**	**Restructuring £000**	**Redundancy £000**	**Agenda for Change £000**	**Equal Pay £000**	**Legal Claims £000**	**Continuing Care £000**	**Other £000**	**Total £000**
Balance at 1 April 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**696**	**239**	**935**
Arising during the year	0	0	0	0	0	0	0	0	0	0
Utilised during the year	0	0	0	0	0	0	0	(408)	0	(408)
Reversed unused	0	0	0	0	0	0	0	(171)	(239)	(410)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**117**	**0**	**117**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	117	0	117
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**117**	**0**	**117**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG.

31. Contingencies

	2015-16 £000	2014-15 £000
31.1 Contingent liabilities		
NHS Litigation Authority Legal Claims	332	0
Net value of contingent liabilities	**332**	**0**

There is a requirement for the Clinical Commissioning Group to note the value of provision carried in the books of the NHS Litigation Authority in regard to ELS and CNST claims.

31.2 Contingent assets

The Clinical Commissioning Group had no contingent assets as at 31 March 2016 (31 March 2015 nil).

32. Commitments

32.1 Capital commitments

The Clinical Commissioning Group had no capital commitments not otherwise included in the financial statements as at 31 March 2016 (31 March 2015 nil).

32.2 Other financial commitments

The Clinical Commissioning Group has no other financial commitments (2014-15 nil).

33. Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

The Clinical Commissioning Group is financed through parliamentary funding and 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 agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The Clinical Commissioning Group is principally a domestic organisation with the 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.

33.1.2 Interest rate risk

The Clinical Commissioning Group is able to borrow from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

The majority of the Clinical Commissioning Group and revenue comes parliamentary funding and the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

The Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33. Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	190	0	190
· Non-NHS	0	2,287	0	2,287
Cash at bank and in hand	0	48	0	48
Other financial assets	0	7	0	7
Total at 31 March 2016	**0**	**2,532**	**0**	**2,532**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	616	0	616
· Non-NHS	0	718	0	718
Cash at bank and in hand	0	145	0	145
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**1,479**	**0**	**1,479**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	9,133	9,133
· Non-NHS	0	12,276	12,276
Private Finance Initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**21,409**	**21,409**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,563	7,563
· Non-NHS	0	9,764	9,764
Private Finance Initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**17,327**	**17,327**

34. Operating segments

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

34.1 Reconciliation between Operating Segments and SoCNE

	2015-16 £000	2014-15 £000
Gross expenditure	447,632	384,871
Income	(3,191)	(3,684)
Total net expenditure reported for operating segments	444,441	381,187
Reconciling items:		
Commissioned Services	444,441	381,187
Total net expenditure per the Statement of Comprehensive Net Expenditure	**444,441**	**381,187**

34.2 Reconciliation between Operating Segments and SoFP

	2015-16 £000	2014-15 £000
Total assets reported for operating segments		
Reconciling items:		
Commissioned Services	4,008	3,087
Total assets per Statement of Financial Position	**4,008**	**3,087**

	2015-16 £000	2014-15 £000
Total liabilities reported for operating segments		
Reconciling items:		
Commissioned Services	(21,602)	(18,333)
Total liabilities per Statement of Financial Position	**(21,602)**	**(18,333)**

	2015-16 £000	2014-15 £000
Total assets	4,008	3,087
Total liabilities	(21,602)	(18,333)
Total net liabilities reported for operating segments	(17,594)	(15,246)
Reconciling items:		
Commissioned Services	(17,594)	(15,246)
Total net liabilities for Statement of Financial Position	**(17,594)**	**(15,246)**

35. 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 (HWB) 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 (NYCC) and East Riding of Yorkshire Council (ERYC) respectively.

The Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2015-16	2014-15
	£000	£000
Income	0	0
Expenditure	19,366	0

Details of the total pooled commissioning budgets for 2015-16 are set out below:

		Health and Wellbeing Board		
	City of York	**North Yorkshire**	**East Riding of Yorkshire**	**Total BCF Pooled Budgets**
	£000	**£000**	**£000**	**£000**
Contributing Organisation				
NHS Vale of York CCG	11,176	6,932	1,258	**19,366**
NHS Airedale Wharfedale and Craven CCG		2,914		**2,914**
NHS Scarborough and Ryedale CCG		7,538		**7,538**
NHS Hambleton Richmondshire and Whitby CCG		9,152		**9,152**
NHS Harrogate and Rural District CCG		9,557		**9,557**
NHS Cumbria CCG		319		**319**
NHS East Riding of Yorkshire CCG			19,212	**19,212**
City of York Council	951			**951**
North Yorkshire County Council		10,315		**10,315**
East Riding of Yorkshire County Council			2,008	**2,008**
Total BCF (Pooled Budgets)	**12,127**	**46,727**	**22,478**	**81,332**

Details of the utilisation of NHS Vale of York CCG contributions in 2015-16 are set out below:

		Health and Wellbeing Board		
	City of York	**North Yorkshire**	**East Riding of Yorkshire**	**Total VOY contributions**
	£000	**£000**	**£000**	**£000**
Supporting Social Care commissioned schemes	6,967	2,314	497	**9,778**
Supporting Health commissioned schemes	2,878	4,378	383	**7,639**
Total utilisation against BCF - identified schemes	**9,845**	**6,692**	**880**	**17,417**
Withheld Performance Fund*	1,331	240	378	**1,949**
Total utilisation of NHS Vale of York CCG contributions	**11,176**	**6,932**	**1,258**	**19,366**

* In line with national policy, the Clinical Commissioing Group has withheld these funds due to failure to achieve performance trajectories agreed for the reduction of emergency admissions. These funds have been retained by the Clinical Commissioning Group to offset increased expenditure related to emergency activity.

36. NHS LIFT investments

The Clinical Commissioning Group has no NHS LIFT investments as at 31 March 2016 (31 March 2015 nil).

37. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Louise Barker Mental Health - Clinical Lead and Governing Body Member - Partner works as Consultant Psychiatrist in Tees Esk and Wear Valley NHS Foundation Trust	**19,123**	**0**	**1**	**0**
Dr Louise Barker Mental Health - Clinical Lead and Governing Body Member - Salaried GP at Haxby Group Practice	**598**	**-2**	**22**	**0**
Dr Emma Broughton - Women and Children's Health and Primary Care Lead Governing Body Member - Partner at Priory Medical Group	**1,247**	**-1**	**61**	**-1**
Dr Tim Maycock - Primary Care Lead and Governing Body Member - Partner at Pocklington Group Practice	**153**	**0**	**8**	**0**
Dr Shaun O'Connell - Planned Care and Prescribing Lead and Governing Body Member - Salaried GP at South Milford Surgery	**653**	**0**	**1**	**0**
Dr Shaun O'Connell - Planned Care and Prescribing Lead and Governing Body Member - Spouse an anaesthetist at York Teaching Hospital NHS Foundation Trust	**204,609**	**-3**	**2,857**	**-800**
Dr Andrew Phillips - Urgent Care Lead and Governing Body Member - Locum GP at Drs NJ Wilson & JF Matthews, based at Helmsely Medical Practice (until August 2015)	**32**	**0**	**0**	**0**
Dr Andrew Phillips - Urgent Care Lead and Governing Body Member - Locum GP at York Medical Group (from October 2015 until February 2016)	**107**	**0**	**6**	**0**
Dr Andrew Phillips - Urgent Care Lead and Governing Body Member - Provides Out of Hours sessions for Northern Doctors Urgent Care	**3,658**	**0**	**32**	**0**
Dr Guy Porter - Governing Body Member - Consultant Radiologist at Airedale NHS Foundation Trust (until September 2015)	**20**	**0**	**12**	**0**
Richard Webb Associate - Governing Body Member - Corporate Director of North Yorkshire County Council	**4,915**	**-719**	**0**	**-675**
Sian Balsom - Co-opted Member of Governing Body - Manager at Healthwatch York - employed by York CVS	**37**	**0**	**0**	**0**
Kersten England - Governing Body Member (until April 2015) - Chief Executive City of York Council	**9,670**	**-327**	**2,215**	**-1,116**
Kersten England - Governing Body Member (until April 2015) - Spouse is Trustee at York CVS	**37**	**0**	**0**	**0**
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group	**259**	**0**	**2**	**0**
Dr Paula Evans - Council of Representatives Chair - Provides out of hours sessions for Harrogate and District NHS Foundation Trust	**5,945**	**0**	**151**	**0**
Dr Paula Evans - Council of Representatives Chair - Partner at York Medical Group which is part of the CAVA City and Vale Alliance	**107**	**0**	**6**	**0**
Dr John Lethem - Governing Body Member and Local Medical Committee member - Partner and GP Prinicipal for Unity Health	**148**	**0**	**0**	**0**
Louise Johnston - Practice Manager Representative - Managing Partner at Unity Health	**148**	**0**	**0**	**0**
Sheenagh Powell - Governing Body Lay Member and Chair of Audit Committee (from 1st June 2015) - Paid member of Harrogate and Rural District CCG Audit Committee	**0**	**-87**	**0**	**-14**
Sheenagh Powell - Governing Body Lay Member and Chair of Audit Committee (from 1st June 2015) - Financial Consultant at Barnsley CCG	**6**	**0**	**6**	**0**
Guy van Dichele Governing Body Member (from May 2015 until August 2015) - Interim Director Adult Social Care, City of York Council	**9,670**	**-327**	**2,215**	**-1,116**
Sharon Stolz - Governing Body Member (from September 2015) - Interim Director of Public Health, City of York Council	**9,670**	**-327**	**2,215**	**-1,116**

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

- NHS England
- NHS Hambleton Richmondshire and Whitby CCG
- NHS Harrogate and Rural District CCG
- NHS Scarborough and Ryedale CCG
- NHS Yorkshire and the Humber CSU
- York Teaching Hospital NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospital 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. All material transactions have been with City of York Council and North Yorkshire County Council.

38. 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 (2014-15 nil).

39. Losses and special payments

The Clinical Commissioning Group had no losses and special payments during 2015-16 (2014-15 nil).

40. Third party assets

The Clinical Commissioning Group had no third party assets as at 31 March 2016 (2014-15 nil).

41. Financial performance targets

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

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

	2015-16 Target £000	**2015-16 Performance £000**	2014-15 Target £000	2014-15 Performance £000
Expenditure not to exceed income	438,146	444,441	385,038	381,187
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	438,146	444,441	385,038	381,187
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	7,602	6,754	8,625	7,044

The CCG has not met the statutory requirement '223H(1) Expenditure not to exceed income' as the actual 2015-16 expenditure performance is £6.295m over the income received. A formal notification of this position was made by the CCG's external auditors, Mazars LLP, to the NHS Commissioning Board (NHS England) in January 2016. A referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 was also made at the same time.

42. Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2015-16 financial year (2014-15 nil).