NHS
Vale of York
Clinical Commissioning Group

Annual Report

2021-22

Annual Report and Accounts 2021-22

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Clinical Chair’s foreword

The last two years have been very challenging for everyone – for our health and care staff, their patients, service users and their carers and families. That is why I'm very proud of the CCG's invaluable work and success achieved before and throughout COVID-19. Reflecting on this and how local staff have supported the aim to improve health and wellbeing outcomes for all our residents highlights how this links so strongly to the core values of our NHS.

After four years as the CCG's Clinical Chair, I stood down from the role in March 2022 to take up a new position as the Humber and North Yorkshire Health and Care Partnership's Clinical and Professional Executive Director.

Fulfilling the role as NHS Vale of York CCG's Clinical Chair has been a huge privilege for me and during that time I have worked with dedicated and talented colleagues that allowed me to both learn with and from them. CCG staff transition to the Humber and North Yorkshire Integrated Care Board on the 1 July 2022. I'd like to remind all members of the CCG team to remember that each everyone one of them are important and valued. I look forward to working alongside them again in our new Humber and North Yorkshire Health and Care Partnership roles where our collective goal is to ensure everyone living in the local area can live a happy, healthy life.

Dr Nigel Wells
Clinical Chair (to 31 March 2022)

Accountable Officer's foreword

This year has been dominated by the ongoing COVID-19 pandemic and the CCG's work has played a central role in continuing to deliver health care to our population despite the very severe disruption caused by the pandemic. A very important element of this work has been working with our partners across our health and care system to find ways to mitigate the negative impact of the pandemic.

This was particularly important at the place most patients start their health journey – in general practice. Increasing capacity so patients were able to consult their GP, face-to-face, by phone or via a video link was a very high priority. We are so very proud of our colleagues in general practice and the success we achieved together. From September 2020, the average number of appointments available at Vale of York GP practices was higher than those in pre-pandemic times, and for some months the number of GP appointments available has been at historically high levels. This happened during a period where general practice was coping with the slings and arrows of the pandemic: sickness, isolation, and infection control and prevention.

The CCG has also commissioned services to increase capacity elsewhere in the local system, to reduce demand, to signpost patients to alternative, more appropriate consultations, to provide residential and care homes with direct and immediate access to medical advice for their residents / patients and to coach patients into improved self-care among other work.

There is a change coming to the CCG and to the structure of the health service across England. The functions and responsibilities of the CCG, plus the five other CCGs in the area that cover East Yorkshire, Northern Lincolnshire, Northern East Lincolnshire, and parts of North Yorkshire, will shortly join the Humber and North Yorkshire Integrated Care System (ICS). This will create a system of some twenty health and local authority partner organisations covering a population of 1.4 million. These changes are also happening across the rest of the country and 42 Integrated Care Systems will be created. This change will come about with the enactment of the Health and Care Bill. This was originally expected on 1 April 2022 but has been delayed and is now expected on 1 July 2022.

During this period of transition many of our staff have made the choice to seek opportunities elsewhere, I want to thank them for all the work they have done on behalf of the residents across the Vale of York, and I wish them the very best for their future careers. For those staff who will transition to the ICS I am confident they will continue to display the qualities that have made them such a success in recent years.

I would like to record my thanks to the CCG member practices for their commitment to supporting the CCG and would like to commend their unwavering commitment to their patients despite the unprecedented challenges of the pandemic.

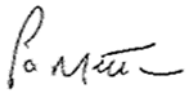
The Governing Body and the CCG's Executive Team have continued to display remarkable resilience, diligence, loyalty, and insight during this last year. I would like to thank them again for their contribution and reiterate my very best wishes for the future.

Our partners across the system will inherit statutory responsibilities that have been maturely and expertly managed. The local health and care system is well placed to make the next steps required to improve the service offer available for residents. I wish them well on this journey.

I am proud of the legacy that the CCG has created, and I would like to thank all my colleagues for their personal support to me during my tenure as Accountable Officer.

Phil Mettam
Accountable Officer

Performance Report



Phil Mettam

Accountable Officer

10th June 2022

1. Performance summary 2021-22

1.1 Local context

NHS Vale of York Clinical Commissioning Group, hereafter referred to as the CCG, commissions healthcare for the Vale of York area including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of over 350,000 people. Its vision is to achieve 'the best in health and wellbeing for everyone in our community' and it works closely with a range of partners to achieve this goal.

It has 25 member practices which now form part of eight primary care networks with list sizes of between 30,000 and 60,000 patients. Further details of the organisational structure are provided in the Members Report on page 59.

1.1.2 The CCG's purpose

The CCG's role is to commission health services for the Vale of York population with specific duties to improve the quality of services, reduce health inequalities, involve and consult with the public and comply with financial duties.

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

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

The CCG and partner's work to improve performance is overseen by the Finance and Performance Committee, a subcommittee of the Governing Body. The committee's objective, in normal times, is to ensure that commissioned services are accessible, and delivered effectively in line with national guidelines and waiting time targets for patients to have the best possible health outcomes. It also focuses on continuous performance improvement in line with the NHS Constitution (2011) and the NHS Oversight Framework (2021-22).

Unfortunately, 2021-22 has been anything but normal. Many of the performance targets have been impossible to achieve for our partner organisations, and for most other organisations across England. Within this context the CCG took steps, working with partners, to minimise the worst effects of the pandemic on the health system and to help speed recovery.

1.1.3 Improvement and Assurance Framework

Ongoing external oversight of the CCG is now through the Humber and North Yorkshire Integrated Care System (HCVICS) with an annual review of the CCG by NHS England and Improvement.

In the NHS Systems Oversight Framework 2021-22, published in June 2021, it is stated that ongoing oversight will focus on the delivery of the priorities set out in the 2021-22 Operational Planning Guidance, including the NHS Mandate, the aims of the NHS Long Term Plan and the NHS People Plan. As part of this, a set of oversight metrics will be used by NHS England and Improvement and ICBs to flag potential issues and prompt further investigation of support needs with ICBs, place-based systems and/or individual trusts and commissioners.

To support this, the oversight framework is built around:

a) Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts, commissioners and ICBs:

    I. quality of care, and access and outcomes
    II. preventing ill health and reducing inequalities
    III. people
    IV. finance and use of resources
    V. leadership and capability.

b) A single set of metrics across ICBs, provider trusts, clinical commissioning groups and primary care, aligned to the five national themes.

c) A sixth theme, local strategic priorities, recognises:

    I. that each ICS faces a unique set of circumstances and challenges in addressing the priorities for the NHS in 2021/22
    II. the renewed ambition to support greater collaboration between partners across health and care to accelerate progress in meeting society's most critical health and care challenges and support broader social and economic development.

d) A description of how ICBs will work alongside regional and national NHS England and Improvement teams to provide effective, streamlined oversight for quality and performance across the NHS.
e) A three-step oversight cycle that frames how NHS England and NHS Improvement teams and ICSs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

1.2 Performance Overview

Performance during 2021-22 has been defined by the continued and negative impact of the pandemic. At all points within the health system this has reduced the abilities of staff and organisations to deliver care at the required speed, resulting in delayed care for many. Many performance standards are not being met.

The year has also been characterised by impending changes to the structure of the health service to be enacted through the Health and Care Bill. This was expected to come into force on 1 April 2022 but has been delayed and is now expected on 1 July 2022. As this bill ends the life of all CCGs as legal entities, it is leading to no small uncertainty for CCG staff. The CCG's functions will be absorbed by the new Humber and North Yorkshire Integrated Care System. As a result, there has been a significant number of staff leaving the CCG. At the same time, there have been restrictions on the ability of the CCG to recruit replacement staff.

2021-22 has been an extremely difficult year for the health service across England, and across the Vale of York. Notwithstanding this, the CCG continued to engage and work closely and collaboratively with its partner organisations. It has been a year, however, where many of the normal performance standards required of the services the CCG commissions have been impossible to deliver for our partner organisations. Key metrics are summarised in Table 1, below.

Table 1 - CCG performance summary in 2021-22 across key NHS targets

Category	Indicator	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
A&E	A&E: % within 4 hours (YTHFT)	≥95%	79.3%	80.6%	80.7%	80.6%	81.0%	76.5%	71.7%	69.2%	69.1%	70.2%	70.8%	71.9%
Diagnostics	Diagnostics: % waiting >6 weeks	≤1%	45.0%	38.1%	35.9%	37.3%	39.2%	39.7%	42.1%	48.8%	46.3%	45.3%	45.7%	47.1%
RTT	RTT: Total incomplete pathways (waiting list)		17,184	17,238	17,960	18,706	18,985	19,354	20,085	20,774	21,326	22,078	22,700	23,490
RTT	RTT incomplete pathways: % within 18 weeks	≥92%	65.6%	63.5%	64.8%	65.5%	68.6%	70.8%	70.1%	68.6%	66.9%	66.4%	66.4%	65.4%
Cancer	% patients seen within 14 days of urgent suspected cancer referral - all cancer types	≥93%	89.5%	91.4%	90.6%	87.5%	94.6%	94.4%	95.2%	93.3%	94.0%	89.1%	85.5%	81.2%
Cancer	% patients seen within 14 days of urgent suspected cancer referral - breast symptoms	≥93%	81.9%	96.1%	92.4%	92.8%	92.9%	92.9%	93.5%	96.5%	97.1%	82.9%	60.7%	38.0%
Cancer	% patients receving first definitive treatment witin 31 days of decision to treat	≥96%	93.9%	97.5%	95.8%	92.4%	96.8%	98.5%	97.5%	96.3%	92.1%	95.4%	94.0%	94.0%
Cancer	Cancer: 31 day subsequent treatment - surgery	≥94%	93.1%	95.5%	76.5%	89.7%	93.9%	92.6%	81.1%	68.2%	82.9%	83.3%	80.4%	79.5%
Cancer	Cancer: 31 day subsequent treatment - drug	≥98%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	98.4%	100.0%	98.6%	100.0%	100.0%
Cancer	Cancer: 31 day subsequent treatment - radiotherapy	≥94%	100.0%	97.9%	100.0%	97.0%	100.0%	100.0%	98.4%	86.8%	77.4%	77.5%	82.4%	75.6%
Cancer	Cancer: 62 day GP referral	≥85%	70.3%	68.6%	68.9%	72.6%	81.4%	75.6%	66.7%	61.3%	73.5%	72.1%	69.2%	70.8%
Cancer	Cancer: 62 day Screening referral	≥90%	78.6%	90.0%	85.7%	84.2%	78.6%	86.4%	52.9%	88.9%	66.7%	64.7%	42.9%	88.2%
Cancer	Cancer: 62 day Status upgrade	-	50.0%	60.0%	100.0%	80.0%	100.0%	100.0%	50.0%	75.0%	50.0%	100.0%	100.0%	100.0%
IAPT	IAPT Access (rolling 3 months)	≥5.5% in Q4 (≥22% full year)	4.7%	4.7%	4.8%	4.6%	4.6%	5.0%	5.3%	5.7%	5.5%	5.4%	5.2%	-
IAPT	IAPT Recovery (rolling 3 months)	≥50%	56.3%	54.8%	54.2%	54.1%	55.6%	54.7%	54.5%	53.2%	52.9%	54.0%	54.1%	-
EIP****	EIP: Within 2 weeks (rolling 3 months)	≥56%	62.0%	63.0%	65.0%	81.0%	75.0%	73.0%	76.0%	70.6%	70.7%	68.4%	75.0%	-

1.2.1 Performance analysis

Local performance standards being lower than the expected level is a consequence of the pandemic. In particular:

- Infection prevention and control measures created bottlenecks to patient pathways and reduced patient throughput. This applied to all parts of the health service, from GP surgeries, through hospitals, through diagnostic services, through residential / care homes and domiciliary services to community services.
- Sickness, and absence for isolation, among clinical and other staff reduced the baseline capacity for care and treatment. This, again, applied to all sectors.
- Sickness, and absence for isolation, among residential home, care home and domiciliary staff reduced the flow of patients out of hospitals thus reducing the ability to flow patients into the hospitals.
- Economic changes created a situation such that residential homes, care homes and domiciliary services found it challenging to recruit into vacant posts and capacity was compromised.
- Within secondary care, the dedication of wards to patients with covid reduced the bed capacity for non-covid work. This reduced hospital throughput impacting on the speed of flow of patients from the Emergency Department into the hospital and reduced the quantity of elective work possible.

These issues and risks are not over and the CCG, together with its partner organisations, continues to mitigate the impact of the pandemic. Of particular note are the following:

- Increasing capacity within primary care so more patients can be seen more quickly.
- Reducing demand on primary care by signposting patients to other services where these are appropriate.
- Reducing demand on the Emergency Department by increasing the capacity of Urgent Treatment Centres and GP Out of Hours services.
- Reducing demand on the Emergency Department by establishing a joint, collaborative, primary / secondary care clinic in primary care to address the expected spike in respiratory infections in children over the winter.
- Making advice and guidance from specialists in secondary care more easily available to primary care clinicians thus enabling more patients to be treated in primary care.
- Increasing capacity for discharging patients from secondary care so patients can leave hospital more quickly by financing additional staffing in partner organisations and arranging additional community beds.
- Supporting staff.

The risks associated with the pandemic continue, as do the steps to mitigate its impact. There is a reasonable expectation that the worst of the pandemic is behind us and that the next months will see an easing of pandemic pressures. This will mean that infection control and prevention measures will gradually reduce thus increasing patient throughput. Covid wards at hospitals will be returned to normal use. Absence for isolation will decline. Sickness rates may decline although it should be noted that there is anecdotal evidence that the health service workforce is exhausted. There is a phenomenon associated with the release of pressure that can result in a sickness spike.

1.3 2021-22 Financial Performance Overview

1.3.1 Financial overview – Financial planning and management

Throughout 2021-22 the CCG has again been operating under an interim financial framework put in place by NHS England and NHS Improvement (NHSE/I) in response to the Covid-19 pandemic. This was implemented and planned for in two separate periods:

H1 – April 2021 – September 2021

H2 – October 2021 – March 2022

Integrated Care Systems (ICS) were provided with a set financial envelope for each period and were required to manage expenditure within this envelope based on adjusted CCG allocations, system top-up and a fixed allocation for Covid related costs. Some specific areas of expenditure continued to be deemed 'outside of envelope', in particular the Elective Recovery Funding and Hospital Discharge Programme. Although these continued to be funded on top of baseline CCG allocations throughout H1 and H2 they were part of an overall ICS fixed funding envelope for each.

The CCG's financial position was also managed and monitored as part of the North Yorkshire and York system financial envelope that included both CCGs and the two main acute hospital providers in this geography. This has provided further opportunity to strengthen our work and collaboration as a system.

Throughout the financial year, several of the changes implemented in H2 of 2020-21 continued which affected the CCG's expenditure on commissioned services, and these amendments were reflected in adjusted allocations.

- Block payment arrangements remain in place for NHS commissioner and NHS provider contracts, calculated centrally and based on 2019-20 values with an adjustment for growth and any additional funding. Charges to commissioners for non-contracted NHS activity were suspended.
- National contracts were put in place for many Independent Sector providers, with payment being made by NHS England and Improvement rather than CCGs.

The CCG has delivered a break-even position across the 2021-22 financial year.

For the second half of the financial year, funding envelopes were split into a baseline allocation linked to individual organisations, and an overall envelope to fund growth and Covid-19 related

costs across the North Yorkshire and York system. Across the system all organisations were able to submit a break-even plan and subsequently deliver a break-even position at year end.

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

1.3.2 Financial overview - QIPP

The CCG has measured delivery of QIPP savings relating to Continuing Healthcare and Running Costs, where delivery has continued through normal operational efficiencies. Savings of £1.2m in Continuing Healthcare mean that this area of spend has again fully delivered its planned £1.0m QIPP savings identified in the CCG's financial plan. In addition, savings of £903k have been delivered within Running Costs budgets, against planned savings of £207k. The CCG also underspent against its Prescribing budget by £645k that has been classified as a QIPP saving.

1.3.3. Financial overview – Governance and control

Temporary amendments were made to the Scheme of Delegation in April 2020 to allow the CCG to flexibly respond to the evolving requirements of the pandemic response, without compromising formal assurance processes. These remained in place through H1 of 2021-22 but were updated for H2 to review and revoke the emergency changes with permanent changes made as appropriate.

The CCG's internal audit function has carried out annual audits covering budgetary control and forecasting and for the fourth year in a row gave the highest level of assurance possible to the CCG's Audit Committee that a strong system of internal control is operating effectively with no recommendations for improvements. The Head of Internal Audit opinion for the year gives an overall rating of significant assurance that controls are effective and operating consistently across all aspects of the CCGs functions.

1.3.4 Preparation of the Annual Accounts

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

1.3.5 Accounting policies

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

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

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

1.3.6 Financing transactions

There have been no financing transactions undertaken by the CCG.

1.3.7 Cash

The CCG delivered its financial statutory duty to have a cash balance at the year-end within 1.25% of the monthly cash draw down or £250k, whichever is lower. The CCG held £51k in cash as of 31 March 2022.

The CCG also has its own internal key financial measures which include maintaining a month-end cash balance within 1.25% of the monthly cash draw down. This was also delivered throughout 2021-22.

1.3.8 Summary of expenditure

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

1.3.8.1 Programme costs

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

For 2021-22 the in-year programme allocation was adjusted throughout the year in line with the interim financial arrangements for expenditure deemed 'outside of envelope', the majority of this relating to the HDP.

The CCG's in-year allocation for programme costs was £564.7m in 2021-22 and total expenditure against this allocation was also £565.6m. When combined with a £903k underspend on running costs, this resulted in the overall in-year break-even financial position.

The graphs below show how the CCG's programme and running cost spend in 2021-22 was split across key areas and provide a comparison against spend in 2020-21.

Fig 1 - An analysis of 2021-22 programme expenditure

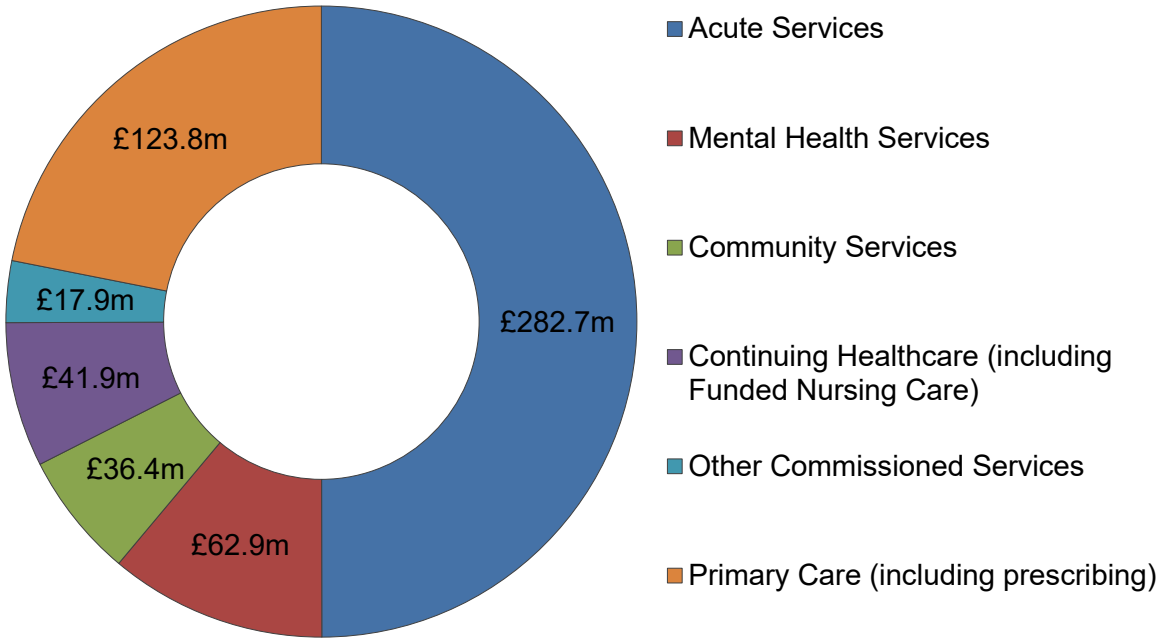
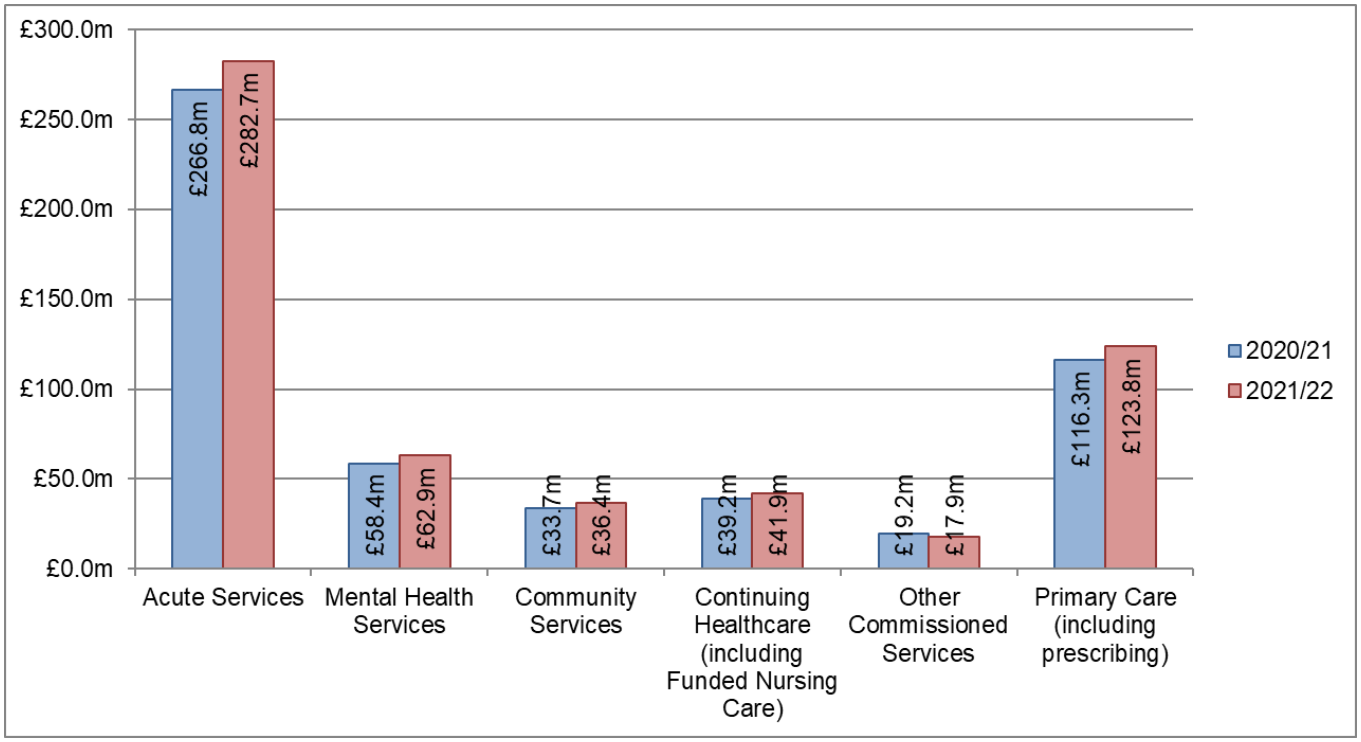


Fig 2 - An analysis of 2020-21 and 2021-22 programme expenditure



1.3.8.2 Running costs

Running cost allocations is used to pay for non-clinical management and administrative support, including commissioning support services.

The CCG's allocation for running costs was £7.0m in 2021-22 and total expenditure against this allocation was £6.1m. An underspend of £903k was achieved, and when taken together with the programme cost position equals the CCG's overall in-year break-even financial position.

Fig 3 - An analysis of 2021-22 running costs expenditure

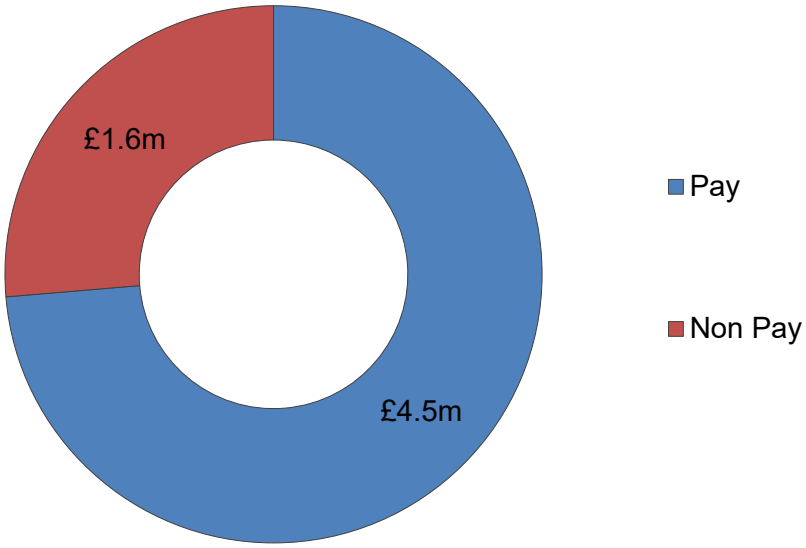
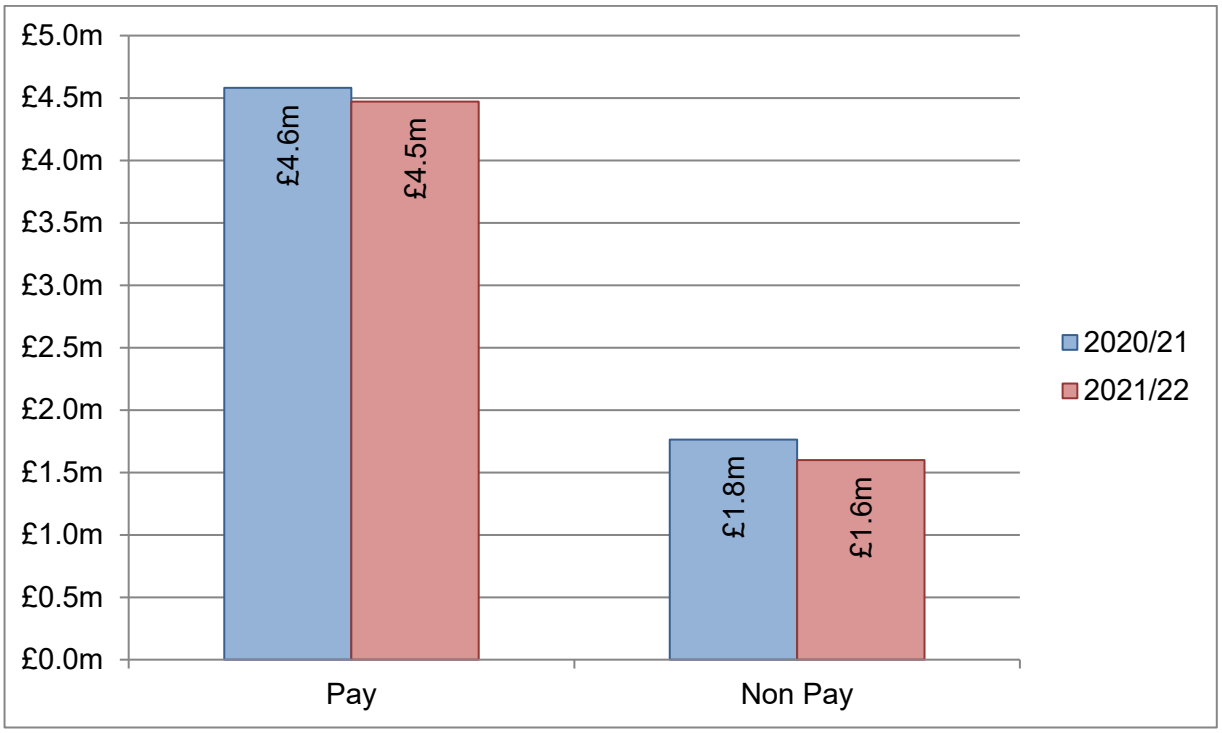


Figure 4 - An analysis of 2020-21 and 2021-22 running costs expenditure



1.3.9 Statement of Going Concern

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

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

1.3.10 Data quality

In 2021-22 the CCG received elements of its business intelligence service from NHS North of England Commissioning Support. There were no concerns regarding the quality of data supplied by them during the year.

1.3.11 Better Payment Practice Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in the notes to the financial statements and are summarised in the tables below for 2021-22.

Non-NHS invoices						
Month	Total invoices paid	Invoices paid on time	% Paid within target	Total value paid (£)	Value paid on time (£)	% Paid within target
Apr-21	986	956	96.96	15,793,850	15,700,769	99.41
May-21	892	867	97.20	12,936,754	12,732,681	98.42
Jun-21	1,059	1,041	98.30	12,807,776	12,692,227	99.10
Jul-21	1,056	1,041	98.58	11,934,270	11,918,116	99.86
Aug-21	941	931	98.94	11,897,130	11,843,543	99.55
Sep-21	991	961	96.97	9,934,955	9,754,306	98.18
Oct-21	1,182	1,168	98.82	12,745,845	12,728,490	99.86
Nov-21	1,091	1,057	96.88	11,464,194	11,349,883	99.00
Dec-21	907	867	95.59	10,313,653	10,157,488	98.49
Jan-22	1,021	955	93.54	14,398,179	13,651,516	94.81
Feb-22	989	969	97.98	15,672,538	15,420,748	98.39
Mar-22	1,094	1,067	97.53	16,259,615	16,187,167	99.55
Totals	**12,209**	**11,880**	**97.31**	**156,158,759**	**154,136,934**	**98.71**

Table 2 - Payment of non-NHS invoices in 2021-22

NHS invoices						
Month	Total invoices paid	Invoices paid on time	% Paid within target	Total value paid (£)	Value paid on time (£)	% Paid within target
Apr-21	74	74	100.00	30,345,121	30,345,121	100.00
May-21	64	64	100.00	28,599,387	28,599,387	100.00
Jun-21	27	27	100.00	28,668,342	28,668,342	100.00
Jul-21	40	38	95.00	28,978,786	28,972,164	99.98
Aug-21	24	24	100.00	28,755,407	28,755,407	100.00
Sep-21	43	41	95.35	28,824,423	28,771,756	99.82
Oct-21	44	41	93.18	32,533,234	32,489,013	99.86
Nov-21	36	35	97.22	29,120,178	29,113,636	99.98
Dec-21	29	29	100.00	30,946,399	30,946,399	100.00
Jan-22	35	35	100.00	30,752,733	30,752,733	100.00
Feb-22	41	39	95.12	31,963,944	31,959,259	99.99
Mar-22	52	51	98.08	29,869,710	29,860,236	99.97
	509	**498**	**97.84**	**359,357,664**	**359,233,451**	**99.97**

Table 3 - Payment of NHS invoices in 2021-22

1.3.12 Control issues

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

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

During 2021-22 the CCG continued its approach to financial planning, management, and delivering responsive services and value within the Covid-19 financial regime. A break-even plan was submitted for H1 and H2 of the financial year and was delivered.

The CCG has continued to work effectively with partner organisations in delivering services within resource envelopes, including delivering on key investment commitments including mental health services and primary care capacity, in line with Governing Body commitments and national planning expectations.

Throughout 2021-22 the CCG has maintained its rigour in financial reporting, forecasting and assessment of financial risk. The CCG has been forecasting delivery of a break-even position throughout the financial year and the Chief Finance Officer of the CCG provides regular detailed financial reports on financial performance against plan and other key financial duties to the CCG's Finance and Performance Committee, the Audit Committee, and the public meeting of the Governing Body and these are subject to independent scrutiny. These reports are also provided to internal and external auditors and to NHS England and Improvement in its role as the CCG's regulatory body.

Financial control received the highest assurance rating from Internal Audit for the second year, alongside no recommendations for improvement.

The CCG continued to make effective use of the National Hospital Discharge Programme fund to work with City of York Council and York & Scarborough Teaching Hospitals Trust to facilitate rapid and timely discharge and maximise available capacity for patients with Covid and those on waiting lists.

Additional non-recurrent funding allocated through Winter were agreed with clear outcomes and each scheme was reviewed through implementation and close-down to assess effectiveness and value for money.

The Head of Internal Audit opinion for the year gives an overall rating of significant assurance that controls are effective and operating consistently across all aspects of the CCGs functions.

1.4 Sustainable development

In October 2020, the NHS published its sustainability goals in "Delivering a 'Net Zero' National Health Service". The aspirations are:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

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

1.4.1 Our areas of focus

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

1. Our care: By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.

2. Our medicines and supply chain: By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.

3. Our transport and travel: By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.

4. Our innovation: By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.

5. Our hospitals: By supporting the construction of 40 new 'net zero hospitals' as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.

6. Our heating and lighting: By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort, and save over £3 billion during the coming three decades.

7. Our adaptation efforts: By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months

8. Our values and our governance: By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

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

The 2021-22 year has seen the majority of staff working from home wherever possible, which will have reduced carbon emissions from work-related travel. However, other workstreams for sustainability initiatives have been suspended due to the pandemic response taking priority over, for example, reducing the use of single-use plastics.

The CCG occupies a portion of an eco-friendly building with rainwater harvesting and heat exchangers to reduce the amounts of fossil fuel and water required to operate the building. The CCG will continue to work towards reducing its carbon emissions in conjunction with its partners.

1.5 Improving quality and safety

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

The CCG's focus on quality and safety is led by the Quality and Nursing Team. The CCG actively seeks patient feedback on health services and engages with the population with the aim of using patient experience to improve services. It also supports primary medical and pharmacy services to deliver high quality primary care services.

The team's work is overseen by the Quality and Patient Experience Committee, a sub-committee of the Governing Body. The committee's objective is to ensure that commissioned services are safe, effective and provide a good patient experience. It also focuses on continuous improvement in line with the NHS Constitution (2011) and the CCG's Quality and Assurance Strategy.

The committee's membership includes four Governing Body members – Lay Member of the Governing Body (Chair) Clinical Chair of the Governing Body (Deputy Chair), the Executive Director of Quality and Nursing (Chief Nurse). The committee's report, which is discussed at the Governing Body meeting, describes how the CCG identifies and seeks assurance on key components to support quality improvement.

These include:

- Quality in Primary Care
- Infection Prevention and Control
- Serious incidents
- Maternity
- Patient experience
- Patient engagement
- Regulatory inspection assurance
- Adult and children safeguarding
- Quality in independent care providers
- Mental health
- Cancer
- Children and young people
- End of life care
- Medicines management

The committee maintained monthly meetings to ensure continued oversight and assurance upon quality and safety of the CCG's commissioned services and work the CCG was undertaking working with partners to ensure patient safety, understand the emerging risks within the system and how these are being mitigated against.

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

1.5.2 Monitoring quality

All services are reviewed in line with the NHS England and Improvement's Quality Monitoring and Escalation Process and services are reviewed dependant on their level of surveillance.

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

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

The CCG has maintained quality and safety discussions with all main commissioned services. A summary below if provided for our highest volume commissioned providers

1.5.3 York and Scarborough Teaching Hospitals NHS Foundation Trust

Although there has been a focus upon recovery of elective services throughout 2021-22, our acute commissioned services have needed to continue responding to the surges in admissions and treating those with COVID-19, and as such, some routine services have been stood down intermittently throughout the recovery period. This has led to an increase in the number of people

waiting for elective routine appointments and procedures. The CCG has and continues to work with partners to ensure all waiting lists are reviewed and assessed against the clinical risk to the patient. The CCG also continues to work with system partners to ensure the elective recovery programme reduces waiting lists and finds ways to transform the way services are delivered in the future.

Following the removal of CQC notices for York and Scarborough Teaching Hospitals NHS Foundation Trust, the formal Quality and Safety Subcontract meeting was re-established. This committee has continued to meet to support improvements and assurance monitoring. Key areas of focus have been response to continued pandemic associated system pressures, concerns arising from learning from Serious Incidents particularly fundamentals of care including nutrition / hydration, infection prevention and control and maternity services.

1.5.4 Primary Care Services

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

Our commissioned services in primary care have delivered a high-quality active response to the delivery of COVID-19 vaccinations ensuring a relentless focus upon our most vulnerable citizens.

1.5.5 Tees, Esk and Wear Valleys NHS Foundation Trust

During 2021 a Quality Board was established, chaired by NHS England and Improvement to support Tees, Esk and Wear Valleys NHS Foundation Trust to achieve improvements and gain assurance relating to safety following their CQC inspection. To avoid duplication, the CCG continues to be represented by North Yorkshire CCG's Chief Nurse at this Quality Board.

An output from this work has seen the CCG's Deputy Chief Nurse and Patient Safety Lead providing additional capacity to the Trust in reviewing historic open Serious Incidents to provide assurance and support closure by a commissioning panel.

As the Quality Board's remit cover the whole Trust across multiple CCGs, we have maintained a Locality Performance and Quality Subcontract meeting combining both CCGs from the Vale of York and North Yorkshire. This has ensured a continued, focussed attention to local services.

1.5.6 Mental health services

Mental health services continued to work throughout the pandemic, developing risk assessment and review systems to ensure that clinical risk was appropriately identified. There are ongoing workforce pressures due to COVID-19, including staff sickness, recruitment and vacancies. The service has revisited its COVID-19 response plan identifying key areas of staff mobilisation that can support essential pathways of inpatient and crisis services, as well as other high-risk areas, including EIP, perinatal and eating disorders.

1.5.7 Children’s mental health services

For children's services, there is now a blended offer of virtual and clinic appointments, although critical and high-risk patients are prioritised for appointments in person. Many appointments and assessments are now conducted virtually, increasing the numbers of children seen within services.

Overall waiting lists have not risen significantly, however there has been a significant increase in referrals towards the end of 2021 and acuity has also risen. Taken together with high rates of staff vacancy despite active staff recruitment there will be an impact on waiting times in 2022 and close attention has been paid to systems for clinical risk assessment and review to maintain patient safety.

The CCG is continuing to work with Tees, Esk and Wear Valleys NHS Foundation Trust and its wider system partners around approaches for future service delivery at all levels of need to ensure access to advice and care with a focus on neurodevelopmental disorders and extending the offer for low mood and anxiety

1.5.8 Adult mental health services

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

1.5.9 Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT) service continue to improve. Referrals are increasing into the service and the team are back at full capacity with an additional 12 trainees due to qualify through this year meaning the locally agreed Access target is currently being met. Staff have also been released to complete the Long-Term Conditions training ensuring that the skill mix is in place for further roll out of LTC pathways in line with the Long-Term Plan ambitions. There is still a small backlog of people waiting for Step 3 treatment, but the number of High Intensity Therapists has been increased to manage this and the Recovery Rate continues to be above 50%.

1.5.10 Crisis service

The 24-7 all age crisis line has been provided by Tees, Esk and Wear Valleys NHS Foundation Trust since the start of the pandemic and has been expanded to include a crisis response practitioner to determine and assess risk at the point of contact. The aim of the service is to reduce the likelihood of self-harm, potential Section 136 presentations, and attendance to A&E.

Community-based crisis alternatives have continued to provide support throughout the pandemic including at the York Safe Haven and York St. John Converge.

Funding has been secured through the Crisis Care Concordat to explore Crisis Alternatives in York and Selby and work is ongoing to develop a sustainable phone-line response to make the routes into and through mental health services clearer and easy to access for people in crisis and those wanting ‘low level’ support.

1.5.11 Community Transformation Programme

The programme has continued at pace with the help of a successful bid for Community Mental Health Transformation funding which will not only bring investment into the work force but will strengthen multi agency partnership working across the city and the Vale of York.

1.5.12 Connecting our city

This is the vision for the City of York developed in the context of the system wide community mental health transformation agenda. It describes a whole system approach informed by place-based social action and asset-based community development, working towards a more integrated, community based, multi-disciplinary mental health service.

1.5.13 Northern Quarter Project across the City of York

The project is progressing with the continued help of a successful bid for Community Mental Health Transformation funding which has secured investment into the voluntary, community and social enterprise work force. The mental health partnership working across the city and the Vale of York continues to work to develop services under the Connecting our City Programme. We have seen around £800,000 invested in services to support people with mental health needs including increased social prescribing, enhancing the recovery and rehabilitation pathway. We have also invested in roles to increase and improve co-production and involvement of people with experience of mental health needs.

1.5.14 Selby transformation

The strong Mental Health Partnership continues in Selby and has developed in the other parts of the Vale bringing together of specialist mental health services, primary care and the voluntary sector to develop the whole system to better support people with emotional and mental health needs.

Tees, Esk and Wear Valleys NHS Foundation have now employed Primary Mental Health Workers in partnership with Primary Care Networks to work within primary care and provide a direct service to people who need them. These roles are providing a bridge between primary care and specialist mental health services, and we are already having positive feedback from people who have accessed these roles as well as a positive impact on demand for secondary mental health services.

As part of the national plan the aim is for every Primary Care Network to have one Primary Mental Health worker in the first year growing to three over the next three years.

We are now focussing on developments for people with an eating disorder and their families. We have commissioned 'Beat' (eating disorder charity – formally the Eating Disorders Association) to support people while they are waiting for specialist services.

In addition, we are developing a Small Grants Scheme to further enhance and grow our community assets via the voluntary, community and social enterprise sector.

1.5.15 Adult Autism and ADHD

Procurement of the assessment and diagnostic service is complete, and provider The Retreat was the successful bidder. The new service began on the 1 April 2022. A waiting list initiative is in place which the CCG continues to monitor against the ongoing rising demand.

Spending Review funds have been used to commission a post diagnostic support service for patients receiving a diagnosis. This will be in the form of a neurodiverse support wellbeing group to provide information on key topics that contribute to physical and mental health as well as providing a forum for autistic adults to meet and share learning and experiences.

1.5.16 Dementia

Progress has been made including early identification, raising awareness in primary care, addressing low diagnosis rates and the provision of pre and post diagnostic support, achieved through the recruitment of four dementia care coordinators and a specialist dementia nurse located in GP practices.

Diagnosis rates remain low however and reflect a national trend largely due to the pandemic, with many older people told to shield and remain at home choosing to delay their memory assessment.

Managing the backlog of appointments and staff absences due to COVID-19, has had an impact on the capacity of the Memory Service resulting in long waits from referral to diagnosis. The CCG is working with Tees, Esk and Wear Valleys NHS Foundation Trust and primary care to look at alternative pathways to diagnosis and currently undertaking an audit with Tees, Esk and Wear Valleys NHS Foundation Trust to identify bottlenecks in the memory service.

1.5.17 Pathway to Recovery Project, Foss Park Hospital.

This project aims to connect people with the right level of care at the right time to help achieve independence and recovery. It brings health and social care services together, along with other partner agencies, to refocus the current discharge processes by looking at how they can support the person’s pathway to recovery and determine what is needed, when how and by who. This multi-disciplinary approach aims to ensure that the patient is provided with the support needed to facilitate their discharge and prevent readmission. Funding has also been secured for a full-time Social Prescriber to work within the multi-disciplinary team to build and maintain effective place-based partnerships with voluntary sector providers and statutory services to support social prescribing options for vulnerable people experiencing mental ill health.

1.5.18 Physical Health Checks for People with Severe Mental Illness

Evidence shows that people with severe mental illness (SMI) die up to fifteen- twenty years younger than the average population; one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. This disparity in health outcomes is partly due to physical health needs being overlooked, both in terms of identification and treatment.

A target set by NHS England and Improvement aims to increase the uptake of physical health checks for patients with SMI to 60% of ‘active’ patients on the mental health Quality Outcome Framework.

Quarter three performance in 2021-22 in the Vale of York is 41.5% compared to 21.2% at Quarter three in 2020-21. Significant improvements have been made across primary care to improve take-up of the recommended health checks. The approaches developed by practices include a 'digital first' approach, bespoke outreach by social prescribers and through liaison with voluntary and third sector organisations and refocusing of existing resources to establish an enhanced primary care mental health team. All City of York Primary Care Networks have made improvements due to coordinated administrative work to identify patients and invite them to take-up the health checks. This approach will be sustained in 2022-23 and a system established for effective recall of patients. A steering group has been established to drive this work under the York Mental Health Partnership; 'Connecting our city.' Joint work is ongoing with City of York Council's Sport and Active Leisure Team to expand delivery of sport and activity experiences to people with a severe mental illness and opportunities for them to participate in these activities. To support this, staff at sports clubs have been offered and taken up Mental Health Awareness for Sport and Physical Activity+ training. So far, 16 have completed the mental health training with a further 22 ongoing. This offer is available for people with a severe mental illness and referrals can be made by GPs and Social Prescriber Link Workers based in primary care.

1.5.19 Resilience Hub

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

1.5.20 Adult Eating Disorders

NHS England and Improvement announced in summer 2021 that all Integrated Care Systems were due to receive the first of three years of transformation funding to develop new and integrated models of primary and community mental health care in 2021-22. The model focuses on pathways for community-based rehabilitation needs including eating disorders, which has been identified as a key priority in year one.

1.5.21 Continuing Healthcare and Section 117 Case Management

Prior to the pandemic the CCG was consistently delivering the national performance expectations for Continuing Healthcare (CHC). National guidance was to cease undertaking eligibility assessments between March and September 2020. In line with other CCGs this resulted in a significant backlog of deferred assessments which were required to be completed by the 31 March 2021 and this was achieved. Throughout 2021-22, the CHC team has exceeded the national target for completing Decision Support Tool assessments within 28 days, with the average exceeding 96%.

Individuals in receipt of Continuing Healthcare have complex health needs and the CCG's CHC team has returned to reviewing those needs annually or more frequently if required. The team actively offer Personal Health Budgets (PHB) to those newly eligible for CHC funding. CHC team members continue to offer a Clinical Case Manager to all those in receipt, whether they take up the offer of a PHB or not.

Clinical Case Managers are involved in those transitioning from Children's Continuing Care into Adult CHC and are involved in commissioning appropriate adult services for those individuals.

The CHC team manages the Fast Track Service in line with the national framework and it works closely with the Specialist Palliative Service and the local hospice.

The Vulnerable People's Team case manage individuals (adults, children and young people) with complex mental health, learning disability and/or autism. The team provides support and advice on the S117 Aftercare process for the discharges from acute mental health hospitals and specialised/forensic commissioning. The team also undertakes quality visits and review the S117 Aftercare for individuals within locality and out of area. These virtual and face to face reviews are completed jointly with social care wherever possible.

The National Safe and Wellbeing reviews were completed for six individuals with a learning disability and/or autism and are recorded within the assuring transformation dataset as being an inpatient in a mental health hospital on 31 October 2021. These were to review and ensure robust quality oversight of their care standards. These were in addition to their 6-8 weekly commissioner oversight visits. The team also continues to be actively involved with the Joint S117 Aftercare Policy steering group review and developing the process to include Children and Young people who are eligible for s117 Aftercare.

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

The CCG through the Continuing Healthcare Team has continued to provide a daily link to the acute trust and active involvement with system partners in improving the timeliness of hospital discharge and the implementation of the early discharge to assess process.

The national discharge programme was implemented with the four Pathways assigned by the acute hospital and Pathway 0 being the hospital discharge route. The Pathways 1-3 continue to

be discussed on the twice daily calls with the appropriate service identified to facilitate the individual's discharge via the three local authorities, CHC and specialist rehabilitation services.

A discharge coordinator from the CCG worked in conjunction with a discharge coordinator from North Yorkshire County Council to provide the service across York and North Yorkshire. Between them they have provided strategic focus for discharge, the ability to unlock any operational blockages and as part of a Silver Tactical Group create a direction for continued improvement for post April 2022.

An enhanced community equipment service has continued to be available throughout the year to rapidly provide suitable equipment seven days a week to help meet individual needs at home and facilitate rapid discharge.

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

The SPoC and the CHC Fast track team held daily calls to triage patient's clinical needs into either the hospice or to home for patients requiring end of life care in the last days or few weeks of their life. The hospice at home service supported patients at home ensuring earlier discharge, while the CHC team sought provision of care at home from private providers. For those requesting to be cared for in a care home the Continuing Healthcare fast track continued to commission a bed and case manage.

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

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

1.5.23 Personal Health Budgets

The CCG has continued to take a proactive approach to personalised care and offered Personal Health Budgets as the default position for people who were eligible for Continuing Healthcare. The CCG has continued to work with the community wheelchair service to further develop their approaches for offering Personal Wheelchair Budgets. This has included raising awareness and seeking feedback through the Wheelchair service user partnership.

1.5.24 Digitisation of Continuing Healthcare

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

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

1.5.25 Quality intelligence

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

The CCG also works closely with its safeguarding partners, the Care Quality Commission, local authority partners, the Police and voluntary sector to ensure that timely information sharing takes place and any early warning signs are captured and responded to.

Feedback from patients and the public is discussed at each Quality and Patient Experience Committee. For each committee meeting an update on recent patient and public involvement work and future plans is provided. Feedback from the CCG’s engagement activity is highlighted and discussions around how this can help to shape the CCG’s commissioning work and decisions have a pivotal role. Both the Quality and Patient Experience Committee and the Governing Body regularly hear patient stories, often from the patients themselves and this helps to ensure that the CCG remains grounded in how its commissioned services are working for people.

1.5.26 Patient insight and feedback

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

1.5.27 Research and development

NHS Vale of York Clinical Commissioning Group (CCG) continues to maintain and develop its statutory duty to 'promote research, innovation and the use of research evidence' (Health and Social Care Act, 2012). The Research and Development Manager supports the National Institute for Health Research (NIHR) Clinical Research Network (CRN) Yorkshire and Humber as a conduit to research in primary care and provides specialist research knowledge to those new to the research landscape, ensuring all local research projects adhere to the UK Policy Framework for Health and Social Care Research (2017).

The role of Research and Development in the pandemic has been recognised as pivotal in 'fighting' COVID 19. R&D has helped by gathering clinical and epidemiological evidence to inform national policy. The nationally prioritised COVID19 research studies have supported the creation of better diagnosis, tested potential new treatments, and helped to drive forward the vaccine trial work.

Our member practices have supported and undertaken Urgent Public Health (UPH) Covid19 studies and have continued with their broad range of NIHR portfolio and local research studies providing a range of opportunities for our local population to participate in research. A total of 419 participants have been recruited during 2021-22 (an increase of 220% from 2020-21) participating in 17 studies resulting in the CCG being ranked as the third highest recruiting CCG in Yorkshire and the Humber in 2021-22.

As the CCG moves forwards towards the Integrated Care System model, growth and delivery of research will support and contribute towards the improvement of population health and provide an evidence base for better health.

1.5.28 Children and Young People (CYP)

1.5.28.1 Special Educational Needs and Disabilities (SEND)

In December 2019 Ofsted and the Care Quality Commission undertook a joint inspection of the local arrangements and services in place for children and young people with Special Educational Needs and Disabilities (SEND) against the statutory framework of the Children and Families Act 2014. This resulted in a Written Statement of Action (WSOA) being provided to the CCG and local authority requiring the submission of an action focussed response to address the areas of improvement that were required. The statement, clarifying that partnership working to improve the experiences and outcomes for children and young people with special educational needs and disabilities would take place throughout 2020-21 was accepted by the regulators. Work has continued at pace despite the pandemic to embed the improvements detailed within the WSOA and preparation underway for the anticipated revisit in 2022.

1.5.28.2 Increased Capacity

The CCG has invested in several SEND specific posts both within the CCG and in the acute provider trust. An Associate Designated Clinical Officer (ADCO) has been in post since Feb 2021 and this post provides capacity to drive improvement and increase assurance around Education,

Health and Care Plans (EHCPs) and effective liaison between health, education and social care. A business support officer for SEND supports this work and has also been in post for 12 months.

A Transition Nurse Lead for CYP with complex health needs has been appointed in July 2021 within the acute hospital trust. Furthermore, additional posts have been created in the Speech and Language therapy team which is equivalent to full-time Speech and Language Therapist, and an Assistant SEND Coordinator post in Therapies offer additional capacity and focus.

1.5.28.3 Joint partnership

The newly developed children and young peoples' wheelchair forum has ensured that voice of children and young people who are wheelchair users are represented and can influence change in practice. Our wheelchair provider, Nottingham Rehabilitation Services (NRS), the Local Authority and the CCG have representatives at the forum and some positive impact is being made including the updating of 'access4all' accessibility map of York.

Parent carers and young people co-produced the new request for statutory assessment, Education, Health and Care plan (EHCP) and the EHCP annual review paperwork in collaboration with education representatives, the LA and VOY CCG.

Six monthly audits have been developed and are used across the SEND partnership to gather evidence of how co-production is being used and embedded in education, health and social care.

During SEND Partnership Board meetings the Parent Carer Forum have reported that families are seeing benefits of joint partnership, co-production, feeling listened to and feeling involved as a partner in the process.

1.5.28.4 Quality assurance and processes

Since February 2021 there has been a single point of access at the CCG for SEND queries. This ensures the CCG can support SEND partnership colleagues in a timely and effective manner.

The ADCO sits on a multiagency EHCP panel and has oversight of CYP's presenting needs, for which health services are involved. This provides an opportunity to monitor performance of each service and the quality of health advice provided.

A health questionnaire was developed to support the process of seeking health advice for EHC needs assessment and is becoming embedded with usage increased from 20% in July - September 2021 to 36 % in October - December 2021. Awareness and training sessions have been delivered to schools and education settings who are usually responsible for supporting the CYP and family to submit the request and inclusion of the questionnaire.

Timeliness of return of the statutory health advice is monitored retrospectively by the LA however the CCG are currently supporting providers to set up internal data capture and monitoring systems to so they can proactively manage their returns and ensure they meet the statutory timeframe.

A health advice template was developed by the SEND Partnership to standardise how advice is returned and to support practitioners to provide coproduced advice that was compliant with the statutory requirements and include how their advice would support the CYP to achieve their holistic outcomes. The use of this standardised template has increased from 45% in June - September 2021 to 74% in September - December 2021. The impact if this is an increase in compliance and quality of the advice.

A Quality Assurance Framework for SEND has been devised, implemented and is fully operational. Multi agency auditing takes place as well as multi agency moderation using a Quality Assurance tool.

The LA leads the multiagency auditing and moderation of audited plans, with health teams undertaking a proportion of the auditing and the ADCO representing health on the multi-agency moderation panel. Findings from the moderation of audits revealed that in September 2020 25% of EHCP's were graded as good or better. In August 2021 86% of EHCP's were identified as being good or better.

Availability and quality of health advice submitted for panel was audited by the ADCO and in June - September 2021 91% of CYP considered at EHC panel had statutory health advice returned. September - December 2021 this had increased to 97%. In terms of quality, between September - December 2021 96% of the advice submitted was complaint, with 13% graded as outstanding.

1.5.28.5 Training and Awareness

A wide range of training events have been jointly delivered by the LA and CCG across the partnership to increase awareness, understanding and practice models within SEND. We continue to develop our workforce strategy to ensure a sufficient, skilled and stable workforce is in place. Feedback from these events has told us that understanding of specific areas such as SEN/EHCP legislation, Outcomes Framework and Joint Partnership have increased in every session.

Other feedback includes quotes explaining how the knowledge learned will be further embedded when it can be put into practice in ‘real life’ cases and quality of practice for example:

"I can provide more advice for colleagues when it comes to seeking child’s voice – especially for non-verbal children".

"I can really think about how I can involve young people in my assessments from the outset and involve them in the decisions I make".

"I will think about how I can co-produce plans with children who find it hard to participate in their meetings".

We have delivered 15 training sessions to health staff including specialist nursing team, school nurses, CAMHS, adult learning disability team, paediatricians, children's therapy team, NRS Wheelchair services, and senior leaders within the CCG. A rolling programme of training has been planned for 2022 which will be jointly delivered by the local authority, the CCG and the Parent Carer forum.

A SEND training package has been developed in partnership with North Yorkshire CCG and the parent Carer Forums for York and North Yorkshire. This training package is for all NHS staff in local providers, and it has also been shared regionally and nationally.

The ADCO and our local Children and Adolescent Mental Health Services (CAMHS) have been working closely with other CAHMS services in the region and with NHSEI to improve processes and quality in relation to statutory health advice for EHCPs. This work has also fed into Council for Disabled Children's CAMHS eLearning module that has been developed and released and a FAQ document that Child Development Centres (CDC) are currently developing to support staff writing advice for EHCPs.

A SEND Champion role has been set up within York and Scarborough Teaching Hospital NHS FT by the Transition Nurse lead and the ADCO. The development of the role is in early stages however the group are very motivated and enthusiastic and there has been suggestion that the champions take responsibility for varying elements of service development e.g voice and participation, quality assurance, training, Local Offer and website updates etc.

1.5.28.6 Transition

The Transition Coordination lead nurse started in post in July 2021 at York Hospital working within the paediatric specialist nursing team.

Since commencing in post they have developed a Transition Standard Operating Policy (SOP) and guidance of transition of CYP depending on level of service involvement and complexity of need. This graduated response to transition need means that those CYP with complex care needs can be referred to the Transition lead who can advise accordingly and can manage a small caseload of CYP with complex care as required. They also support the implementation of a transition pathway for CYP with long term conditions, supporting clinical colleagues in providing effective and timely transition to adult services for the young people on their caseloads. The Transition coordinator is supporting the Trust to develop a database of CYP who are on a transition pathway and is supporting colleagues to ensure that a CYP journey onto adult teams or primary care is smooth and purposeful. There is work to be done around measuring impact and outcomes in relation to this role and transition for CYP and the Lead nurse is working with regional Transition Network to develop these.

1.5.28.7 Special school and community children's nursing

The CCG has continued to work closely with York and Scarborough Teaching Hospital NHS Foundation Trust to improve the quality of community services for children and special school nursing. Reporting against the quality metrics for the agreed new specification has begun, with a

focus upon quality narrative and articulation of outcomes for children and young people and their families.

1.5.28.8 End of Life care for children and young people

The CCG has continued its investment into end-of-life care for children and young people. By working in partnership with York and Scarborough Teaching Hospital NHS Foundation Trust's Community Children's Team and Martin House Children's Hospice, the joint aim is to increase workforce skills and capacity to enable more children to be supported at home. The revised reporting arrangements for the community children's team now includes information regarding the quantitative and qualitative impact upon children, young people and their families.

1.5.29 Quality improvement and supporting our Partners in Care

Our most vulnerable residents are those who have care needs whether they live in a care home, supported living accommodation, or receive domiciliary/ supportive care. In partnership with health, social care and third sector partners, the Quality and Nursing Team continues to support all independent care providers to provide high quality, safe, effective care, and experience for residents. The Team also work with colleagues to support market and business continuity.

Work stream priorities over the past year have been influenced through locally identified needs, the national framework and guidance for Enhanced Health in Care Homes with priority given to needs arising from the pandemic. This includes support with resident and staff vaccination programmes, testing, visiting, outbreaks management, guidance, training and more.

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

- Continuity of service across the independent care sector
- reducing the impact of COVID through timely infection prevention and control advice, guidance, and support
- wellbeing support for health and social care staff and residents
- Supporting digital solutions to improve access to timely care and support such as telemedicine, virtual consultations, and pulse oximeters
- Supporting a reduction in unnecessary admissions
- Supporting safe and timely hospital discharges
- the supply of communication systems to all care homes, and some supported living settings (tablet devices, Capacity Tracker, NHS email accounts)
- Further building the network of clinical primary care leads and community nursing leads for each care home.
- Continued communication through weekly bulletins and fortnightly virtual meetings to support care providers across the sector
- Training has continued both face-to-face and in a virtual format

1.5.30 Summary of achievements throughout the pandemic

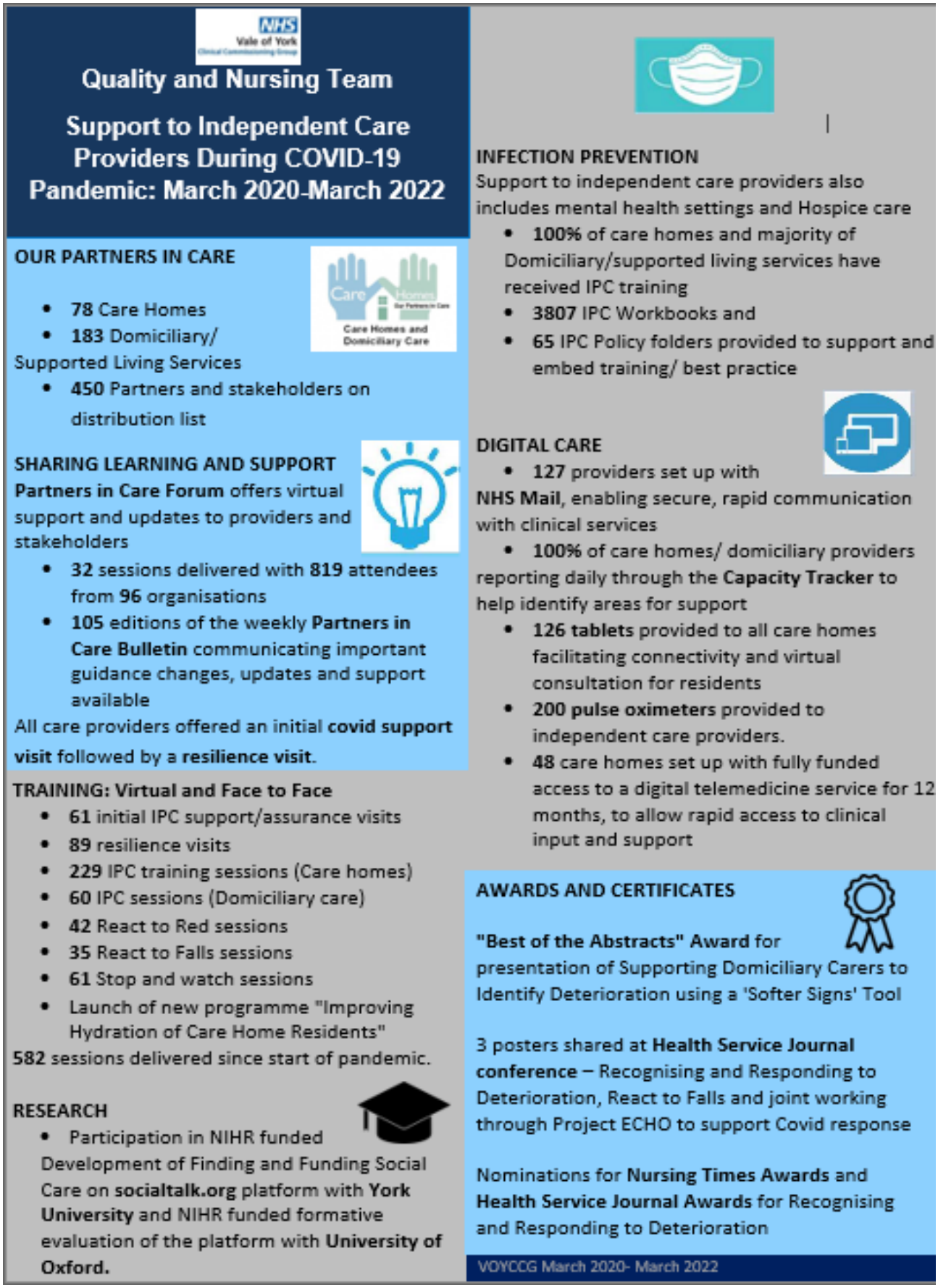


Fig 5 – A summary of achievements throughout the pandemic

1.5.31 Covid support provided throughout the pandemic

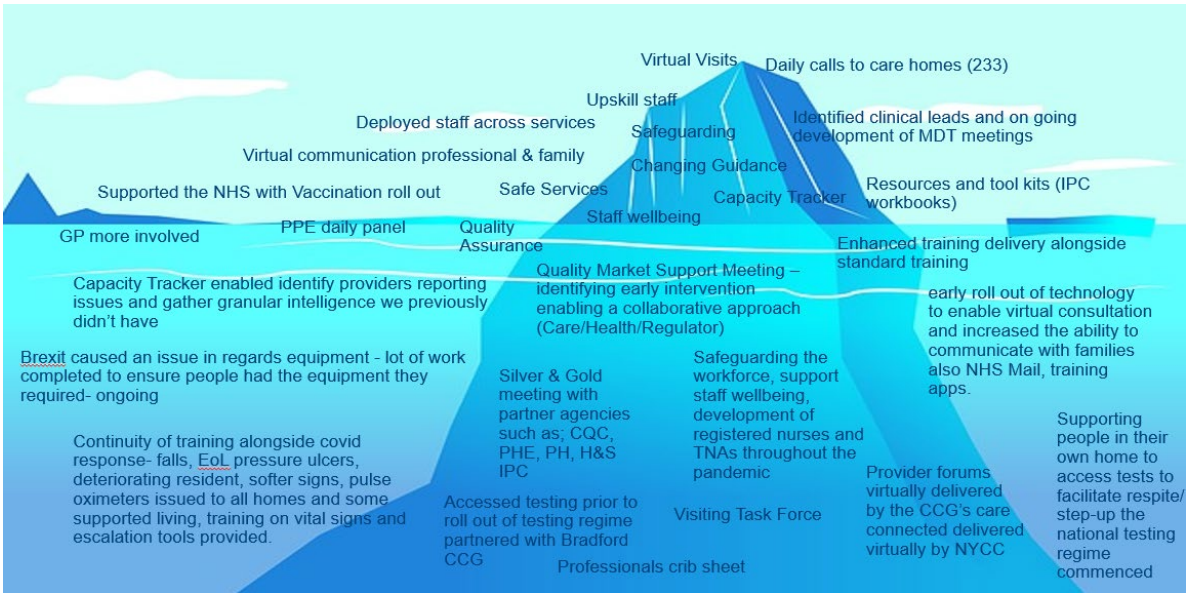


Fig 6 - Covid support provided throughout the pandemic

The diagram above describes how the CCG have worked alongside colleagues to support the Independent Care sector during the pandemic.

The CCG's Quality and Nursing Team have continued to support quality assurance work and the implementation of action plans where necessary, either face to face or virtually. Emphasis continues proactive work to prevent transmission of Covid-19 and other infectious diseases. Providers that experienced outbreaks are offered visits by the team to ensure all interventions and support are in place to manage the situation. As guidance in relation to Covid-19 has changed the team have flexed their approach as necessary to ensure response is timely, proportionate and adds value. The CCG alongside Colleagues in NYCC secured funding to distribute IPC manuals and workbooks to all care homes and domiciliary care agencies across the geography ensuring every member of staff had their own resource.

The past year has observed a further strengthening of relationships with colleagues across the local authorities and public health, community nursing teams and other stakeholders.

Recognising the approach in supporting care homes during the pandemic the Nursing Team was recognised as a winner in the North Yorkshire County Council Innovation Awards 2021. The Team are honoured to have been included in this recognition alongside colleagues at NYCC. This relationship has benefitted collaborative working for example where home closures/ moves of residents at short notice have been required. As the CCG transitions into new ways of working as an ICS there are plans to pilot an integrated team which will see the Nursing Team and North Yorkshire County Council's Quality Improvement Team join together to provide a true health and social care response to support the sector.

The Nursing Team were successful in sharing the work supporting independent care providers using a virtual learning platform during the Covid-19 pandemic as part of the HSJ National Patient Safety Congress in 2021 under the covid response category. As part of this work the

CCG collaborated with Project ECHO to facilitate twice weekly partners in care forums which now occur fortnightly with contribution into other education programmes led by ECHO.

1.5.32 Enhanced Care in Care Homes (EHCH)

During the past year work to strengthen the Care Home Lead GP and Nursing networks has gained traction. The CCG are supporting the frailty agenda and ensure representation for care homes alongside social care colleagues. Work in relation to personalised care planning, frailty scores and urgent care response is underway led by Primary care colleagues.

The CCG Nursing Team is also working with the District Nursing Team to develop delegation of blood glucose testing and insulin injections to care staff. This is a programme that will deliver real positive changes for residents who require support with the administration and management of insulin and improve safety as a result.

The DN team are also collaborating with the Nursing Team in the CCG to look at how wound care and support with continence assessment may be improved further.

1.5.33 Telemedicine

As part of a system response to significant challenges faced by the Health and Social Care sector, the NHS Vale of York CCG have offered a fully funded 24/7 digital care telemedicine service to our older adults. 'Immedicare' has been commissioned to compliment the current support offered by the system and offers an alternative method for care home staff in accessing timely advice and intervention for residents. It is anticipated approximately 47 nursing and residential homes within the Vale of York will utilise the service.

The service is a partnership between Airedale NHS Foundation Trust, and technology partner Involve. This service is currently supporting several hundred residential care and nursing homes throughout the UK, which uses secure video conferencing technology to connect care homes directly to an experienced NHS clinical support team based in a specialist Digital Care Hub; located at Airedale NHS Foundation Trust. Benefits the service is intended to deliver for care homes are:

- Provide early intervention to reduce time to treatment for residents.
- Allow access to expert clinical advice and support for staff at any time.
- Full access to clinical records by clinical staff to provide a comprehensive clinical assessment and ongoing monitoring.
- Keeping residents in familiar surroundings to help reduce anxiety and support living well.

The service is fully integrated into local health and social care system, allowing the call handlers to make a referral onwards to other services where required. The service has clinical responsibility for a resident until case is closed or referred to a local healthcare professional.

Homes are encouraged to contact the service for any residents they have concerns about, the service is able to assist with a wide range of conditions including for example:

Medication advice, suspected infections, falls, abdominal pain, pain management, general deterioration, swallowing difficulties, seizures and drowsiness, verification of expected death. The service also offers training and clinical supervision for staff.

1.5.34 Training Provision

It has remained vital that care staff are supported with the right training to undertake their roles the importance of this has been recognised more than ever during the pandemic. Aside from IPC training The Quality & Nursing Team have a comprehensive offer to care providers which is well evaluated, and care staff engage well with.

1.5.35 Early Identification of Deterioration

Unless staff can identify if a resident's condition has deteriorated and the subsequent need for onward escalation then support from health care responders is limited. As the Immedicare service is installed in homes the Nursing Team offer training to maximise the impact of support available.

The team have continued to deliver important training and support with all independent care providers to recognise the early signs of deterioration in residents. This has been made possible by using a ‘softer signs’ Recognition and Responding to Deterioration tool that enables earlier conversations to be held with the health care team and person-centred plans to be put in place to meet the resident’s needs.

This helps to instigate earlier interventions to prevent further deterioration and transfers to hospital when they are not always necessary. This has been invaluable during the pandemic with extra training to support care staff in making physiological observations and the implementation of Pulse Oximeter equipment. All care settings have been provided with Pulse Oximeters along with training to support the monitoring of residents, particularly those with, or a suspected COVID-19 diagnosis.

This proactive approach to identify early intervention was recognised by the Nursing Times Awards in 2020 resulting in the CCG achieving a finalist status and more recently the team presented a poster and presentation at the HSJ Patient Safety National conference 2021 receiving a certificate award for best oral presentation and abstract.

The Improvement Academy and colleagues from NHSE are interested in working with the team to further develop this approach to include how changes in cognition might be incorporated. The Nursing Team have already demonstrated positive impact of the tools when used for mental health and hope to develop this further over the next year alongside the 'React to Dementia' training package.

1.5.36 React to Red

The prevention of pressure ulcers remains a high priority in local care settings. The CCG has continued to support care staff and residents through the continued implementation of the React to Red programme. This work identified as another proactive approach to health and care, was recognised the Health Service Journal in its Patient Safety Award 2020

1.5.37 React to Falls Prevention

Preventing falls in health and care settings continues to be a priority. Work to reduce the risk of falls continues through the 'React to Falls Prevention' programme. Despite the pandemic, care homes have continued to request training and support and the CCG's Quality and Nursing Team has been a constant by providing virtual or face to face support. The CCG's React to Falls Prevention work has seen a significant impact in reduction of avoidable harm and admission to hospital. This was recognised in 2021 by the HSJ National Patient Safety Conference under the Education and Training poster category where the team shared learning from focussed piece of work reducing risk of falls in care homes.

1.5.38 E. Coli bacteraemia Reduction Programme

As part of the CCG's commitment to supporting independent care providers the nursing team are leading on a quality improvement programme aimed at reducing the incidence of E. Coli bacteraemia across NHS Vale of York CCG and North Yorkshire CCG care homes.

Literature acknowledges poor hydration as a major contributory factor to a higher rate of E. Coli bacteraemia across the locality, and with this in mind, the team will be embarking on a programme of work working with care staff to focus on supporting optimum hydration in residents of care homes. The team recognise many homes have innovative ways of working to help support residents with their drinking, homes will be approached by the nursing team with the offer to participate should they wish.

The programme will involve face to face training and the use of workbooks to explore ways of improving service user hydration. As part of the project care homes will be supported to evaluate their current hydration assessment and monitoring tools and progress improvements where appropriate. The training includes good continence care, catheter hygiene and includes advice around the 'No Dip' principles for testing urine in suspected UTI.

Through improving recognition and response to hydration needs of residents in care homes, it is anticipated that the following outcomes might be achieved:

- Reduce avoidable harm caused through poor hydration
- Enhance clinical outcomes (reduce need for antimicrobial treatment, hospital conveyance/ admissions)
- Improve experience for residents in care homes
- Improve staff experience/ safety culture
- Improve antimicrobial stewardship

The work has several drivers to help achieve the strategic aim and homes are already engaged with the team.

1.5.39 Discharge standards/ learning from incidents

Led by the Chief Nurse, a consultation with stakeholders has led to the development of a set of agreed Discharge Standards. These are based on national guidance and best practice but most importantly informed on by local colleagues to provide a consensus on expectations across settings for what good discharge looks like. It describes how staff involved in the resident journey

can contribute to successful transfers of care. It is anticipated that these standards can be placed into action, ensuring that resident safety and positive journeys in care can be protected.

1.5.40 Equipment

Necessary to maintain independence and safety for residents' equipment provision is closely managed by the CCG. During the past year activity to maintain timely provision despite the challenges of the pandemic and Brexit has continued. Ensuring return of equipment promptly remains a focus of work and the CCG are continuously supporting comms for the recycling of equipment where no longer required.

One care home is looking to start a pilot of onsite equipment provision. This will allow for items that are frequently required and pose a low risk but a high impact on the resident's quality of life to be made available through an agreed process and stored in a storeroom at the home. This will be evaluated to determine if there are wider benefits for both staff, resident safety and the wider system and learning shared.

1.5.41 Research and Education

The Nursing Team have contributed towards the development of a module on the socialcaretalk.org platform, finding and paying for social care sitting on the advisory group led by York University. The team have also been involved in the formative evaluation of socialcaretalk.org with Oxford University.

Linking with research and education is important to the CCG and the Quality and Nursing Team have been active in supporting the new undergraduate Nursing programme at the University of York St John. This is regarded as a real positive development encouraging growth in the number of nursing students across the geography who will link particularly with community and have exposure in social care settings as they move through the course towards their degree qualification.

Maintaining strong links with Skills for Care and other stakeholders who support the social care sector continues to be important for workforce and development.

1.5.42 Maternity services

Maternity services have continued fully throughout the pandemic and throughout 2021-22 have resumed all face-to-face activity. This has been a challenging time as the Trust has needed to carefully balance the needs of partners visiting for key appointments and ensuring safety for when being with their partner during and following labour.

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

Serial Sonography has now been implemented at YSTHFT ensuring the Trust is compliant with the Saving Babies Lives Care Bundle.

Whilst significant progress was made in 2020-21 in the roll out of Continuity of Carer for midwifery led care, this has been stalled due to challenges within the midwifery workforce. A workforce review has been undertaken and a trajectory for how continuity of carer can be achieved over the next 18months subject to increase in midwife recruitment. This however will require significant financial investment in addition to a recent uplift made for core in patient care. However, the most restrictive factor is the shortage of midwives available for recruitment. Options for imaginative recruitment, international recruitment and increase of midwifery training places are being taken forward, however this is likely to take longer than the ambitions set out in the Long-Term Plan to ensure overall maternal safety is prioritised underpinned by staff health and wellbeing initiatives.

The CCG continues to work closely with the Local Maternity System to transition oversight and assurance of serious incidents to ensure there is expertise and the opportunity for wider scrutiny and learning. A clear process is now in place for independent LMS scrutiny at Trust internal assurance panel or indeed if warranted an independent investigator appointed from another provider within the LMS. These arrangements ensure the CCG continues to maintain its statutory responsibilities whilst fuller the LMS maintains oversight and assurance upwards to the Local Maternity System Delivery Board and the Executive Oversight and Assurance Boar.

Progress has been made with system partners in the development of maternal Medicine Networks to ensure expertise for women with the most complex health needs and the development of Maternal Mental Health services ensuring clear pathways and collaboration with expanding perinatal mental health services.

1.5.43 Safeguarding

CCGs have a statutory responsibility to ensure that both the organisation itself and the providers from which services are commissioned, prioritise the safety and wellbeing of children and adults. This work is led by a small, established team of safeguarding nurses and doctors.

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

- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements.
- An established Designated Professionals Team including a Designated Doctor and Nurse for Safeguarding Children and Children in Care, and a Designated Paediatrician for Child Deaths.
- Named GPs for Safeguarding Children and Adults and, as part of collaborative arrangements with North Yorkshire CCG, a Named Nurse and Specialist Nurse for Safeguarding in Primary Care (Children and Adults).
- Regular reporting into the CCG Quality and Clinical Governance Committee from the Designated Professionals Team and the Primary Care Safeguarding Nurses

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

1.5.44 Work undertaken by the Designated Professionals Team during 2021-2

- The Designated Professionals Team have continued to work with safeguarding children, children in care and safeguarding adults' colleagues across the North Yorkshire and Humber footprint to develop a proposed model for safeguarding arrangements in the new ICS. This model was agreed by the Integrated Care Board and work is now ongoing to ensure that these arrangements are in place to support the new organisation in June 2022. An interim lead Designated Nurse (nominated by the group) has been appointed to lead on this work. Standard presentations have been developed to ensure that all Safeguarding Partnerships and Boards can receive assurance on the ICS arrangements and the primary of place-based safeguarding as we move to the new operating model.
- The number of cases which have reached a threshold for a statutory case review remains high. This represents a considerable amount of work for all safeguarding teams across the partnership but is essential if learning is to be extrapolated and integrated into practice.
- High levels of support are offered by the Designated Professionals team to safeguarding leads across NHS and private provider organisations. Regular online meetings, monthly safeguarding bulletins, advanced level training and reflective supervision support professional practice and help to build resilience in challenging times.
- Primary Care training continues via the well-established and well-evaluated Hot Topics programme.
- A new Domestic Abuse policy, specifically designed for use within Primary Care across North Yorkshire, has been disseminated to all GP Practices. The policy aims to ensure that Primary Care staff are aware of their duty to be alert to signs of domestic abuse, to respond appropriately to disclosures of domestic abuse and to support victims and survivors.
- The Primary Care Safeguarding Training Guidance has been updated providing a valuable reference for Primary Care staff to identify what level of training they require to meet the safeguarding duties and responsibilities of their roles.

- All Primary Care Safeguarding Training has continued virtually in 2021/22 with 778 staff attending Level 3 Safeguarding training. In addition, 132 administration staff attended 'Managing Safeguarding Information' training in February 2022.

1.5.45 Safeguarding Adults

- The Designated Professionals for Safeguarding Adults have continued to work closely with partner organisations to reduce the risks of abuse and neglect, and chair key subgroups for the Safeguarding Adults Board whilst addressing safeguarding concerns, supporting care homes and working strategically to learn lessons from emerging themes, trends, risks and safeguarding reviews.
- The team have been directly involved in multiple cases completing section 42 enquiries and providing safeguarding advice and expertise by telephone and in complex case meetings. The complexity of cases has increased over the last year as the needs of the most vulnerable groups have risen and care provision has been challenged.

1.5.46 Safeguarding Children

- The team has been closely involved with Partnership work and continue to chair key sub-groups. A number of multi-agency procedures and guidance documents have been reviewed and updated to ensure compliance with best practice and national guidance.
- The Designated Nurses have led on a multi-agency response to learning from national report on Sudden Unexpected Death in Infancy. The work has focussed on supporting professionals to feel more competent and confident in their work with the most vulnerable families to reduce risk. A multiagency training programme has been commenced across North Yorkshire and York and is supported by local practice guidance and media campaign.
- ICON has now been formally launched across NHS England and Improvement's Northern Region and work is underway with the Tri-Service Safeguarding Partnership to deliver a global implementation campaign across defence.
- The CCG has funded a new post which aims to ensure appropriate health contribution towards information sharing and decision making at Initial Child Protection Conferences. Recruitment to this post has been successful and the new processes have been established.
- The National Referral Mechanism (NRM) pilot across North Yorkshire and York has been extended until June 2022. The NRM is a framework for identifying and referring potential child victims of modern slavery. Primary Care has contributed to the process by providing relevant and proportionate information to aid the panel's decision and the Named Nurse for Primary Care acts as the health representative on the local NRM panel.

1.6 Engaging people and communities

1.6.1 Introduction

Our vision is to achieve the best health and wellbeing for everyone in our community, and this can only be achieved by putting them at the heart of our work. Over the last few years, we have built strong foundations in public engagement and this section of the report illustrates the volume, and impact of meaningful engagement that took place with our Vale of York community. Due to COVID-19, this last year has continued to be challenging for the NHS. However, it still allowed for partnership working that was strong and helped to support the vulnerable. We could not have done this without the amazing support of our colleagues, partners and communities across the local system and we want to thank them for their determination in working collaboratively and supporting our local populations throughout this challenging time.

1.6.2 Our responsibilities

We are answerable to our patients, the public and our local communities. We must always consider the benefits of involving the public in our work and seek feedback about services we commission. We follow a set of guidance established by NHS England and Improvement and as outlined in the Health and Social Care Act (2012). We formally report our community engagement activities through the Quality and Patient Experience Committee, that occurs monthly, and is chaired by the Lay Member representative for Patient and Public involvement.

At the start of each committee, we aimed to hear story from a local patient or service user. Throughout COVID-19 that is been difficult, but we still had received reports and feedback that helped to ensure that the patient / service user voice remained at the heart of every meeting.

In late summer 2021, the Head of Engagement left the organisation to move to another role with the NHS. However, we still have a dedicated Communications and Engagement Team that firmly purports that engagement is everyone’s business – everyone being all staff within the CCG and its stakeholders in primary, social, acute and mental health care.

The Engagement Team's toolkit provides staff with resources to help them to assess the level of public and patient engagement that is needed within any project large or small. To ensure that participation activity reaches diverse communities and groups with distinct health needs we use a Quality and Equality Impact Assessment tool to assess and measure the potential impact of proposed service changes or reviews, as well as the need for patient and public involvement. More information can be found on the CCG's website at www.valeofyorkccg.nhs.uk.

1.6.3 Our engagement principles

Our engagement principles, that are provided in the table below. These underpin the aims of our involvement work.

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

Table 4 - Our engagement principles

1.6.4 How we engage

We created a range of engagement opportunities to gather views and enable people to get involved and have their say. The information we receive is always rich in personal experience and helps the CCG to shape commissioning decisions, service specifications and improvement programmes.

In 2021-22, we continued with our aim to reach those that are deemed to be digitally excluded by reaching out, where possible due to COVID-19. We continued with our engagement work online but we also, where possible conducted interviews via phone conversations, we issued hard copies of surveys and worked with the voluntary sector and public facing clinicians to gather feedback.

Building relationships with our partners across the health, care and the voluntary sector has been, and remains essential, to garner the views of our community. We continue to use a variety of mechanisms and networks to involve the local population and gather feedback.

Digital communications and engagement through videos, e-newsletters and social media platforms such as the CCG's dedicated Facebook, Instagram, YouTube and Twitter accounts are our key digital communications channels. These platforms have followers that include key stakeholders such as providers, partners, local MPs, councils and voluntary sector partners and members of the public and our metrics show that our messages have reached many thousands of people.

1.6.5 Focusing on population health and the needs of our communities

While in the Vale of York we are considered to have the healthiest population in the North of England, there are still inequalities and we have growing numbers of older people. Although age does not cause ill health, as we age, we accumulate disease. Chronic illness combined with mental health problems increases the need for health and care services. To meet the challenges of an ageing population and an increasing number of people living with multiple conditions, we have focused on working in partnership with our communities, partners, and stakeholders.

2021-22 saw the continued growth of the influence of Primary Care Networks, which has brought general practices together to enable the greater provision of proactive, personalised, co-ordinated and more integrated health and social care. Primary Care Networks are small enough to provide the personal care that is valued by both people and GPs, but large enough to have impact alongside better economies of scale through the collaboration between GP practices and local health and social care system providers.

Dedicated communications and engagement support remains embedded within our Primary Care Networks to provide support and to help develop services around the specific needs of local patients. Through our work with Primary Care Networks, we have been able to focus on the population health needs of the community, and work across health and social care and the voluntary sector to improve patient experience and outcomes for that population.

We are committed to address health inequalities across the Vale of York and working closely with both our expert colleagues in the Humber and North Yorkshire Integrated Care System and Public Health colleagues on Public Health Management strategies.

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

1.6.6 Working with our local Healthwatch partners and forums

The CCG worked closely with colleagues at Healthwatch organisations to seek the views of patients, carers and service users. Healthwatch’s role is to provide a single point of contact for people to report their experiences, concerns or their compliments about health and social care. The CCG received copies of the feedback and used these to work with providers in primary care, acute care and community services to improve the experience for patients. To represent the

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

1.6.7 Clinical engagement

In 2021-22, despite the pandemic, we managed to continue some of our Protected Learning Time sessions for our clinical stakeholders. Fundamentally the Protected Learning Time aims to improve patient care by providing a focused learning time for healthcare professionals.

The sessions help to enhance the CCG's engagement with clinicians from our member practices and set aside dedicated time for primary care colleagues to learn and share best practice. Unfortunately, due to the huge pressures on primary care, two of the planned sessions have not taken place, but it is an aim of the Designated Clinical Care of the Humber and North Yorkshire Integrated Care System to reinstate these important training and learning sessions.

1.7 Reducing health inequality

1.7.1 An introduction to health inequalities

As a commissioner of healthcare, the CCG has a statutory duty to work to reduce health inequalities which the Kings Fund has defined as:

'…avoidable, unfair and systematic differences in health between different groups of people.' (Kings Fund 2021).

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

Differences in health outcome between populations have complex causes, and different models have been produced to try and understand how they arise. One key model proposes that health is determined by:

a) **Physiological risks** such as high blood pressure, chronic stress, high cholesterol; *which themsleves are determined by…*
b) **Causes**, such as smoking, poor diet, and lack of activity; *which themselves are detemined by…*
c) **Causes of the causes**, including:
    - Psycho-social risks such as isolation, low self esstem, and low perceived power
    - Risk conditions such as poverty, discrimination, debt, poor educational status (PHE 2017).

Good quality and accesible healthcare services play a vital role in influencing these outcomes, although not perhaps as large a role as we might think (accounting for an estimated 15-40% of the determinants of health (Kings Fund 2018). Additionally, it should be borne in mind that

healthcare does not always reduce *inequalities* in health outcomes, and can often serve to excarcerbate them, a phenomenon known as the 'Inverse Care Law':

'The desired product of healthcare systems is health gain… but the world over, the more any community needs good medical care, the less likely it is to receive it'.
Julian Tudor Hart, The Political Economy of Health Care, 2005

1.7.2 The NHS commitment to tackle health inequalities

In order to avoid the inverse care law, the NHS has committed not only to delivering equitable and accessible health services, but using its reseources in a proporitionate universal manner in order to reduce inequalities between populations. The NHS Long Term Plan 2019 promised 'more NHS action on prevention and health inequalities' and set out a series of prevention measures and investments on issues like smoking, obesity, alcohol, air pollution and antimicrobial resistance, as well as a commitment to improving the health of the poorest fastest and tackling inequalities through the resources at the disposal of health and care.

Population health need is one of our key drivers as a CCG, and we intend to use the CORE20PLUS5 framework developed by the NHS England Health Inequalities Team in 2021 to organise our work. This means that together with other members across the Humber and North Yorkshire health and care system we will be using new and existing resources to focus help and support on the 20% most deprived residents in our communities ('CORE20'), as well as key populations who receive substantially worse access and poorer outcomes, such as the homeless population or those with addictions, often referred to as inclusion health groups ('PLUS'), and finally five key clinical areas which have been identified for targeted work on reducing inequalities ('5').

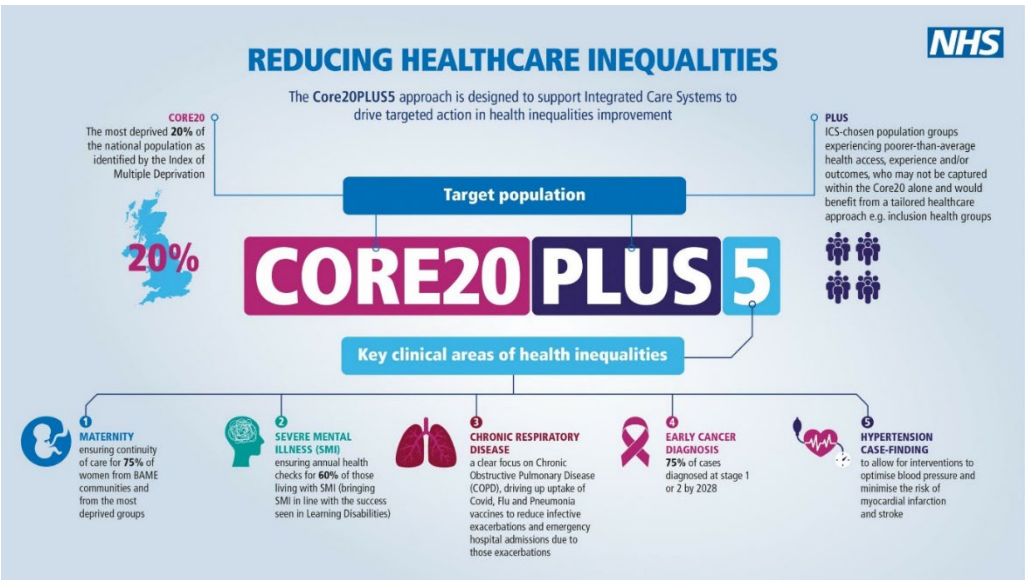


Fig 7 - Reducing health inequalities CORE20 PLUS 5

1.7.3 Health Inequalities in the Vale of York

To do this, there is a requirement for us to understand population health needs, and so the CCG's strategic plan echoes the overarching ambitions set out in the three Joint Health and Wellbeing Strategies published by our Local Authority areas, together with their corresponding Joint Strategic Needs Assessments. In addition, the CCG Governing Body's Board Assurance Framework includes a section giving assurance to members on a quarterly basis on work the CCG is doing to tackle health inequalities.

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

- Since the CCG was created in 2013, its population (those registered to our member general practices) has grown by around 4.5%, from around 350 thousand people to over 369 thousand people.

- In March 2022, the CCG had a registered population of 369,003 people, with 117,768 people living in the 'Vale' area of the CCG which lies within North Yorkshire County Council boundaries, and 251,235 living in the 'City' Area, which is mainly within City of York council area but also includes the registered population of Pocklington practice within the East Riding of Yorkshire area.

- York city has become more culturally and religiously diverse over the last two decades, with a Black and Minority Ethnic (BME) population of 9.8% (non-White British) compared to 4.9% in 2001.

- Selby district has an area in Selby West ward with a population of 1,425 people that is in the 10% most deprived in England. Selby East and Selby West wards between them areas within the bottom 20% most deprived in England, and have the highest rates of income deprivation, children 0-15 living in poverty, households in poverty and benefit claimants in the Vale area, with rates higher than England's average.

- York has one area in Westfield Ward with a population of 1,647 that is in the 10% most deprived in England, and 6 areas with a combined population of 9,479 within the bottom 20% most deprived in England.

- Across the two local authority areas, where the most patients in the CCG's geography live (North Yorkshire and York), there are large inequalities in health outcomes between the poorest and richest areas, and in some of the risk factors which explain these outcomes:
    - **Premature mortality**: a three- to five-fold difference in expected deaths from preventable causes.

    - **Life expectancy**: a 3-year average gap between the highest and lowest wards in York of 10.3 years (Male) and 7 years (Female), and in North Yorkshire of 9.6 years (Male) and 6.5 years (Female).

- **Emergency admissions to hospital**: there is a 50% range (York) and 60% range (North Yorkshire) in the standardised admissions ratio between wards in each area.

- **Societal risk factors**: 9.9% of the population in North Yorkshire and 8.5% in York live in fuel poverty, whilst 14.4% in North Yorkshire and 12.9% in York live alone.

- **Health behaviours**: Smoking prevalence ranges from 8.4% in Hambleton to 14.4 in Harrogate (11.9% in York). In York 56.9% of adults are overweight or obese compared to 64.8% in Scarborough. (2019 data, with more recent data affected by COVID-19).

- Our population is slowly getting older. By 2025, it is estimated that the 65+ population in York will have increased by 16%; the 85+ population in York will have increased by 32%; and the 0-19 population will have risen by about 9%. South Hambleton and Ryedale Primary Care Network (PCN) has the highest proportion of its population over 65 years of all the PCNs within the CCG, and this is the second highest level in North Yorkshire and York area. However, age is not a cause of ill health per se; as people age co-morbidities tend to accumulate, but while ageing is not preventable, we can delay the onset of chronic diseases across our population and 'compress' the number of years people live in an unhealthy state into as small a period as possible.

- In nearly all disease areas, there are proportionately more patients on registers in the Vale area of the CCG than City, with the exception being Depression and Severe Mental Illness where there are proportionately more patients on registers in City than Vale, and with smoking as a risk factor where proportions are similar. These comparisons use Quality Outcomes Framework data. This is not an unbiased estimation of disease prevalence and may also indicate either over- or under-diagnosis; additionally, it reflects the age profile of City practices, with a younger population less likely to have chronic long-term conditions.

- As of March 2022, there are 1,327 people on a learning disability register in the CCG's geographic area, with 859 of them living in the 'city' area and 465 living in the 'Vale' area.

1.7.4 Taking a population health approach to care

One of the biggest challenges facing health and care in our area is the growth in the number of people living with long-term conditions such as kidney disease, asthma, or diabetes. Many of these conditions can be prevented, and even after diagnosis the onset of more serious symptoms can be delayed through a preventive approach. Over the last decade, there has been an increase in the number of patients on primary care disease registers in the Vale of York.

Population health approaches recognise that the NHS cannot simply organise its way out of these trends through greater efficiency and must therefore work with partners such as Local Authority Public Health teams on the wider social and behavioural factors which keep people well or support them with their conditions beyond the hospital or surgery door.

One way we have been doing this in the Vale of York is through the Population Health Management (PHM) Tool. This applies public health expertise to routine health datasets to

understand current and future health and care needs, so action can be taken to design proactive models of care. The box below defines the difference between wider 'population health' and the narrower 'population health management' tool:

Population Health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partners

Population Health Management improves population health by data driven planning and delivery of care to achieve maximum impact. It includes segmentation, stratification and impact modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

(NHSEI PHM Flatpack)

PHM is, in essence, a 'quality improvement cycle' applied to whole populations rather than individuals. It needs 3 capabilities: the right **infrastructure** to bring together linked data on populations across primary, secondary, and social care; the right **intelligence** to understand what the data is telling us; and the evidence-based **interventions** which are implemented and evaluated.

1.7.5 Examples of our population health management

1.7.5.1 Our work in Selby

Selby Town Primary Care Network (PCN), which is made up of four GP practices serving an urban population of more than 50,000 patients, took part in a 20-week Population Health Management project through national programme provider Optum UK.

It meant local NHS staff working with partners across the Selby district such as Humber and North Yorkshire Integrated Health System, Selby District Council, North Yorkshire County Council's Public Health and Stronger Communities teams and Community Services and York and Scarborough Teaching Hospitals NHS Foundation Trust – as well as the third sector through the Two Ridings Community Foundation – to develop support for patients aged 50-64 with moderate hypertension and frailty, based on their needs.

The diversity of partners involved meant the focus could be on finding wide-ranging solutions to support people's health and wellbeing, rather than purely medical interventions.

We asked patients aged between 50-64 in Selby Town PCN about the issues that most affect them, including medication and digital access. Our patients told us that that they unable to access online services, that they felt anxious because of COVID-19 and were struggling with a lack of motivation.

Their feedback showed that they wanted more exercise and activity sessions, such as swimming and yoga, and more groups to help and motivate them. Gathering this feedback has meant that we can start to develop new services with our patients, for our patients.

Fig 8 - Patient feedback in Selby Town Primary Care Network

Martin, a local patient, took redundancy from his role as an operations manager in the engineering industry during the COVID-19 pandemic, and planned to use his early retirement to get on top of his health. However, it was being contacted by the PCN team to take part in the Population Health Management project that provided the "nudge" he needed to get moving.

He said: "My job was very stressful with long hours, and I didn't have a lot of time to look after myself. After I took redundancy, my son was telling me I needed to do something, and I took that letter as inspiration to say; "I'm going down this route, I'm going to talk to these people and see what they can offer and how they can help me. I had the first telephone call with one of the team and it was really, really good. I think we must have been on the telephone for two hours. It was a really good conversation – she went through all my issues. It really inspired me to know there was something I could get involved with. Since having that telephone conversation I've been coming to the meetings and trying to improve my health."

Source: *'Living Well with Diabetes' in York*

1.7.5.2 Our work in York

In February 2021, we commenced a pilot project in York, using a population health management approach to tackle inequalities in York and improve the health of people living with Diabetes. What we found out was that over 10,000 people live with Type 2 Diabetes in York, and the data showed that for people who had more than one long term condition, Diabetes was the most common *first* condition.

A group of partners from the NHS, local authority and voluntary sectors came together to look more closely at the data on our diabetic population, choosing a 'cohort' of people to work with,

and building a 'logic model' of change by which we hoped we could support people to live well with diabetes and avoid progression into living with multiple long-term conditions.

We then worked through Social Prescribing Link Workers within GP practices to proactively reach out to our cohort, helping them build a personalised asset-based plan for their care, making sure they were aware of good resources to manage their diabetes, and helping them to get the support they needed to live healthy lives.

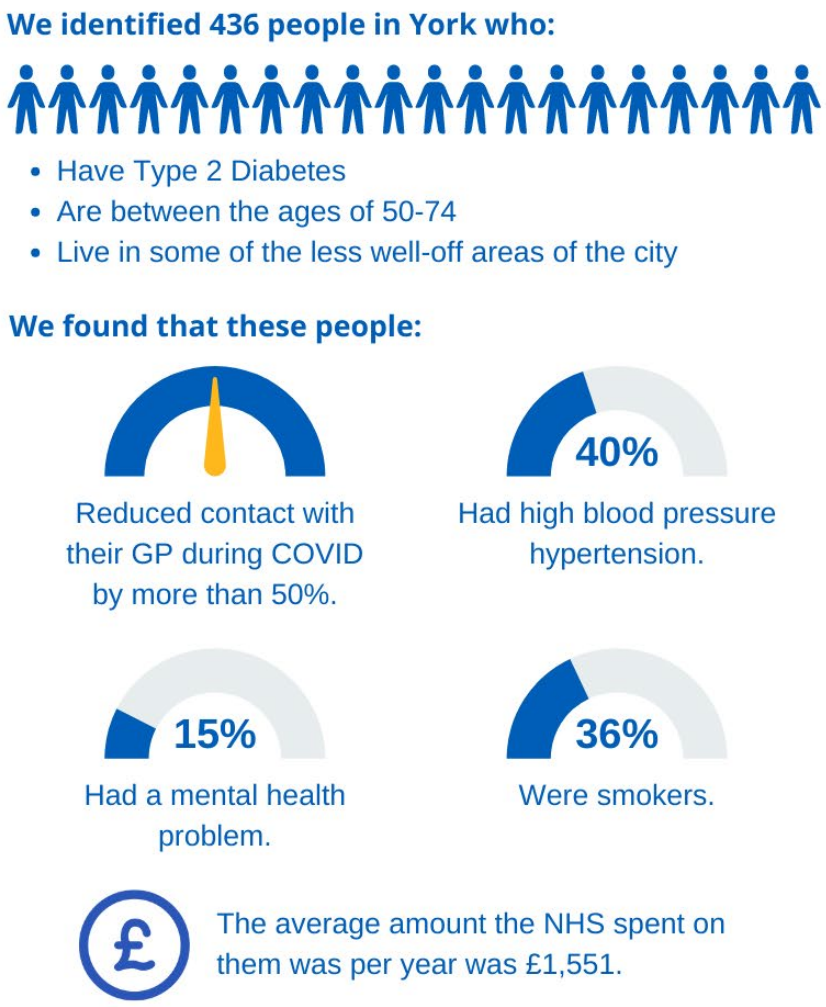


Fig 9 - Results of our population health management work (Diabetes focus) in York

1.7.6 Reducing Inequalities through targeted prevention

1.7.6.1 A targeted model for NHS Health Checks in York

Everyone between the ages of 40 and 74 is eligible for an NHS Health Check every five years, which is a cardiovascular health risk assessment that aims to identify early signs of disease and help people improve their chances of staying healthy.

In York, we knew that if we didn't take a population health approach to NHS Health Checks, the people taking up their offer may not be those most in need of the intervention.

Working with Nimbuscare Ltd – made up of 11 GP practices in the York area and the Public Health Team at City of York Council, we co-designed a model for Health Checks which used a population health management approach to:

- Ensure NHS Health Checks are targeted to the people most likely to benefit, through using primary care data and proactive GP text /letter invites.
- Develop onward pathways from a health check into preventative services.
- Use our local assets to make sure the checks are done in the most deprived areas of the city, as well as using digital and other tools to make them more efficient.

This new service was launched in October 2021 and has so far seen over 400 patients.

1.7.6.2 Reducing Vaccine Inequality

As the COVID-19 vaccine was rolled out, we knew that like other vaccine programmes, not everyone would feel the confidence or motivation to take up the offer, and inequalities between population groups would emerge; this was borne out by data which showed lower take-up in a number of groups, including certain ethnic minority communities, those with learning disabilities and mental illness, those from deprived socio-economic backgrounds, those for whom English is a second language, transient and migrant workers, those homeless, those not-registered with GPs, and traveller communities.

The CCG has led a programme of work along with partners in public health, local authority community teams, primary care and third sector organisations to break down barriers to take up of the COVID-19 vaccination programme, including arranging pop-up vaccination sites in areas of the CCG which have lower take-up, clinics at venues serving marginalised groups such as Carecent in York, engagement with a wide variety of faith and religious groups and arranging culturally-appropriate and communication, placing vaccination clinics in rural and remote areas of the CCG geography, and laying on specialist vaccination sessions aimed at providing a welcoming and supportive environment for those with a learning disability.

1.8 Health and wellbeing strategy

1.8.1 York Health and Wellbeing Board

Up to 31 March 2022, the CCG's Clinical Chair was the vice-chair of the York Health and Wellbeing Board and played an active part in the Health and Wellbeing Board (HWBB).

The CCG's Acting Executive Director of Primary Care is also a HWBB member and has played an active role at meetings; particularly in relation to updates on the provision of the COVID-19 vaccination programme.

Additionally, the Chair of the York Health and Care Collaborative (YHCC) is a member of the HWBB and provides regular updates to the Board on the work undertaken against their priorities.

The Consultant in Public Health, a joint appointment between the CCG and City of York Council, has taken on the role of lead officer for the HWBB. He regularly meets with both the Chair of the HWBB and the Health and Wellbeing Partnerships Co-ordinator to agree agenda items, workshops, and other board related matters. He acts as substitute for the Director of Public Health on the board when she is unable to attend and is also an active participant at HWBB meetings in terms of bringing a variety of papers and presentations covering many themes. This year these have included progress updates on the ongoing NHS Reforms, the local shadow Place Board - the York, Health and Care Alliance; COVID-19 and the refresh of the local Joint Strategic Needs Assessment (JSNA).

The CCG also plays an active role in the local Population Health Hub group; the HWBB's Mental Health Partnership and Ageing Well Partnership as well as the boards newly established Children and Young People's Health and Wellbeing Programme Board. These groups are focused on the delivery of the priorities within the current York Joint Health and Wellbeing Strategy.

1.8.2 North Yorkshire Health and Wellbeing Board

The North Yorkshire Health and Wellbeing Board is a partnership between local CCGs, North Yorkshire County Council, and other stakeholders to improve the health and wellbeing of its local communities. In 2021-22 it brought together partners to encourage integrated working and commissioning between health and social care that delivered the right care, in the right place and at the right time for people in North Yorkshire.

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

Due to the COVID-19 pandemic, the Health and Wellbeing Board met twice in 2021-22. The reason for this was a decision by the Chair and Vice-Chair who each recognised that the priority of colleagues on the Health and Wellbeing Board was to manage the day-to-day response to the pandemic and to prepare for recovery.

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

Being a key player in the Mental Health and Learning Disabilities Partnership, comprising of Tees, Esk and Wear Valleys NHS Foundation Trust and North Yorkshire County Council.

- its contribution to the ongoing development of the JSNA, including developmental work of data profiles for primary care.

- Playing a key role in the Learning Disabilities Autism Group and its area groups as well as leading on transformation that resulted in good progress on discharges from hospital.

- Proactively contributing to initiatives on Delayed Transfers of Care and reflecting the requirements of the Right to Reside Discharge Policy.

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

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

- Leading on the vaccination programme in North Yorkshire and York.

- The liaison with partners on the North Yorkshire County Council Weekly COVID-19 Gold Sessions that focussed on the review of data and priority areas including the Testing and Tracing Strategy, enforcement, and compliance

- As part of the Health Protection Coronavirus Regulations, the CCG continued to play a fundamental role in the Strategic Coordinating Group of the North Yorkshire Local Resilience Forum, a partnership of local agencies working together to manage emergencies. The CCG was part of the risk conversations, and important work to identify where it could support organisations with their regulatory requirements. The CCG's Accountable Officer attended the North Yorkshire Local Resilience Forum press conferences, and the CCG continued to support multiagency communications that included specifically relating to the vaccine rollout as well as counteracting misinformation.

  Looking ahead, from 1 July 2022, the work of CCG will be subsumed into the statutory Integrated Care System for Humber and North Yorkshire Integrated Care System (HNYICS) where it is envisaged that the effective working relationships with the HWBB will continue. For example, the HWBB will be represented on the Integrated Care Partnership, whilst the ICS will be represented on the HWBB. The HWBB will be consulted on the Five-Year Plan to be developed by the ICS and, in turn, the HWBB will liaise with the HNYICS about its Joint Health and Wellbeing Strategy and related matters.

1.8.3 East Riding Health and Wellbeing Board

The CCG also maintains a place on the East Riding Health and Wellbeing Board and continues to contribute towards the achievement of the Joint Health and Wellbeing Strategy for the area.

For each of the above Health and Wellbeing Boards, the CCG has consulted with the HWBB Boards, and the Chairs are in agreement with the CCG's contribution to the delivery of the HWB strategy.

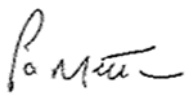
Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises of three sections:

1. The **Corporate Governance Report** sets out how we have governed the organisation during 2021-22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

2. The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

3. The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.



Phil Mettam

Accountable Officer

10th June 2022

2. Members Report

2.1. Council of Representatives

During the period of COVID-19 restrictions, the Council of Representatives did not hold formal meetings but replaced these with an informal monthly update session. Attendance at formal meetings is therefore not reported. Details of the CCG's member practices can be found on the CCG website at www.valeofyorkccg.nhs.uk.

2.2 Governing Body

In 2021/22 the Governing Body held five virtual meetings due to the COVID-19 pandemic. Three meetings were live on the Zoom platform and two were recorded in full with an unedited version of recordings made available on the CCG's YouTube channel immediately after the meeting. All meetings were quorate.

In workshop format consideration was given to the Three Horizons Framework: Business as Usual, Disruptive Innovation and Emerging Future in the context of the CCG maintaining accountability and the transition to an integrated care system.

Governing Body Member	Governing Body Role	Attendance (public meetings)
Dr Nigel Wells	CCG Clinical Chair	4/5
Simon Bell	Chief Finance Officer	4/5
David Booker	Lay Member and Chair of Finance and Performance Committee	5/5
Michelle Carrington	Executive Director of Quality and Nursing / Chief Nurse	5/5
Dr Helena Ebbs	North Locality GP Representative	5/5
Phil Goatley	Lay Member and Chair of Audit Committee and Remuneration Committee	4/5
Julie Hastings	Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee	4/5
Phil Mettam	Accountable Officer	5/5
Denise Nightingale	Executive Director of Transformation, Complex Care and Mental Health	5/5
Stephanie Porter	Interim Executive Director of Primary Care and Population Health	3/5
Dr Chris Stanley	Central Locality GP Representative	5/5
Dr Ruth Walker	South Locality GP Representative	4/5
Vacant	Secondary Care Doctor	N/A

Attendees - Non-voting		
Dr Andrew Moriarty	YOR Local Medical Committee Representative	4/5
Sharon Stoltz/ Fiona Phillips	Director of Public Health, City of York Council/ Assistant Director of Public Health, City of York Council	3/5

Table 5 - Governing Body member meeting attendances

2.1.3 Governing Body member biographies

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

Nigel joined the CCG team from Beech Tree Surgery, Selby. He moved to York in 1998 after qualifying in medicine at Dundee University. He trained in Leeds and York and started work as a GP in 2003. Nigel worked as a locum GP in York for three years. He was a GP partner in Consett Medical Centre Co. Durham before joining Beech Tree Surgery in 2008. He is a GP trainer and has an interest in finance, management, and service provision. Nigel has set up alternative NHS services in podiatry and community ultrasound within the Vale of York and other CCGs. He stepped down from his role as Clinical Chair on 31 March 2022 to take up a new role the Designate Clinical Lead for Humber and North Yorkshire ICS.

Phil Mettam
Accountable Officer

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

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

Michelle Carrington
Executive Director of Quality and Nursing

Michelle is a registered nurse with over 35 years of experience, mainly in acute care, patient safety and quality. She has held a number of senior roles including Practice Development and Service Improvement, Assistant Chief Nurse and Head of Patient Safety.

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

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

Denise joined us from NHS Bassetlaw CCG where she was the Executive Chief Nurse. Previously she has worked as an Executive in an acute setting. She has led a hospital re-provision and has undertaken significant service re-configurations. Denise has held roles in the Department of Health and within a Strategic Health Authority implementing the Choice and Independent Treatment Centre agendas.

Simon Bell
Chief Finance Officer

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

Simon is a qualified accountant and graduate of the NHS Finance Management Training Scheme. He has worked in the NHS for 25 years across a number of provider and commissioning organisations including Chief Finance Officer roles in CCGs based in the Southwest of England.

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

Dr Helena Ebbs
GP Representative for the North Locality

Helena has been a GP partner at Pickering Medical Practice since 2012. After graduating from Sheffield Medical School in 2003 she spent her first few years working in South Yorkshire in hospital medicine, before moving to North Yorkshire to train as a GP. She has an interest in mental health, frailty and rural general practice.

Dr Ruth Walker
GP Representative for the South Locality

Ruth graduated from Edinburgh Medical School in 1999 and came to York to complete her GP training. She has worked at Scott Road Medical Centre in Selby since 2004, initially as a salaried GP before becoming a partner in 2013. Ruth has special interests in mental health and health inequalities and enjoys her role teaching third-year medical students at Hull York Medical School.

Dr Chris Stanley
GP Representative for the York Locality

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

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

David trained as a social worker and worked in a number of roles in local government and third sector organisations. His latest role was as UK Director for Volunteering at Barnardo's. In his role as Lay Member of the CCG's Governing Body, David helps to ensure the CCG is efficient and responsive and listens to the views of local stakeholders. He has a special interest in promoting mental health services for children.

Phil Goatley
Lay Member and Chair of the Audit Committee

Phil joined the CCG in July 2018 after serving as Humberside's Police Assistant Chief Officer between 1999 and 2017. During his 18 years at Humberside Police, Phil was responsible for all non-operational services.

Prior to that Phil briefly worked in banking before joining the public sector - joining the Audit Commission, where he specialised in value-for-money studies with a focus on policing. Phil has been committed to public services for most of his career and wanted to continue to put something back into the community following his retirement from Humberside Police in 2017. He has been married for 27 years and has a teenage son.

Julie Hastings
Lay Member for Patient and Public Involvement

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

Members in attendance

Sharon Stoltz
Director of Public Health for City of York Council

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

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

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

2.2 Internal governance arrangements

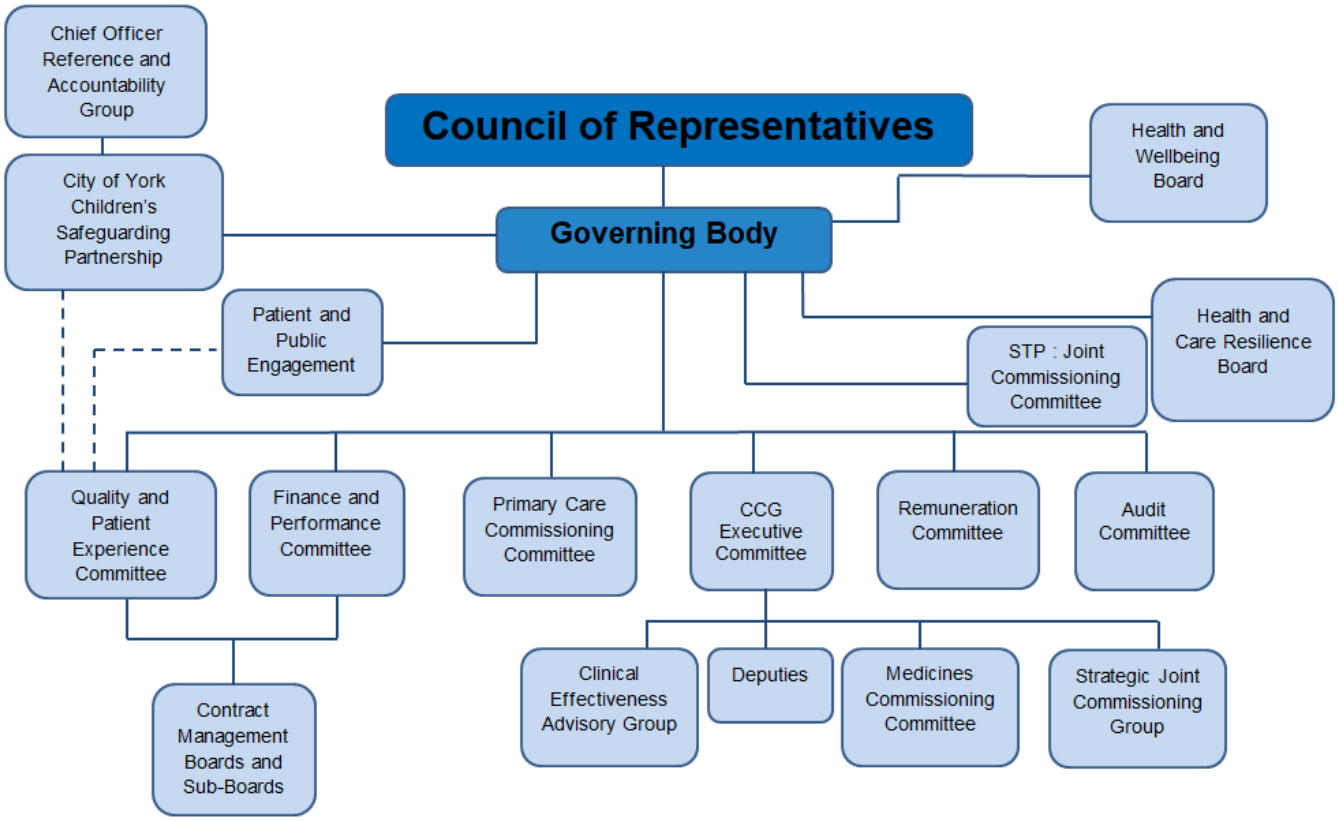


Fig 10 - The CCG's Internal governance arrangements

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. All Committees undertake an annual review of their terms of reference and effectiveness. The approach of assurance through exception- based reporting, adopted during the interim governance arrangements in response to the COVID-19 pandemic, continued. Meetings were via Microsoft Teams except the Primary Care Commissioning Committee which was on the Zoom platform and accessible to members of the public.

Committee	Role and performance highlights
Strategic Committees	
Audit Committee	Chaired by the Lay Member with the lead role in governance and conflict of interest, the Audit Committee provides the Governing Body with independent assurance through critically reviewing the CCG's financial reporting and internal control principles and ensuring an appropriate relationship with both internal and external auditors is maintained. It has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control; internal audit; external audit; reviewing the findings of other significant assurance functions including counter fraud and security management and financial reporting. In 2021-22 the Committee met seven times, one of which was an extraordinary meeting for approval of a number of policies. It was quorate on each occasion. There is a schedule of preceding private meetings of members with internal and/or external audit who are represented at each meeting. **Members:** Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee David Booker, Lay Member and Chair of Finance and Performance Committee Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Secondary Care Doctor - Vacant **Performance/Highlights:** Regular updates on progress against Financial Recovery Plan Approval of Annual Report and Annual Accounts Regular assurance from internal and external audit on reports issued to management Approval of internal audit and external audit plans Monitoring the implementation of audit recommendations Updates on the Board Assurance Framework Annual review of Internal Audit Charter and Working Together Protocol Information Governance assurance Regular updates on counter fraud and security including approval of annual work plan and review of the organisation's annual self-assessment against NHS Counter Fraud Authority's Standards for Commissioners Processes for review of Committee effectiveness, internal audit effectiveness, counter fraud and security effectiveness, and external audit effectiveness

Committee	Role and performance highlights
Remuneration Committee	The Remuneration Committee makes recommendations to the Governing Body on: terms and conditions of employment for the CCG's Governing Body members; pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the CCG; recruitment and retention premia and annual salary awards where applicable; allowances under any pension scheme it might establish as an alternative to the NHS pension scheme; severance payments of employees and contractors - seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money'; policies and instructions relating to remuneration; and any significant amendments to the terms and conditions of employment which affects all employees of the CCG generally (for example changes to the Agenda for Change terms and conditions). The Committee did not convene in 2021/22 but members considered two items via email. **Members:** Phil Goatley, Lay Member and Chair of Remuneration Committee and Audit Committee David Booker, Lay Member and Chair of Finance and Performance Committee Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee
Finance and Performance Committee	The paramount role of the Committee, which met 12 times in 2021-22 and was quorate on each occasion, is to oversee and scrutinise the financial recovery and performance of the CCG. From May 2021 the Committee agreed to move to bi-monthly formal meetings to facilitate the regional transition to integrated care system status. Alternate months, from June, would take the form of an informal briefing session although urgent business would be included if required. A financial performance report and performance update continued to be included at each meeting. **Members:** David Booker, Lay Member and Finance and Performance Committee Chair Simon Bell, Chief Finance Officer Michelle Carrington, Executive Director of Quality and Nursing/Chief Nurse

Committee	Role and performance highlights
	Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Phil Mettam, Accountable Officer Denise Nightingale, Executive Director of Transformation, Complex Care and Mental Health Stephanie Porter, Interim Executive Director of Primary Care and Population Health **In attendance (non-voting):** Caroline Alexander, Assistant Director of Delivery and Performance, to May 2021 Abigail Combes, Head of Legal and Governance, for specific items Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee James McQuillan, Interim Assistant Director of Delivery and Performance, from June 2021 **Performance / highlights:** Monthly Financial Performance Report Monthly performance impact assessment of response to and recovery from COVID-19, changed from July 2021 to update by exception including assurance on progress relating to the move to integrated care system Urgent Care Transformation Programme updates to August 2021 Approval of a number of contract awards/extensions Financial planning 2021/22 Emergency Preparedness, Resilience and Response Assurance Return and Policy North Yorkshire and York Winter Plan Continued emphasis that Vale of York CCG is committed to lead on the development of collaborative working within the wider NHS and Local Authority systems, based on achievable financial plans
Quality and Patient Experience Committee	The Quality and Patient Experience Committee met nine times in 2021/2 and was quorate on all but one occasion. The overall objective of the Committee is to ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement in line with the NHS Constitution (2011) underpinned by the CCG Quality Assurance Strategy. In line with the NHS Constitution, this also includes actively seeking patient feedback on health services and engaging with all sections of the population with the intention of improving services and, as a membership organisation,

Committee	Role and performance highlights
	working with NHS England and NHS Improvement, to support primary medical and pharmacy services to deliver high quality primary care, including patient experience. **Members:** Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Michelle Carrington, Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience) Dr Nigel Wells, Clinical Chair of the Governing Body (Deputy Chair) Secondary Care Doctor - Vacant **In attendance (non-voting):** Victoria Binks, Head of Engagement, to July 2021 Abigail Combes, Head of Legal and Governance, for specific items Sarah Fiori, Head of Quality Improvement and Research Ashely Green, Chief Executive Officer, North Yorkshire Healthwatch Jacqui Hourigan, Designated Nurse Safeguarding Children Karen McNicholas, Senior Quality Lead, Children and Young People, to September 2021 Paula Middlebrook, Deputy Chief Nurse Christine Pearson Designated Nurse Safeguarding Adults Gill Rogers, Patient Experience Lead Louise Wootton, Associate Designated Clinical Officer for SEND, from September 2021 Janet Wright, Chair, Healthwatch York **Performance / highlights:** Patient / staff stories Quality and Patient Experience Report Safeguarding Adults and Children updates 'Waiting Well' Briefing North Yorkshire and Vale of York CCGs' Annual Learning Disability Mortality Review 1 April 2020 to 31 March 2021 Medicines Safety Assurance from GP Practices 'Two years on: The benefits and learning from Protected Learning Time for Primary Care' Equality and Quality Impact Assessment: Proposed Closure of Posterngate Surgery – Hemingbrough Branch Learning Disability Mortality Review (LeDeR) Annual Report 2020-21 North Yorkshire and York CCG Safeguarding and Looked after Children Annual Report 2020-21 North Yorkshire and York Safeguarding Adults Annual Report 2020-21

Committee	Role and performance highlights
	MAPPA (Multi Agency Public Protection Arrangements) Annual Report 2020-21 Focused meetings on Primary Care and Maternity Services
	The Primary Care Commissioning Committee met five times as per transitional arrangements and was quorate on each occasion. **Membership is NHS Vale of York CCG unless otherwise stated:** Julie Hastings, Lay Member and Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee Simon Bell, Chief Finance Officer David Booker, Lay Member and Chair of Finance and Performance Committee David Iley, Primary Care Assistant Contracts Manager, NHS England and NHS Improvement North Region (Yorkshire and the Humber) Phil Goatley, Lay Member and Chair of Audit Committee and Remuneration Committee Phil Mettam, Accountable Officer Stephanie Porter, Interim Executive Director of Primary Care and Population Health A representative from each of the Primary Care Networks (PCN) - Dr Paula Evans represented South Hambleton and (North) Ryedale PCN, and Dr Tim Maycock represented Central York PCN Fiona Bell-Morritt, Lead Officer Primary Care, Vale Shaun Macey, Acting Assistant Director of Primary Care Dr Andrew Moriarty, YOR Local Medical Committee representative Sharon Stoltz, Director of Public Health, City of York Council Gary Young, Lead Officer Primary Care, City Healthwatch representative Health and Wellbeing Board representative Practice Manager **Performance / highlights:** Regular updates on development of Primary Care Networks Regular updates on Coronavirus COVID-19 Regular Primary Care Risk Report Primary Care Dashboard Social Prescribing in the Vale: An overview of the impact and benefits Personalised Care for Learning Disability Health Checks Proposed Closure of Posterngate Surgery – Hemingbrough Branch Primary Care Safeguarding Local Enhanced Service Funding Support Costs for GP 'Covid Laptops'

Committee	Role and performance highlights
	Primary care updates from NHS England and NHS Improvement North

Table 6 – Strategic committee meeting highlights and attendances in 2021-22

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

Table 7 – Remuneration Committee meeting attendances in 2021-22

The Committee did not convene during 2021-22 but two items were considered by members via email.

2.2.1 Non-Remuneration Committee member attendances

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

In addition to Helen Darwin, Lucy Townend, Human Resources Manager, and Becky Blackburn, Human Resources Advisor, provided a range of general HR advice to the CCG during the 2021-22 financial year. The HR service was hosted by North Yorkshire CCG.

2.3 Register of Interests

The CCG's registers of interest are published online and can be viewed on the CCG website at https:www.valeofyorkccg.nhs.uk-publications- and search 'register'.

2.4 Personal data related incidents

There have been no incidents that were reported to the Information Commissioner's Office during 2021-22.

2.5 Statement of Disclosure to Auditors

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

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

2.6 Modern Slavery Act

NHS Vale of York CCG supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

2.7 Statement of Accountable Officer's Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable.
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money.
- Ensuring the CCG exercises its functions effectively, efficiently, and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state-of-affairs of the Clinical

Commissioning Group and of its income and expenditure, Statement of Financial Position, and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

I also confirm that:

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

2.8 Governance Statement

2.8.1 Introduction and context

NHS Vale of York CCG is a body corporate established by NHS England on 1 April 2014 under the National Health Service Act 2006 (as amended).

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

As of 1 April 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2.8.2 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and

objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

2.8.3 Governance arrangements and effectiveness

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

For further information on the work of the CCG's members and committees, please see the information on page 68 - 73.

2.8.4 UK Corporate Governance Code

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

2.9.5 Discharge of Statutory Functions

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

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

2.8.6 Risk management arrangements and effectiveness (Definitions)

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

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

Risk Management Process - According to ISO 31000, a risk management process systematically applies management policies, procedures, and practices to a set of activities

intended to establish the context, communicate and consult with stakeholders, and identify, analyse, evaluate, treat, monitor, record, report, and review risk**.**

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

2.8.7 The CCG's approach

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

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

Risk is also proactively managed through the CCG's impact assessment work. A Quality Impact Assessment, Equality Impact Assessment and Privacy Impact Assessment are carried out on all business cases for change. These documents are completed by those with the expertise to complete them and highlight and identify risks as a working document and early enough to inform decision making about how much risk the organisation is prepared to tolerate.

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

The CCG, in April 2020, agreed an interim governance position which suspended the use of the Risk Policy and Strategy during the COVID-19 pandemic. Whilst risk would still form part of the reports to the committees, particularly Finance and Performance Committee and Quality and Patient Experience Committee, the focus of all of the CCG time and resource was on matters related to the pandemic. This was initially on the local response to the pandemic including testing, hospital capacity and community support and in the medium term looking at recovery work and ensuring that services could be delivered effectively going forward.

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

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

2.8.8 Risk appetite

The CCG recognises the importance of having a documented statement that reflects its approach to risk appetite-tolerance in line with British Standard BS31100 which provides direction and boundaries on the risk that can be accepted at various levels of the organisation and how the organisation responds to risk to ensure that the level of risk and any associated reward are to be balanced.

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

- The lower the appetite for risk, the less the CCG is willing to tolerate the consequence and there is a requirement for higher levels of controls and assurance to manage the risk.

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

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

2.8.9 Risk appetite statement

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

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

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

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

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

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

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

2.8.10 Risk identification

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

2.8.10.1 Internal methods of Identification

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

2.8.10.2 External Methods of Identification

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

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

2.8.11 Risk assessment

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

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

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

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

Risk assessments are carried out locally by identified staff.

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

2.8.12 Risk analysis and evaluation

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

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

- Adverse incidents (including Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) incidents), PALS, complaints and claims

are analysed on a six-monthly basis.

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

2.8.12.1 Major risks

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

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

Table 8 – Major risks

2.8.13 Other sources of assurance

2.8.13.1 Internal Control Framework

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

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

The CCG uses a Board Assurance Framework for the purposes of monitoring progress against each of the CCGs strategic objectives. The CCG currently has 7 strategic objectives which the Board Assurance Framework reports on:

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

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

All CCG risks are then populated on the Board Assurance Framework to enable the Governing Body oversight of all of the risks and the direction of travel for these. The Head of Legal and Governance attends the Committee to present the Board Assurance Framework and provides access to the full risk register in the event that any member of the Governing Body wishes to scrutinise the detail of a specific risk which, as a result of the risk assessment, is being managed by another committee.

2.8.13.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework. The CCG's annual conflicts of interest audit has been completed and significant assurance given that effective arrangements are in place. Recommendations as to the regular updating of declarations on the CCG website were given.

2.8.13.3 Data Quality

The CCG receives a Business Intelligence service via Northeast Commissioning Support, with data checked and validated internally. The Governing Body and Committee reports were reviewed during 2021-22 and no concerns have been raised regarding data quality. The format of reporting is reviewed on a regular basis to ensure that data is reported to the levels of detail required.

2.8.13.4 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

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

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.8.13.5 Business Critical Models

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

2.8.13.6 Third party assurances

The CCG receives financial transaction and reporting services from the NHS Shared Business Services. Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives financial transaction and reporting services from NHS Business Services Authority with regards to prescribing. Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives financial transaction services from NHS Digital with regards to GP Payments. Service auditor reports are received on an annual basis and gives assurance on this business arrangement.

The CCG receives payroll services from the national NHS Electronic Staff Record (ESR), administered by Victoria Pay Services. Service auditor reports are also received on an annual basis and gives assurance on this business arrangement.

The CCG receives Information Technology and Business Intelligence services from NECS. Assurance is gained through regular contract monitoring and review meetings where outstanding issues are raised and resolved, and future improvements are discussed and agreed.

2.8.13.7 Control Issues

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

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

2.8.14.1 Delegation of functions

The CCG has not delegated any of its functions for the current financial year.

2.8.14.2 Counter fraud arrangements

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

In January 2021 the NHS Counter Fraud Authority (NHSCFA) issued the NHS Requirements which provided detailed information on how the Government Functional Standard 013 Counter Fraud must be applied across the NHS. The Requirements outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In April 2021 the LCFS produced an annual counter fraud plan aligned to the standards.

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

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

The CCG's counter fraud arrangements are currently in compliance with the NHS Requirements published by the NHSCFA. These arrangements are underpinned by the appointment of the LCFSs, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's standards, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA. The 2020-21 assessment for the CCG was completed with reference to the NHS Requirements. The assessment was submitted in May 2021 with an overall rating of Amber. The self-assessment was reviewed by the Chief Finance Officer and Audit Committee Chair and was submitted prior to the NHSCFA deadline of the 31 May 2021. The return was also shared with Audit Committee members within the 2020-21 Annual Counter Fraud Report.

The LCFS provided a response to the Counter Fraud Functional Standard Return on behalf of the CCG in May 2022. This looked at the CCG's compliance to the NHS Requirements within the 2021-22 financial year and was reviewed by the Chief Finance Officer and Audit Committee Chair prior to its submission.

2.9 Head of Internal Audit Opinion

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS VALE OF YORK CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 2022

1. Introduction

The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Governing Body in the completion of its Annual Governance Statement, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

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

2. Executive Summary

This Head of Audit Opinion forms part of the Annual Report for NHS Vale of York Clinical Commissioning Group, in which the planned internal audit coverage and outputs during 2021/22 and Audit Yorkshire's Key Performance Indicators (KPIs) are detailed.

Key Area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2021 to 31st March 2022 provides Significant Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. In the Head of Internal Audit Opinion for 2020/21 we reported that the Internal Audit Standards Advisory Board (IASAB) had issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020). The pandemic has continued to have an impact on the progression of the audit programme during 2021/22 but not to the same level as in 2020/21. We have delivered the planned audit work, subject to agreed changes, and have continued to follow the advice provided in the above guidance to ensure we remain compliant with the PSIAS. Where there has been an impact on the audit programme this has been communicated to and agreed with the Audit and Governance Committee and clear records of any changes have been maintained via our progress reports. The audit programme at the CCG has also been undertaken in the context of the imminent transition to Integrated Care Boards (ICBs). An element of our audit work during 2021/22 has been to support and provide assurance on this transition process.
Planned Audit Coverage and Outputs	The 2021/22 Internal Audit Plan has been substantially delivered as planned. This position has been reported within the progress reports across the financial year and any changes to the audit programme have been captured in these.

Key Area	Summary
	Audit coverage in 2021/22 has been focussed on: • The organisation's Risk Management and Assurance Framework • Core and mandated reviews, including follow up • A range of individual risk-based assurance reviews • Management and oversight of transition to the Integrated Care Board. The following changes were made to the planned coverage: • Cancellation of the Data Security and Protection Toolkit due to NHSD confirmation that this is not a required audit for CCGs in 2021/22. Due to the imminent introduction of the ICB however, a decision has been taken to undertake assurance work on the IT Risk Registers instead, in order that the ICB can be assured at the outset that good IT/IG controls are in place and operating as expected, or that appropriate action plans are in place to mitigate any risks. This will be included in our transition work. i. Cancellation of 1 audit on CHC – Fast Track due to a key member of staff leaving the organisation. A significant proportion of the audit plan was given to the review of the arrangements relating to the closing down of NHS Vale of York Clinical Commissioning Group and the setting up of the Humber and North Yorkshire Integrated Care Board (HNYICB). As required by the due diligence checklist, Audit Yorkshire and senior officers from the CCG have been active members of numerous programme boards. In particular, those tasked with the closing down governance, information governance and financial arrangements. Audit work is ongoing to consider the design and operation of shadow governance arrangements, place readiness and progress against the due diligence checklist. Further work is planned in this area in the first quarter of 2022/23 as a result of the delayed transition to ICBs.
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

3. Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

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

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

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

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

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

4. The Opinion

My opinion is set out as follows:

1. Basis for the opinion
2. Overall opinion
3. Opinion Definitions
4. Commentary
5. Considerations for your Annual Governance Statement
6. Looking Ahead

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

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

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

2. **Overall Opinion**

Our **overall opinion** for the period 1st April 2021 to 31st March 2022 is:

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

3. Opinion Definitions

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

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

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

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

<u>The design and operation of the Assurance Framework and associated processes.</u>
A combined audit of the Governance Framework and associated Risk Management processes was undertaken in 2021/22, for which a significant assurance opinion was given.

Audit testing found that the composition of the Governing Body is in line with the CCG's Constitution, with good attendance recorded at the Governing Body meetings. Testing also confirmed that the Governing Body received regular assurance from the CCG's Sub Committees, both statutory and non-statutory, and that all committees are acting in accordance with the Scheme of Delegation.

The Risk Management Strategy in place accurately reflects the CCG's process for Risk Management, with the Risk Appetite Statement being documented together with details of the organisational risk tolerance levels acceptable to manage individual risks and to inform effective decision making.

The Board Assurance Framework (BAF) was found to contain details of the seven strategic objectives that support delivery of the CCG's commitments, taking into consideration the CCG's transition to the Integrated Care System. It was recommended that this Framework would be enhanced with the usage of target risk scores as well as target dates.

<u>Closedown and Transition</u>
A key element on the 2021/22 Audit Plan has been to review the transitional arrangements relating to the closing down of NHS Vale of York CCG and the setting up of the Integrated Care Board (ICB). As required by the Due Diligence Checklist created by NHS England, Audit Yorkshire and senior officers from NHS Vale of York CCG have been active members of numerous programme boards, in particular, those tasked with the closing down of governance, Information Governance and Financial arrangements, as well as attending the overarching Transition Board. Audit work is ongoing to consider the design and operation of shadow governance arrangements, place readiness and progress against the due diligence checklist. Further work is planned in this area in the first quarter of 2022/23 as a result of the delayed transition to ICBs.

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

Core & Risk Based Reviews Issued

We have issued to date:

2 **high** assurance opinions:	Budgetary Control and Key Financial Controls Partnership Working with YSTHFT
5 **significant** assurance opinion:	Conflicts of Interest Personal Health Budgets Primary Care Commissioning – Commissioning and Procurement Follow Up Community Paediatric Commissioning Risk Management and Governance Arrangements
1 **limited** assurance opinions:	Mental Health Quality of Discharges**
0 **low** assurance opinions:	
2 reviews without an assurance rating	Mental Capacity Act – Benchmarking exercise on readiness Recommendation Tracking – Benchmarking exercise

** Draft report only.

Follow Up

A total of 62 Internal Audit recommendations have been live during 2021/22 (this includes recommendations from previous years' reports that were still live at 1 April 2021).

During the course of the year we have undertaken work to track the implementation of Internal Audit Recommendations. The Recommendation clear up summary 2021/22 was as follows:

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
1	4	8	49	62	8%

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

5. Consideration for your Annual Governance Statement

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

A significant overall opinion has been provided. Attention is drawn to the fact that one audit report has been issued in 2021/22 with a "limited assurance" opinion. This is an audit report entitled "Mental Health, Quality of Discharges" and at the time of writing this opinion, this report remains in draft whilst we wait to meet with the Executive Director to discuss.

Our testing on the Quality of Mental Health Discharges has identified the following issues:

- The commissioning process failed to explicitly address the CCG's oversight of the service and how it would be assured on the quality of the discharge process.

- Limited quality measures are therefore in place and reported to the CCG
- Metrics used to report on serious incidents and patient experiences are limited and therefore further quality measures are required.
- Metrics that are currently in place are not being reported against on a consistent basis.

It is anticipated that these measures will take time to address and we will therefore be undertaking a follow up of this audit post 1st July 2022 when the CCG will have transitioned into the Integrated Care Board.

No other limited or low assurance reports have been issued in 2021/22.

6. Looking Ahead

This opinion is provided in the context that NHS Vale of York Clinical Commissioning Group, like other organisations across the NHS, continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and COVID-19 recovery. The COVID-19 pandemic continues to impact the NHS financial framework and the roll out of the vaccine programme and the emergence of COVID-19 variants has continued to require significant focus and effort.

During the COVID-19 response, there has been increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This has continued during 2021/22 and subject to the passing of legislation collaboration will be placed on a statutory footing from 1 July 2022. At this point the Clinical Commissioning Group will transition to the Humber and North Yorkshire Integrated Care Board and will no longer be a statutory body in its own right. The Integrated Care Board will become the statutory body, supported by six places. Vale of York will become known as York and will form one of these places. The formal move to system working at Humber and North Yorkshire and place level will require robust accountability and assurance arrangements to ensure statutory functions and the system wide financial envelope are delivered.

Helen Higgs
Head of Internal Audit and Managing Director
Audit Yorkshire
May 2022

2.10 Remuneration and Staff Report

2.10.1 Remuneration Report

2.10.1.1 Remuneration Committee

Details of the composition of the remuneration committee and its meetings can be found in the Members Report on page 61.

2.10.1.2 Policy on the remuneration of senior managers

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

2.10.1.3 Remuneration of Very Senior Managers

Very Senior Managers' pay rates are set by taking into account the guidance from NHS England on the Pay Framework for Very Senior Managers in CCGs. HR advice has been provided to the Remuneration Committee from the shared HR service.

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

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

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

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

The tables on pages 93 - 96 show the CCG's Senior Manager Remuneration, including salary and pension benefits for 2020-21 and 2021-22.

2.10.1.5 Senior Manager Remuneration 2021-22 (including salary and pension entitlements) (subject to audit)

2021-22						
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr N Wells - Clinical Chair (to 31 March 2022) - see (a) and (b)	110-115	0			0	110-115
P Mettam - Accountable Officer - see (c)	105-110	0			17.5-20	125-130
S Bell - Chief Finance Officer	120-125	0			25-27.5	150-155
M Carrington - Executive Director of Quality and Nursing	95-100	0			25-27.5	120-125
D Nightingale - Executive Director of Transformation, Complex Care and Mental Health	95-100	0			0	95-100
S Porter - Interim Executive Director Primary Care and Population Health	90-95	0			102.5-105	190-195
D Booker - Lay Member	10-15	0			0	10-15
P Goatley - Lay Member	10-15	0			0	10-15
J Hastings - Lay Member	10-15	0			0	10-15
Dr H Ebbs - North Locality GP Governing Body member - see (a)	5-10	0			0	5-10
Dr C Stanley - Central Locality GP Governing Body Member - see (a)	10-15	0			0	10-15
Dr R Walker - South Locality GP Governing Body member - see (a)	10-15	0			0	10-15

NB all senior managers are continuing except where stated.

(a) Dr N Wells, Dr H Ebbs, Dr C Stanley and Dr R Walker are engaged under contract for services arrangements for their Governing Body roles. Under this arrangement they are afforded Practitioner status for pension purposes. The amount included in the salary column above includes the CCG's employer pension contributions. These engagements are paid through the CCG's payroll with taxation and national insurance deducted at source.

(b) Dr N Wells' remuneration disclosed above is remuneration for his CCG roles only and includes his role as Clinical Chair (banded remuneration £75-80k) and Named GP for Safeguarding in Primary Care (banded remuneration £35-40k). Dr N Wells was also seconded to Clinical Chair of Humber Coast and Vale Integrated Care System. Total remuneration in 2021-22 across both organisations

(c) P Mettam is seconded to Humber, Coast and Vale Integrated Care System for 1 day per week. The remuneration disclosed above relates to his CCG role of Accountable Officer only. Total remuneration in 2021-22 across both organisations was £155-160k.

(d) Alongside his Governing Body role (banded remuneration £5-10k), Dr C Stanley was remunerated for his role as Clinical Lead for the North Yorkshire and York Digital Transformation Programme Board in 2021-22 (banded remuneration £0-5k).

(e) Dr R Walker was seconded to the Humber Coast and Vale Integrated Care System as GP Clinical Lead for Mental Health and Learning Difficulties during 2021-22. The remuneration disclosed above relates to the CCG's cost of remuneration only. Total remuneration in 2021-22 was £10-15k.

(f) Co-opted members of the governing body are non voting members and do not receive remuneration for their role. Co-opted members have therefore been excluded from the table above.

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

(h) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the

Table 9 – Senior Manager Remuneration 2021-22

2.10.1.6 Senior Manager Remuneration 2020-21 (including salary and pension benefits)(subject to audit)

2020-21						
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr N Wells - Clinical Chair - see (a) and (b)	150-155	0			95-97.5	245-250
P Mettam - Accountable Officer - see (c)	105-110	0			12.5-15	115-120
S Bell - Chief Finance Officer	120-125	0			35-37.5	155-160
M Carrington - Executive Director of Quality and Nursing	90-95	0			27.5-30	120-125
D Nightingale - Executive Director of Transformation, Complex Care and Mental Health	80-85	100			10-12.5	95-100
Dr A Lee - Executive Director of Primary Care and Population Health (to 31 Oct 2020)	45-50	0			12.5-15	55-60
S Porter - Interim Executive Director Primary Care and Population Health (from 1 Nov 2020)	35-40	0			12.5-15	45-50
D Booker - Lay Member	10-15	0			0	10-15
P Goatley - Lay Member	10-15	0			0	10-15
J Hastings - Lay Member	10-15	0			0	10-15
Dr H Ebbs - North Locality GP Governing Body member - see (a)	5-10	0			0	5-10
Dr C Stanley - Central Locality GP Governing Body Member - see (a)	5-10	0			0	5-10
Dr R Walker - South Locality GP Governing Body member - see (a)	10-15	0			0	10-15

NB all senior managers are continuing except where stated.

(a) Dr N Wells, Dr H Ebbs, Dr C Stanley and Dr R Walker are engaged under contract for services arrangements for their Governing Body roles. Under this arrangement they are afforded Practitioner status for pension purposes. The amount included in the salary column above includes the CCG's employer pension contributions. These engagements are paid through the CCG's payroll with taxation and national insurance deducted at source.

(b) Dr N Wells remuneration disclosed above is total remuneration from the CCG and includes his role as Clinical Chair (banded remuneration £75-80k), his role as Named GP for Safeguarding in Primary Care (banded remuneration £35-40k) and his role as Clinical Chair of Humber Coast and Vale Integrated Care System (banded remuneration £130-135k).

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

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

(e) Co-opted members of the governing body are non voting members and do not receive remuneration for their role. Co-opted members have therefore been excluded from the table above.

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

(g) The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Table 10 – Senior Manager Remuneration 2020-21

2.10.1.7 Senior Manager Pension benefits as of 31 March 2022 (subject to audit)

2021-22								
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
P Mettam - Accountable Officer	0-2.5	2.5-5	45-50	140-145	1,122	47	1,193	0
S Bell - Chief Finance Officer	0-2.5	0	45-50	95-100	846	29	897	0
M Carrington - Executive Director of Quality and Nursing	0-2.5	0-2.5	40-45	105-110	778	33	828	0
S Porter - Interim Executive Director Primary Care and Population Health	5-7.5	10-12.5	30-35	70-75	556	100	671	0

(a) Dr N Wells, Dr H Ebbs, Dr C Stanley and Dr R Walker are engaged under contract for services arrangements for their Governing Body roles. Under this arrangement they are afforded Practitioner status for pension purposes and the pension disclosure requirements do not apply to their Governing Body roles with the CCG. Dr N Wells is a member of the NHS Pensions scheme with relation to his role as Clinical Chair of Humber, Coast and Vale Integrated Care System however this is not disclosed above as this role is recharged in full.

(b) P Mettam's pension disclosed above includes pension accrued from his secondment to Humber, Coast and Vale Integrated Care System.

(c) No pension figures for D Nightingale who opted out of the pension scheme from 01/03/21.

(d) Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

Table 11 - Senior Manager Pension benefits as of 31 March 2022

2.10.1.8 Senior Manager Pension benefits as of 31 March 2021 (subject to audit)

2020-21								
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr N Wells - Clinical Chair - see (a)	7.5-10	22.5-25	10-15	30-35	52	168	231	0
P Mettam - Accountable Officer	0-2.5	2.5-5	45-50	135-140	1,042	44	1,122	0
S Bell - Chief Finance Officer	2.5-5	0-2.5	45-50	95-100	780	35	846	0
M Carrington - Executive Director of Quality and Nursing	0-2.5	0-2.5	35-40	105-110	723	31	778	0
D Nightingale - Executive Director of Transformation, Complex Care and Mental Health	0-2.5	2.5-5	45-50	135-140	0	0	0	0
Dr A Lee - Executive Director of Primary Care and Population Health (to 31 October 2020)	0-2.5	0	30-35	55-60	424	9	461	0
S Porter - Interim Executive Director Primary Care and Population Health (from 1 November 2020)	0-2.5	0-2.5	25-30	60-65	505	13	556	0

(a) Dr N Wells, Dr H Ebbs, Dr C Stanley and Dr R Walker are engaged under contract for services arrangements for their Governing Body roles. Under this arrangement they are afforded Practitioner status for pension purposes and the pension disclosure requirements do not apply to their Governing Body roles with the CCG. Dr N Wells is a member of the NHS Pensions scheme with relation to his role as Clinical Chair of Humber, Coast and Vale Integrated Care System.
(b) Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment.

Table 12 – Senior Manager pension benefits as of 31 March 2021

2.10.2 Cash equivalent transfer values

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

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

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

2.10.3 Real increase in CETV

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

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

There were no payments made for compensation on early retirement or for loss of office in 2021-22.

2.10.5 Payments to past directors (subject to audit)

There have been no payments to past directors in 2021-22.

2.10.6 Fair Pay Disclosure (subject to audit)

2.10.6.1 Percentage change in remuneration of highest paid director

	Salary and allowances
The percentage change from the previous financial year in respect of the highest paid director	0%
The percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6%

Table 13 – Percentage change in remuneration

There is no percentage change from the previous financial year in respect of the highest paid director. The percentage change from the previous year in respect of employees of the entity is due to a number of factors including the national pay award of 3%. Other business as usual factors include progression through pay scales, re-bandings and no longer employing apprentices.

2.10.6.2 Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in NHS Vale of York CCG in the financial year 2021-22 was £175k – £180k (0% increase against 2020-21: £175k – 180k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table. Directors have not received any payments for performance or bonuses and as such salary is total remuneration.

	25th percentile	Median	75th percentile
2021-22			
Total remuneration	£22,549	£39,027	£54,764
Pay ratio information	7.87: 1 (the mid-point of the highest paid director was 7.87 times the 25th percentile of the workforce)	4.55: 1 (the mid-point of the highest paid director was 4.55 times the median of the workforce)	3.24: 1 (the mid-point of the highest paid director was 3.24 times the 75th percentile of the workforce)
2020-21			
Total remuneration	Not calculated	£33,779	Not calculated
Pay ratio information	Not calculated	5.25: 1 (the mid-point of the highest paid director was 5.25 times the median of the workforce)	Not calculated

Table 14 – Pay ratio information

In 2021-22, no employees (2020-21, no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £20k - £25k to £175k - £180k (2020-21: £15k - £20k to £175k - £180k).

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

The median pay ratio has reduced in 2021-22 due to the impact of the national pay award on the organisation's workforce (no uplift to the highest paid director). There have also been changes to the organisation's structure and vacancies throughout the year impacting on this ratio.

2.11 Staff Report

2.11.1 Number of senior managers (subject to audit)

Pay band	Total
Band 8a	7
Band 8b	8
Band 8c	4
Band 8d	8
Band 9	0
VSM	5
Governing Body	7
Any other spot salary	3

Table 15 – Senior managers by band

2.11.2 Average number of people employed (subject to audit)

	2021-22		
	Permanently employed	Other	Total
	Number	Number	Number
Total	**105**	**4**	**109**

Table 16 – Average number of people employed

2.11.3 Salaries and wages (subject to audit)

	2021-22		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	4,886	328	5,214
Social security costs	502	0	502
Employer contributions to NHS Pension scheme	911	0	911
Apprenticeship Levy	10	0	10
Gross employee benefits expenditure	**6,309**	**328**	**6,637**

Table 17 – Salaries and wages

2.11.4 Staff composition (subject to audit)

Pay band	Female	Male
Band 8a	4	3
Band 8b	7	1
Band 8c	3	1
Band 8d	4	4
Band 9	0	0
VSM	3	2
Governing body	3	4
Any other Spot Salary	1	2
All other employees (including apprentices)	66	17
Total	**91**	**34**

Table 18 – Staff composition

2.11.5 Sickness absence data

The staff sickness percentage for 2021-22 was 3.64%.

2.11.6 Staff turnover percentages

The staff turnover percentage for 21-22 was 1.27%.

2.11.7 Staff engagement percentages

The CCG has an active staff engagement group which carries out its own methods of staff "temperature checks" rather than participate in the national staff survey, on the basis that local surveys can provide more frequent assurance that is tailored to local needs.

2.11.8 Staff policies

The CCG maintains a full suite of policies intended to promote staff wellbeing, as well as equality and diversity. The 2021-22 year has again seen the majority of staff working from home as part of the response to Covid-19, and the home working policy has been reviewed in order to ensure that national guidance is being followed. A comprehensive programme of health and wellbeing initiatives was set up. These included undertaking individual risk assessment for all our staff, which a particular focus on at risk categories such as ethnic minority staff, pregnant workers and those with underlying health conditions and were followed up with 1-1 health and wellbeing conversations. Throughout the year further individual support was provided along with regular staff briefings and innovative on-line support sessions.

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

As a Disability Confident employer, the CCG actively encourages people with disabilities to apply for positions in the organisation. Applicants applying for roles within the CCG, who declare a

disability, will be eligible for a guaranteed interview, providing they meet the minimum criteria within the person specification for the vacancy. The CCG is also signed up to the Mindful Employer Charter, documenting our commitment to show a positive and enabling attitude to employees and job applicants with mental health issues.

The CCG maintains active links with regional and national equalities and diversities groups and works towards shared equalities goals with the CCGs that will form part of the NHS Humber and North Yorkshire ICS with effect from 1 July 2022. The focus of such activity over the past year has been on the establishment of staff networks for specific protected characteristics under the Equalities and Human Rights Act.

2.11.9 Social Partnership Forum

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

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

- Engages employers and trade union representatives in meaningful discussion on the development and implications of future policy.
- Provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce.
- Promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

2.11.10 Trade Union Facility Time Reporting Requirements

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

2.11.11 Relevant union officials

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

Table 19 - Relevant union officials

2.11.12 Percentage of time spent on facility time

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

Table 20 - Percentage of time spent on facility time

2.11.13 Percentage of pay bill spent on facility time

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

Table 21 - Percentage of pay bill spent on facility time

2.11.14 Paid trade union activities

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

Table 22 - Paid trade union activities

2.11.15 Other employee matters

2.11.15.1 Expenditure on consultancy

The CCG incurred expenditure of £36k on consultancy during 2021-22. The consultancy services purchased in 2021-22 were to support the establishment of the Hospital Discharge Programme, and as such funding was allocated to the CCG to cover this expenditure in full.

2.11.15.2 Off-payroll engagements

2.11.15.2.1 Off-payroll engagements as at 31 March 2022

For all off-payroll engagements as at 31 March 2022 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2022	2
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 23 - Length of all highly paid off-payroll engagements

All existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

2.11.15.2.2 Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245(1) per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	13
Of which:	
Number not subject to off-payroll legislation(2)	7
Number subject to off-payroll legislation and determined as in-scope of IR35(2)	0
Number subject to off-payroll legislation and determined as out of scope of IR35(2)	6
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 24 – Off payroll workers engaged at any point during the financial year

2.11.15.3 Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year.	12

Table 25 – Off-payroll engagements / senior official engagements

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

There were no payments made relating to exit packages in 2021-22.

2.12 Parliamentary Accountability and Audit Report

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

Annual accounts

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

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Vale of York Clinical Commissioning Group ('the CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of Matter – transfer of the CCG's functions to the Integrated Care Board

We draw attention to notes 1.1 (going concern) and 17 (events after the reporting period) of the financial statements, which highlight that the Health and Care Act 2022 gained Royal Assent on 28 April 2022. As disclosed in notes 1.1 and 17 of the financial statements, the CCG's functions will transfer to a new Integrated Care Board from 1 July 2022. Given services will continue to be provided by another public sector entity, the financial statements are prepared on a going concern basis. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

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

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

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to

the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

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

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2021/22 and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

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

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

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

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

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

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

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the members of the Governing Body of NHS Vale of York CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

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

MJKirkham
Mark Kirkham (Jun 16, 2022 14:42 GMT+1)

Mark Kirkham, Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

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The Primary Statements

Notes to the Accounts

Statement Of Comprehensive Net Expenditure for the Year Ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from services	2	(1,139)	(734)
Other operating income	2	(557)	(949)
Total operating income		**(1,696)**	**(1,683)**
Staff costs	4	6,637	6,483
Purchase of goods and services	5	566,595	534,998
Depreciation	5	9	9
Provision expense	5	(86)	25
Other operating expenditure	5	170	144
Total operating expenditure		**573,325**	**541,659**
Net operating expenditure		**571,629**	**539,976**
Comprehensive net expenditure for the year		**571,629**	**539,976**

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

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets			
Property, plant and equipment	8	0	9
Total non-current assets		**0**	**9**
Current assets			
Trade and other receivables	9	2,171	4,357
Cash	10	51	167
Total current assets		**2,222**	**4,524**
Total assets		**2,222**	**4,533**
Current liabilities			
Trade and other payables	11	(39,507)	(37,694)
Provisions	12	(60)	(147)
Total current liabilities		**(39,567)**	**(37,841)**
Assets less liabilities		**(37,345)**	**(33,308)**
Financed by taxpayers' equity			
General fund		(37,345)	(33,308)
Total taxpayers' equity		**(37,345)**	**(33,308)**

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

The financial statements on pages 1 to 29 were approved by Audit Committee on behalf of the Governing Body on 31st May 2022 and signed on its behalf by:

Phil Mettam
Accountable Officer
10th June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000
Changes in taxpayers' equity for 2021-22	
Balance at 1 April 2021	**(33,308)**
Changes in taxpayers' equity for 2021-22	
Net operating expenditure for the financial year	(571,629)
Net funding	567,592
Balance at 31 March 2022	**(37,345)**

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

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

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(571,629)	(539,976)
Depreciation	8	9	9
(Increase)/decrease in trade and other receivables	9	2,186	(1,562)
Increase in trade and other payables	11	1,813	11,227
Provisions utilised	12	(1)	(17)
Increase/(decrease) in provisions	12	(86)	25
Net cash outflow from operating activities		**(567,708)**	**(530,294)**
Cash flows from financing activities			
Grant in aid funding received		567,592	530,369
Net cash inflow from financing activities		**567,592**	530,369
Net increase/(decrease) in cash	10	**(116)**	**75**
Cash at the beginning of the financial year		**167**	92
Cash at the end of the financial year		**51**	**167**

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

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

The Health and Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and the abolishment of clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. The Bill was given Royal Assent and became an Act of Parliament on the 28th April 2022. The intention is that all the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.

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 a going concern basis. The statement of financial postion has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 Accounting Convention

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

1.3 Joint arrangements - Interests in Joint Operations

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

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

Notes to the Financial Statements

The Clinical Commissioning Group has entered into three pooled budget arrangements with partner organisations in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the management of commissioning health and social care resources related to the Better Care Fund (BCF). All parties to these agreements contribute to a pooled commissioning budget which is overseen by the relevant Health and Wellbeing Board (HWB).

Whilst the section 75 agreements constitute joint operations under IFRS 11, the substance of the commissioning transactions related to the Funds' spending plans indicates that neither the Clinical Commissioning Group nor the councils are either a joint operator or lead commissioner. Therefore, each organisation accounts for its own transactions without recognising its interest in its share of total assets, liabilities, revenue and expenditure that related to the whole Funds. The income and expenditure relating to these arrangements are detailed in Note 15 - Joint Arrangements - Interests in Joint Operations.

The Clinical Commissioning Group has entered into pooled budgets with North Yorkshire County Council, City of York Council, East Riding of Yorkshire Council and the following Clinical Commissioning Groups:

NHS Bradford District and Craven CCG
NHS East Riding of Yorkshire CCG
NHS North Yorkshire CCG
NHS Morecambe Bay CCG

For the City of York HWB, the Clinical Commissioning Group hosts the pooled budget. For the North Yorkshire and East Riding of Yorkshire HWBs, the hosts are North Yorkshire County Council and East Riding of Yorkshire Council respectively. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreements.

1.4 **Income**

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

- The Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The Clinical Commissioning Group is to similarly not disclose information where income is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- The Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England and NHS Improvement. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Income in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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

Payment terms are standard, reflecting cross government principles.

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

1.5 Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid.

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

1.5.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost to the Clinical Commissioning Group recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

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

1.6 Other Expenses

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

Notes to the Financial Statements

1.7 Property, Plant and Equipment

1.7.1 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.

1.7.2 Measurement

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

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

1.7.3 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.

1.7.4 Depreciation

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

Notes to the Financial Statements

1.8 **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.

1.8.1 **The Clinical Commissioning Group as Lessee**

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

1.8.2 **The Clinical Commissioning Group as Lessor**

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.

1.9 **Cash**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

1.10 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

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

1.11 **Clinical Negligence Costs**

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

1.12 **Non-Clinical Risk Pooling**

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

Notes to the Financial Statements

1.13 **Financial Assets**

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

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

1.13.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.13.2 **Impairment**

For all financial assets measured at amortised cost, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables at an amount equal to lifetime expected credit losses.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14 **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.

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

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

Notes to the Financial Statements

1.15 **Value Added Tax**

Most of the activities of the Clinical Commissioning Group are outside the scope of Value Added Tax (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.

1.16 **Losses and Special Payments**

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

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

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

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

1.17.1 **Critical Accounting Judgements in Applying Accounting Policies**

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

1.17.2 **Sources of Estimation Uncertainty**

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

Accruals:

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

Prescribing - the full year figure is estimated on the spend for the first 10 months of the year based upon historic prescribing patterns. Within the total reported prescribing expenditure for 2021-22, 16.3% is based on estimated figures with a value of £9.024m. Due to the value of this, a review of the accuracy level for prescribing estimates throughout 2021-22 has been carried out and shows 96.5% accuracy.

General Medical Services (GMS) and Personal Medical Services (PMS) - the full year figure for the Quality and Outcomes Framework (QOF) of £5.340m is estimated based on GP practice achievement in 2020-21. Payment for 2021-22 will be reconciled and paid to GP practices in June 2022.

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

The GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 Leases being for implementation in 2022/23, and the government implementation date for IFRS 17 Insurance Contracts still subject to HM Treasury consideration.

Notes to the Financial Statements

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position, the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Clinical Commissioning Group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Clinical Commissioning Group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Clinical Commissioning Group's incremental borrowing rate. The Clinical Commissioning Group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022-23, the Clinical Commissioning Group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The application of IFRS 16 Leases from 1st April 2022 will mean that building leases currently classified as operating leases will be brought on to the Statement of Financial Position. They will be recognised as right-of-use assets offset by lease liabilities representing the financing. The right-of-use assets will be depreciated with depreciation and interest being charged through the Statement of Comprehensive Net Expenditure. Were this standard applied in 2021-22 right-of-use assets of approximately £706,000 would be included on the Statement of Financial Position. The Clinical Commissioning Group's lease for photocopiers is deemed to be low value under IFRS 16 and as such no adjustment is required.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. The standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The impact of this standard has not yet been assessed.

2. Operating Income

	2021-22 Total £'000	2020-21 Total £'000
Income from services		
Non-patient care services to other bodies	395	276
Prescription fees and charges	639	449
Other contract income	105	0
Recoveries in respect of employee benefits	0	9
Total income from services	**1,139**	**734**
Other operating income		
Rental revenue from operating leases	29	0
Charitable and other contributions to revenue expenditure: non-NHS	8	65
Non cash apprenticeship training grants revenue	2	6
Other non-contract revenue	518	878
Total other operating income	**557**	**949**
Total operating income	**1,696**	**1,683**

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

3. Disaggregation of Income - Income from Services

	2021-22				2020-21
	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	Total contract income	Total contract income
	£'000	£'000	£'000	£'000	£'000
Source of income				28	
NHS	115	0	105	220	0
Non NHS	280	639	-	919	734
Total	**395**	**639**	**105**	**1,139**	**734**

	2021-22				2020-21
	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	Total contract income	Total contract income
	£'000	£'000	£'000	£'000	£'000
Timing of income					
Point in time	0	0	0	0	9
Over time	395	639	105	1,139	725
Total	**395**	**639**	**105**	**1,139**	**734**

4. Employee Benefits and Staff Numbers

4.1 Employee Benefits

	2021-22		
	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	4,886	328	**5,214**
Social security costs	502	0	**502**
Employer contributions to NHS Pension scheme	911	0	**911**
Apprenticeship Levy	10	0	**10**
Gross employee benefits expenditure	**6,309**	**328**	**6,637**
Less recoveries in respect of employee benefits (note 4.1.1)	0	0	0
Total net employee benefits	**6,309**	**328**	**6,637**

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

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

4.1.1 Recoveries in Respect of Employee Benefits

	2021-22 Total £'000	2020-21 Total £'000
Employee benefits		
Salaries and wages	0	(7)
Social security costs	0	(1)
Employer contributions to the NHS Pension Scheme	0	(1)
Total recoveries in respect of employee benefits	0	**(9)**

4.2 Average number of people employed

	2021-22			2020-21
	Permanently employed Number	Other Number	Total Number	Total Number
Total	**105**	**4**	**109**	**115**

4. Employee Benefits and Staff Numbers (continued)

4.3 Exit Packages Agreed in the Financial Year

There were no exit packages agreed in 2021-22 (2020-21: nil).

There were no payments for other agreed departures made in 2021-22 (2020-21: nil).

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

4.4 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating Expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Purchase of healthcare from other CCGs and NHS England	1,996	3,390
Purchase of healthcare from foundation trusts	318,711	308,922
Purchase of healthcare from other NHS trusts	32,969	31,732
Purchase of healthcare from other WGA* bodies	960	0
Purchase of healthcare from non-NHS bodies	83,211	67,498
Prescribing costs	54,829	53,425
General ophthalmic services	96	90
GPMS, PMS and APMS	57,448	52,144
Rentals under operating leases	188	153
Supplies and services – clinical	240	274
Supplies and services – general	11,574	13,128
Consultancy services	36	151
Establishment	1,196	758
Transport	2,161	2,097
Premises	605	1,026
Audit fees	56	56
Other non statutory audit expenditure	12	9
Internal audit services	40	39
Other professional fees	120	6
Legal fees	89	67
Education, training and conferences	56	28
Non cash apprenticeship training grants	2	5
Total purchase of goods and services	**566,595**	**534,998**
		28
Depreciation charges		
Depreciation	9	9
Total depreciation charges	**9**	**9**
Provision expense		
Provisions	(86)	25
Total provision expense	**(86)**	**25**
Other operating expenditure		
Chair and Non-Executive Members	118	119
Research and development (excluding staff costs)	35	20
Expected credit loss on receivables	1	5
Other expenditure	16	0
Total other operating expenditure	**170**	**144**
Total operating expenditure	**566,688**	**535,176**

* Whole of Government Accounts. This is pass through funding to Community Health Partnerships, one of the Department of Health and Social Care property companies.

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

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

6. Better Payment Practice Code

6.1 Measure of Compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS payables				
Total Non-NHS trade invoices paid in the year	12,209	156,159	10,483	129,812
Total Non-NHS trade invoices paid within target	11,880	154,300	10,200	127,131
Percentage of Non-NHS trade invoices paid within target	**97.31%**	**98.81%**	**97.30%**	**97.93%**
NHS payables				
Total NHS trade invoices paid in the year	509	359,358	1,091	351,286
Total NHS trade invoices paid within target	498	359,233	1,061	351,008
Percentage of NHS trade invoices paid within target	**97.84%**	**99.97%**	**97.25%**	**99.92%**

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

There were no payments made in relation to the late payment of commercial debts (2020-21: nil).

7. Operating Leases

7.1 As Lessee

In 2021-22, the Clinical Commissioning Group leased its corporate offices (West Offices) from the City of York Council. The tenancy agreement for this space has not been signed.

The Clinical Commissioning Group leases additional office space for Continuing Healthcare staff from York and Scarborough Teaching Hospitals NHS Foundation Trust. The tenancy agreement for this space has not been signed.

7.1.1 Payments Recognised as an Expense

	2021-22			2020-21
	Buildings £'000	Other £'000	Total £'000	Total £'000
Payments recognised as an expense				
Minimum lease payments	186	2	**188**	153
Total	**186**	**2**	**188**	**153**

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

7.1.2 Future Minimum Lease Payments

	2021-22		2020-21
	Other £'000	Total £'000	Total £'000
Payable			
No later than one year	2	**2**	2
Between one and five years	6	**6**	8
Total	**8**	**8**	**10**

7. Operating Leases (continued)

7.2 As Lessor

7.2.1 Rental Revenue

	2021-22 £'000	2020-21 £'000
Recognised as income		
Rent	29	0
Total	**29**	**0**

In 2021-22, the Clinical Commissioning Group sub-leased two areas within West Offices to NHS England and NHS Improvement and North of England Commissioning Support Unit under short term licences to occupy.

7.2.2 Future Minimum Rental Revenue

	2021-22 £'000 NHSE Bodies	2021-22 £'000 Total	2020-21 £'000 Total
Receivable			
No later than one year	11	11	0
Total	**11**	**11**	**0**

The lease agreements are short term with a three month notice period. There is no signed agreement with North of England Commissioning Support Unit and so no future minimum rental revenue is included in the note above.

8. Property, Plant and Equipment

	31 March 2022 Information technology £'000	31 March 2021 Information technology £'000
Cost or valuation at 1 April	18	18
Cost or valuation at 31 March	**18**	**18**
Depreciation 1 April	9	0
Charged during the year	9	28
Depreciation at 31 March	**18**	**9**
Net book value at 31 March	**0**	**9**
Purchased	0	9
Total at 31 March	**0**	**9**
Asset financing		
Owned	0	9
Total at 31 March	**0**	**9**

8.1 Cost or Valuation of Fully Depreciated Assets

The cost or valuation of fully depreciated assets still in use was as follows.

	2021-22 £'000	2020-21 £'000
Information technology	18	0

8.2 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Information technology	2	10

9. Trade and Other Receivables

	Current 31 March 2022 £'000	Current 31 March 2021 £'000
NHS receivables: revenue	966	3,130
NHS prepayments	46	64
NHS accrued income	579	465
Non-NHS and other WGA receivables: revenue	84	64
Non-NHS and other WGA prepayments	37	320
Non-NHS and other WGA accrued income	55	11
Non-NHS and other WGA contract receivable not yet invoiced/non-invoice	399	245
Expected credit loss allowance - receivables	(2)	(1)
VAT	6	58
Other receivables and accruals	1	1
Total trade and other receivables	**2,171**	**4,357**

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

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

9.1 Receivables Past their Due Date but Not Impaired

	31 March 2022		31 March 2021	
	DHSC Group Bodies	Non DHSC Group Bodies	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000	£'000	£'000
By up to three months	4	9	690	32
By three to six months	0	1	0	0
By more than six months	0	19	0	28
Total	**4**	**29**	**690**	**60**

10. Cash

	31 March 2022 £'000	31 March 2021 £'000
Balance at 01 April	167	92
Net change in year	(116)	75
Balance at 31 March	**51**	**167**
Made up of:		
Cash with the Government Banking Service	51	167
Cash in statement of financial position	**51**	**167**
Balance at 31 March	**51**	**167**

11. Trade and Other Payables

	Current 31 March 2022 £'000	Current 31 March 2021 £'000
NHS payables: revenue	1,036	1,232
NHS accruals	232	6
Non-NHS and other WGA payables: revenue	6,257	11,994
Non-NHS and other WGA accruals	30,391	23,228
Social security costs	70	69
Tax	64	58
Other payables and accruals	1,457	1,107
Total trade and other payables	**39,507**	**37,694**

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

Other payables include £92,689 outstanding pension contributions at 31 March 2022 (31 March 2021: £91,739).

12. Provisions

	Current 31 March 2022 £'000	Current 31 March 2021 £'000
Restructuring	0	103
Continuing care	60	44
Total	**60**	**147**

The Clinical Commissioning Group has no non-current provisions.

	Restructuring £'000	Continuing Care £'000	Total £'000
Balance at 1 April 2021	**103**	**44**	**147**
Arising during the year	0	60	**60**
Utilised during the year	0	(1)	**(1)**
Reversed unused	(103)	(43)	**(146)**
Balance at 31 March 2022	**0**	**60**	**60**
Expected timing of cash flows			
Within one year	0	60	**60**
Balance at 31 March 2022	**0**	**60**	**60**

The Clinical Commissioning Group made a provision for a restructuring payment in 2019-20. The member of staff was put at risk as a result of a restructure in year however was seconded to another NHS organisation and has remained seconded with them since. The provision has been reversed in 2021-22 as this member of staff will permanently transfer to the ICB when the Clinical Commissioning Group is abolished and therefore the provision is no longer required.

The provision for continuing care relates to the potential cost for continuing care reviews. There is uncertainty regarding the outcomes and timings of individual case reviews.

13. Financial Instruments

13.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

The Clinical Commissioning Group is financed through parliamentary funding and so it is not exposed to the degree of financial risk faced by business entities. The Clinical Commissioning Group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Clinical Commissioning Group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Clinical Commissioning Group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Chief Finance Officer and internal auditors.

13.1.1 Market Risk

The Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Clinical Commissioning Group has no overseas operations. The Clinical Commissioning Group does not borrow and therefore has low exposure to interest rate and currency rate fluctuations. The Clinical Commissioning Group does not have any securities or investments and therefore has low exposure to price risk.

13.1.2 Credit risk

The majority of the Clinical Commissioning Group's revenue comes parliamentary funding and the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note. The majority of these receivables are with NHS organisations and are therefore deemed to be low risk.

13.1.3 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.

13.1.4 Financial Instruments

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

13. Financial Instruments (continued)

13.2 Financial Assets

	31 March 2022 Financial assets measured at amortised cost £'000	31 March 2021 Financial assets measured at amortised cost £'000
Trade and other receivables with NHSE bodies	1,444	2,286
Trade and other receivables with other DHSC group bodies	101	1,310
Trade and other receivables with external bodies	484	321
Cash	51	167
Total at 31 March	**2,080**	**4,084**

13.3 Financial Liabilities

	31 March 2022 Financial liabilities measured at amortised cost £'000	31 March 2021 Financial liabilities measured at amortised cost £'000
Trade and other payables with NHSE bodies	1,195	949
Trade and other payables with other DHSC group bodies	268	394
Trade and other payables with external bodies	36,452	35,117
Other financial liabilities	802	581
Total at 31 March	**38,717**	**37,041**

14. Operating Segments

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

15. Joint Arrangements - Interests In Joint Operations

The Clinical Commissioning Group has entered into three pooled budget arrangements with partner organisations, under section 75 of the Health Care Act 2006 for the management of commissioning resources related to the Better Care Fund (BCF). All parties to these agreements contribute to a pooled commissioning budget which is overseen by the relevant Health and Wellbeing Board (HWB).

The three pooled arrangements relate to City of York, North Yorkshire and East Riding of Yorkshire Health and Wellbeing Board boundaries.

For the City of York HWB, the Clinical Commissioning Group hosts the pooled budget. For the North Yorkshire and East Riding of Yorkshire HWBs, the hosts are North Yorkshire County Council and East Riding of Yorkshire Council respectively.

15.1 Interests In Joint Operations

			Amounts recognised in CCG accounts	
			2021-22	2020-21
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Expenditure**	**Expenditure**
			£'000	**£'000**
Better Care Fund - City of York Health and Wellbeing Board	NHS Vale of York CCG City of York Council	Health and Social Care pooled commissioning budget	13,331	12,728
Better Care Fund - North Yorkshire Health and Wellbeing Board	NHS Vale of York CCG NHS Bradford District and Craven CCG NHS North Yorkshire CCG NHS Morecambe Bay CCG North Yorkshire County Council	Health and Social Care pooled commissioning budget	8,733	8,256
Better Care Fund - East Riding Health and Wellbeing Board	NHS Vale of York CCG NHS East Riding of Yorkshire CCG East Riding of Yorkshire County Council	Health and Social Care pooled commissioning budget	1,540	1,439

16. Related Party Transactions

Details of related party transactions in 2021-22 are as follows:

	Expenditure with Related Party £'000	Income from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Andrew Moriarty - Governing Body - Local Medical Liaison Officer, Selby and York - GP My Health	3,767	0	0	0
Dr Andrew Moriarty - Governing Body - Local Medical Liaison Officer, Selby and York - YORLMC LTD	379	0	0	0
Sharon Stolz - Governing Body attendance - Director of Public Health, City of York Council	12,105	218	1,584	76
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Surgery	3,061	0	0	0
Dr Helena Ebbs - Governing Body GP - GP Partner Pickering Medical Practice	2,050	1	4	0
Dr Ruth Walker - Governing Body GP - GP Partner Scott Road Medical Practice	1,304	0	0	0
Dr Christopher Stanley - Governing Body GP - Haxby Group Practice	5,501	1	118	0
Dr Christopher Stanley - Governing Body GP - Nimbuscare Limited	2,202	2	50	2
Beech Tree Surgery	3,061	0	0	0
Dalton Terrace Surgery	969	0	0	0
Elvington Medical Practice	1,833	0	5	0
Escrick Surgery	554	0	0	0
Front Street Surgery	853	0	0	0
Haxby Group Practice	5,501	1	118	0
Helmsley Medical Centre	517	0	0	0
Jorvik Gillygate Practice	2,723	0	0	0
Kirkbymoorside Surgery	1,668	6	0	0
Millfield Surgery	1,343	0	0	0
MyHealth	3,767	0	0	0
The Old School Medical Practice	951	0	0	0
Pickering Medical Practice	2,050	1	4	0
Pocklington Group Practice	2,874	1	0	0
Posterngate Surgery	3,136	0	0	0
Priory Medical Group	7,913	1	7	0
Scott Road Medical Centre	1,304	0	0	0
Sherburn Group Practice	1,583	0	0	0
South Milford Surgery	2,748	0	0	0
Stillington Surgery	1,045	0	0	0
Tadcaster Medical Centre	1,460	0	0	0
Terrington Surgery	404	0	0	0
Tollerton Surgery	991	0	0	0
Unity Health	1,783	0	0	0
York Medical Group	5,635	1	0	0

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

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

- NHS England and NHS Improvement
- NHS North Yorkshire CCG
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust

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

Details of related party transactions in 2020-21 are as follows:

Please note that the related party transactions in 2020-21, as shown below, have been restated for the 2021-22 statutory accounts and are now shown on an accruals basis rather than a cash basis to ensure consistency with 2021-22.

	Expenditure with Related Party £'000	Income from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Aaron Brown - Governing Body - Local Medical Liaison Officer, Selby and York - GP York Medical Group	5,579	4	19	0
Dr Andrew Moriarty - Governing Body - Local Medical Liaison Officer, Selby and York - GP My Health	3,147	1	0	0
Dr Andrew Moriarty - Governing Body - Local Medical Liaison Officer, Selby and York - YORLMC Limited	377	0	0	0
Sharon Stolz - Governing Body attendance - Director of Public Health, City of York Council	13,424	225	5,380	45
Dr Nigel Wells - Clinical Chair - Council of Representatives, Finance and Performance Committee and Governing Body - GP Partner Beech Tree Surgery	3,030	0	0	0
Dr Helena Ebbs - Governing Body GP - GP Partner Pickering Medical Practice	2,031	0	11	0
Dr Ruth Walker - Governing Body GP - GP Partner Scott Road Medical Practice	1,248	1	7	0
Dr Christopher Stanley - Governing Body GP - Haxby Group Practice	4,755	1	11	0
Dr Christopher Stanley - Governing Body GP - Nimbuscare Limited	1,929	0	4	0
Beech Tree Surgery	3,030	0	0	0
Dalton Terrace Surgery	960	0	0	0
East Parade	73	1	0	0
Elvington Medical Practice	1,934	0	0	0
Escrick Surgery	1,463	0	0	0
Front Street Surgery	959	0	1	0
Haxby Group Practice	4,755	1	11	0
Helmsley Medical Centre	569	0	0	0
Jorvik Gillygate Practice	3,091	1	1	0
Kirkbymoorside Surgery	1,275	6	0	1
Millfield Surgery	1,277	0	0	0

MyHealth	3,147	1	0	0
The Old School Medical Practice	882	0	0	0
Pickering Medical Practice	2,031	0	11	0
Pocklington Group Practice	3,074	0	4	0
Posterngate Surgery	2,709	1	1	0
Priory Medical Group	7,615	4	106	0
Scott Road Medical Centre	1,248	1	7	0
Sherburn Group Practice	1,568	0	0	0
South Milford Surgery	2,406	0	10	0
Stillington Surgery	1,007	0	0	0
Tadcaster Medical Centre	1,529	0	0	0
Terrington Surgery	380	0	0	0
Tollerton Surgery	895	0	0	0
Unity Health	1,776	0	7	0
York Medical Group	5,579	4	19	0

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

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

- NHS England
- NHS North Yorkshire CCG
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- South Tees Hospitals NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust

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

17. Events After the End of the Reporting Period

There is one non-adjusting post balance sheet event. This relates to the Health and Care Bill which was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England. ICBs will take on the commissioning functions of CCGs. The Bill passed on 28th April 2022 and the intention is that the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022 (2020-21: none).

18. Financial Performance Targets

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

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

	2021-22		2020-21	
	Target	**Performance**	**Target**	**Performance**
Expenditure not to exceed income	577,601	577,599	548,187	548,184
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	571,631	571,629	539,979	539,976
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	6,949	6,071	6,935	6,343

19. Losses and Special Payments

19.1 Losses

	2021-22		2020-21	
	Total Number of Cases Number	**Total Value of Cases £'000**	**Total Number of Cases Number**	**Total Value of Cases £'000**
Administrative write-offs	0	0	4	7
Total	**0**	**0**	**4**	**7**

These amounts are reported on an accruals basis but excluding provisions for future losses.

19.2 Special Payments

There were no special payments in 2021-22 (2020-21: nil).