NHS Harrogate and Rural District Clinical Commissioning Group

Annual Report 2019-2020

NHS
Harrogate and Rural District
Clinical Commissioning Group

Introduction

Welcome from Amanda Bloor, Accountable Officer
North Yorkshire Clinical Commissioning Groups (NHS Hambleton Richmondshire and Whitby, NHS Harrogate and Rural District, NHS Scarborough Ryedale)

Welcome to our annual report for the year which ends on 31 March 2020. This report highlights the work we have been doing this year to drive better healthcare outcomes for the people of Harrogate and Rural District and to empower local people to take informed decisions about their own health and wellbeing in partnership with health professionals.

This will be our last annual report as Harrogate and Rural District CCG. As you will read in this report substantial work has been undertaken this year to bring together three North Yorkshire CCGs (Hambleton Richmondshire and Whitby CCG, Harrogate and Rural District CCG, and Scarborough and Ryedale CCG) as the North Yorkshire Clinical Commissioning Group from 1 April 2020. By coming together as a larger, strategic organisation we can transform how we deliver healthcare. This new approach to healthcare commissioning is great news for the people of North Yorkshire. It will enable closer collaboration and consistency of approach, enabling us to amplify the impact of our resources and expertise. This does not mean we will dilute either our clinical or local focus – both remain at the heart of how we will deliver for our communities.

This year has seen a journey of significant change for the CCG. We received approval from NHS England to establish the Yorkshire Clinical Commissioning Group on 1 April 2020 in November last year. I am excited about the transformative potential of our new unified approach. As a single organisation we will be able to:

- Ensure consistency of decision making for the people of North Yorkshire.
- Provide a more agile and responsive service which maintains a local focus but enables us to obtain better value for money by commissioning at scale.
- Harmonise our commissioning policies to eliminate variation and help reduce health inequalities.
- Eliminate unnecessary duplication and bureaucratic boundaries to work more efficiently together and with our partners.
- Reduce administrative costs to enable more investment in front line health services.

- Share good practice and adopt the best from each of the three existing CCGs.
- Speak as a unified commissioning voice for the benefit of our local population.
- Work more strategically on a larger footprint with our local and regional partners.

The merger builds on work started last business year. In 2018 each of three CCGs' Governing Bodies agreed to implement a single management team across the organisations. A single Accountable Officer has been in place since December 2018 and a full leadership team for the three North Yorkshire CCGs was in place by November 2019. Teams across all three CCGs have been working diligently this year to identify opportunities to align, eliminate redundancy and plan collectively for the future.

While work has been underway to prepare to launch the North Yorkshire CCG on 1 April 2020 we have remained very focused on the 'day job' and improving health and care outcomes for local people. In Harrogate and Rural District we have:

- Launched the Harrogate and Rural Alliance[1]. This alliance brings together district nurses, social and primary health care to provide an integrated, person-centred, service. The Alliance ambition is that together we will create a single service owned by the community and by all of our colleagues which has the person and community at its centre, and delivers good outcomes and value for money.
- Continued our self-care and prevention campaigns to support people in living healthier lives, longer, which reduce the need for intervention from a healthcare service.
- Developed the North Yorkshire Mental Health and Learning Disabilities Strategic Partnership Board which brings together health and care decision makers across the county to collectively improve mental health and learning disability provisions for our population.
- Worked with our community medical equipment supplier to enhance return of no-longer needed equipment so it can be recycled and reused, reducing cost pressures on the service.
- Launched an innovative new programme to support parents manage normal infant crying and to prevent abusive head trauma injuries to babies caused by shaking, also referred to as 'shaken baby syndrome'.
- Enhanced mental health support for young people and adults with the introduction of two websites. Young people aged 11-18 can now access Kooth[2], a website offering free online counselling and emotional wellbeing support. Adults now can access a website improving

[1] You can learn more on the Harrogate and Rural Alliance (HARA website) at http://harrogatealliance.co.uk/
[2] https://www.kooth.com/

access to psychological therapies (IAPT) service, which offers talking therapies treatments[3]. The website includes an option to self-refer online without having to go through a GP.

- Actively supported the World Cycling Championships which took place across North Yorkshire in September 2019 through partnership working to ensure patient safety and healthcare was not disrupted for the duration of the event.
- Worked with North Yorkshire County Council to fund Living Well Coordinators who work in partnership with people in the community to identify and support early interventions which will prevent ill health.

This year I have been working tirelessly with my team to ensure that the funds that we safeguard are spent effectively and efficiently to secure the best options for the people of the Harrogate and Rural District. As a public body, fiscal efficiency is essential and we want to make sure every penny we spend is spent in the right place. Significant financial challenge remains across the NHS in England and we remain fully focused on ensuring we play our part to deliver efficient, financially sustainable services.

I am strongly encouraged by the transformative work underway to deliver health care collaboratively and consistently for North Yorkshire. I am looking forward to continuing our work to build strong partnerships, bring patient-centred healthcare into the community, and empower healthy choices across North Yorkshire in the year ahead.

Our accomplishments this year have been achieved through wide and joint collaboration across and beyond Harrogate and Rural District, including from colleagues here at the CCG, our local, regional and national health and care partners, local authorities and, most importantly, the people we serve. Thank you all for being part of what we have achieved this year.

If you have any feedback on this report or any of the work we do I am always happy to hear from you.

Amanda Bloor

Accountable Officer

23 June 2020

[3] https://northyorkshireiapt.co.uk/

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1 Performance Overview

1.1 Introduction

This report is designed to give you an overview of our priorities and achievements in 2019/20.

In this 'Performance overview' section you will learn more about our responsibilities, how we work and what some of our key achievements this year have been. In the performance analysis which follows, starting in section 6, we look in more detail at our activities, as well as key healthcare indicators, to assess how well we have performed. In the accountability report which can be found in section 7 on page 76 you can find out about our members, our senior leadership team and how we make decisions. Finally, from page 142, you will find our annual accounts which we produce each year and submit to NHS England. Throughout this document we provide signposts to where you can view or find more information.

You will read in this report about significant work we have undertaken this year across three North Yorkshire CCGs – NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG – as we prepare to become the North Yorkshire CCG from 1 April 2020. We are confident that the committed enabling work that has been done by our staff, partners and the wider community this year will enable a smooth transition for the new business year to ensure we continue to provide the quality services rightly expected of us.

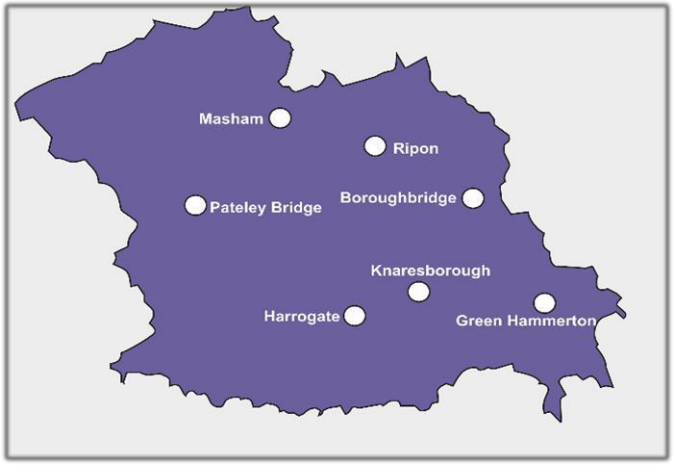
1.2 What we do

We are responsible for purchasing (or 'commissioning') healthcare services for around 162,000 people in Harrogate and the surrounding area.

The services we commission include the majority of healthcare services that local people may need to access either in hospital or in the community.

We commission:

- Primary health care which includes General Practice (GP) services.
- Planned hospital care, which includes non-emergency surgery and maternity services.
- Urgent and emergency care, including ambulances.
- Mental Health services.



- Children's Services.
- Rehabilitation care.
- Community health services, such as occupational health and physiotherapy.

Our staff are responsible for commissioning and delivering healthcare services across the locality. We also provide assurance to NHS England that quality and performance standards are met and in line with national healthcare policy.

1.3 Our Vision

Our work is driven by a clear vision:

> **By working with patients, public and partners we will secure high quality services, in the most appropriate setting, making maximum use of available resources. Through clinical leadership and collaborative working we will achieve the best possible health outcomes for all our local population.**

By working in this way we believe we will improve the healthcare outcomes for the people of Harrogate and Rural District by ensuring high quality healthcare in the right place at the right time delivered by the right people.

1.4 Our values

We have a strong commitment to our values, which run through everything we do. Our values are:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

1.5 About us, Our Community and How We Work

We are a clinically led membership organisation of our seventeen local GP practices. This means that health professionals with current patient experience are leading the decisions we make. Our Council of Members, comprised of one GP partner from each practice, meets every eight weeks throughout the year to discuss strategic issues and share best practice. The Council of Members is supported by the CCG's senior leadership team.

The CCG's Governing Body includes GPs who each take the lead for a clinical priority area, such as Medicine Management, Vulnerable People and Primary Care, and to drive improvements. Our Governing Body also includes three independent lay members and a secondary care doctor who help represent the patient voice and provide an independent view, rigour and challenge to the commissioning decisions for local services.

We actively involve local population and patients in decisions which impact them. You will read more about how we do this in this report.

We are accountable to our members, local people and NHS England. We demonstrate our accountability in a number of ways, such as holding our Governing Body meetings in public, publishing our commissioning plan each year, and producing annual accounts which are independently audited.

If you want to know more about how we are structured, roles and responsibilities, and how we make the decisions which affect you, you may wish to see our constitution[4]. You can also see papers and minutes from our Governing Body and Primary Care Commissioning Committee on our website[5].

1.6 Enabling Work to Create the North Yorkshire CCG

On 5 November 2019 we received approval from NHS England and NHS Improvement to merge the three North Yorkshire CCGs. We will begin operating as the NHS North Yorkshire Clinical Commissioning Group from 1 April 2020.

Our merger will help us collectively achieve the benefits of a single, aligned, strategic organisation, consistent with the national aspirations for CCGs as described in the NHS Long Term Plan[6]. As a single organisation we will be able to:

- Eliminate unnecessary duplication and bureaucratic boundaries to work more efficiently together and with our partners.

[4] http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/constitution/hard-ccg-constitution-v4.0-june-2017-final-nhse-approved-website-version.pdf
[5] http://www.harrogateandruraldistrictccg.nhs.uk/
[6] https://www.england.nhs.uk/long-term-plan/

- Ensure consistency of decision making for the people of North Yorkshire.
- Provide a more agile and responsive service which maintains a local focus but enables us to obtain better value for money by commissioning at scale.
- Reduce administrative costs to enable more investment in front line health services.
- Share good practice and adopt the best from each of the three existing CCGs.
- Speak as a unified commissioning voice for the benefit of our local population.
- Work more strategically on a larger footprint with our local and regional partners.

The merger builds on work started in the last business year. In 2018 each of three CCGs' Governing Bodies agreed to implement a single management team across the organisations. A single Accountable Officer has been in place since December 2018 and a full leadership team was in place by November 2019.

Teams across all three CCGs have also been working diligently this year to identify opportunities to align, eliminate redundancy and plan collectively for the future.

1.7 Working with our Partners

We could not succeed without working closely with our partners. Collectively we can deliver the best possible outcomes for the people of the Harrogate and Rural District area. This section will give you a sense of the network of people and organisations working to make this happen. Working with local people is essential to make sure we commission services that meet the needs of everyone living in Harrogate and Rural District.

1.7.1 Patient Participation Groups (PPGs)

Our patient partners represent the patient voice and provide meaningful input into proposed projects and service developments. They are invaluable to the work we do. You can read more about them and how you can get involved in sections 2.6.1 and 6.6.

1.7.2 Primary Care Organisations

Primary care organisations include general practices and membership organisations which represent them. Collectively these organisations provide a number of healthcare services in the community to our patients.

1.7.3 NHS Providers

Four NHS trusts provide the majority of services to our patients. These are: Harrogate and District NHS Foundation Trust (HDFT); Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV); York Teaching Hospitals NHS Foundation Trust (YTHT); and Leeds Teaching Hospitals NHS Trust (LTFT) which provides more specialist care when needed.

1.7.4 Local Authorities

We work in partnership with public health colleagues and jointly with North Yorkshire County Council and Harrogate Borough Council to commission a number of services, such as the mental health crisis service, and befriending and respite support for carers.

1.7.5 West Yorkshire and Harrogate Health and Care Partnership Integrated Care System

Made up of 9 CCGs, local authorities, acute and mental health care providers and other health organisations the West Yorkshire and Harrogate Health and Care Partnership enables these organisations to work closely together to plan services and address the challenges facing health and care services across the region.

1.7.6 Community and Voluntary Sector

We work closely with Harrogate and Rural District's active community and voluntary sector who make significant contributions to local health care

1.7.7 NHS England

We work closely with NHSE to ensure local challenges and successes are understood and best practice can be shared across the whole NHS.

1.8 Multi-organisation Partnership Boards

We actively participate in a number of cross-organisational boards. These include partnership boards and planning groups, some of which focus on particular health services and health conditions. Collectively these boards enable us to work more closely with our partners and take decisions together where that may have benefits for local residents. Our main strategic partnerships are:

1.8.1 Health and Wellbeing Board

This strategic partnership across North Yorkshire brings together a broad spectrum of healthcare providers, elected members and HealthWatch North Yorkshire. The board is committed to delivering the Joint Health and Wellbeing Strategy[7], which considers the needs of our residents collectively. Through a 'joint needs assessment' we are able to set the priorities for integrated working, get the best offer for people across Harrogate and Rural District and achieve the strategic priorities across North Yorkshire[8].

1.8.2 North Yorkshire Mental Health and Learning Disability Strategic Partnership Board

Formed in 2018, this board brings together partners from across North Yorkshire[9]. The board aims to move away from a traditional commissioner and provider relationship to a transparent partnership approach, using its collective expertise to focus on what matters. This will enable us to think collectively about key issues such as how we invest to reduce unwarranted variation in outcomes across North Yorkshire, how we transform services by harnessing digital and technology developments and how we focus on a greater range of accessible locally based services.

1.8.3 Continuing Healthcare Board

This board operates across North Yorkshire to provide strategic oversight to the improvement of quality and efficiencies within continuing healthcare. Continuing healthcare supports our most vulnerable patients. It is essential that we ensure robust arrangements for decision making and delivery of care are in place including ensuring value for money.

1.8.4 Harrogate Public Sector Leadership Board

This board is made up of all key public sector organisations across Harrogate. The aim is to support a "One Public Service" vision and facilitate local agencies coming together seamlessly to deliver more cohesive, joined up and unified local services.

1.8.5 Transforming Care Partnership

The three North Yorkshire CCGs and key partners[10] have worked closely together on a programme of work to deliver enhanced community services for people of all ages with a learning disability, autism or both. This includes improving community services so

[7] More on the Joint Health and Wellbeing Strategy can be found at http://www.nypartnerships.org.uk/jhws
[8] More information on the Health and Wellbeing Board and the full joint needs assessment can be found at: https://www.northyorks.gov.uk/joint-strategic-needs-assessment
[9] Members of the board include The three North Yorkshire CCGs, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), North Yorkshire County Council (NYCC) Adult Social Care, NYCC Children's Services, NYCC Public Health.
[10] Key partners include including Health colleagues, Local Authority, NHS England, families, children and young people.

that people can live near their family and friends, and making sure that the right services with the right staff and skills, are in place to provide the support needed.

1.9 Covid-19

In March 2020, the UK Government announced that due to the Covid-19 pandemic and the rapid rise in UK infection rates that the population of the country would be required to enter lockdown as of Monday 23 March 2020. Acute hospital providers stopped taking non-urgent, routine cases to free up capacity and a list of non-urgent procedures to be put on temporary hold, was distributed. Routine referrals were triaged, given clinical advice and asked to see their GP if their condition changed. All patients with possible Covid-19 symptoms were asked first contact NHS 111 rather than attend their GP practice in the first instance. Telephone appointments and video consultations reduced the number of face to face contacts. Primary Care Networks (groups of GP Practices working together) then created hot and cold sites. Hot sites for people to attend with suspected Covid-19 symptoms and cold sites for people with non-Covid related symptoms to attend.

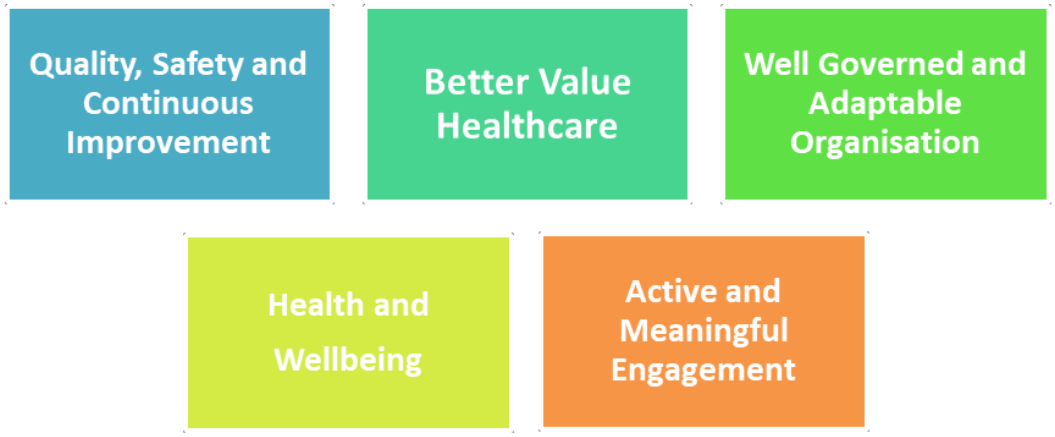
Incident Control process were put in place including Gold and Silver Command Groups and daily escalation calls were implemented with the whole health and social care system to enable rapid decision making. Additional funding was made available to GP practices and other providers for Covid-19 related expenditure. A Covid-19 Risk Register was set up with weekly monitoring by the Quality and Clinical Governance Committee to ensure all risks across the CCG were captured and mitigated accordingly.

The rapid response of the CCG's digital technology service was crucial in providing the tools to enable the organisation and GP practices to continue functioning and serving the population of the CCG. Our GPIT digital team acted quickly to distribute over 400 laptops to GP practices to support home working, prioritising vulnerable/at risk staff who were either pregnant or with underlying health conditions, to work remotely. The CCG also procured and rolled out a series of tablet devices to every care home in North Yorkshire to enable care homes to liaise remotely with their GP practices regarding patient care and receive training on the correct use of PPE.

The leadership of the CCG acted quickly in sending staff home to work remotely, providing laptops, equipment and secure VPN connections where required and phased the closure of the main CCG offices.

1.10 Our CCG's Key Strategic Objectives

We have five strategic objectives which were agreed by our Governing Body in February 2017. These objectives help us prioritise our work, and drive our decision making. Our strategic objectives are:



Quality, Safety and Continuous Improvement: To ensure that the care we commission is of high quality, safe and sustainable, improves health outcomes and wellbeing and provides a good patient experience.

Better Value Healthcare: To meet the economic challenges and changes in the NHS by commissioning efficient and cost effective services and better value healthcare.

Well Governed and Adaptable Organisation: To be a well governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services using innovative approaches to meet the future healthcare needs of our population.

Health and Wellbeing: To shift the emphasis towards optimising opportunities for maintaining health and wellbeing, promoting patient responsibility to choose well, accessing the right services at the right time and in the most appropriate place, and empowering patients to be better able to self-manage their own long-term conditions.

Active and Meaningful Engagement: To work in close partnership with local people as well as all organisations that commission or provide care for our population to embed meaningful engagement into the CCGs decision making processes.

2 Delivering Our Strategic Objectives

2.1 Quality, Safety and Continuous Improvement

We have worked hard this year to ensure the healthcare we commission is of high quality, is safe and sustainable, improves health outcomes and wellbeing and provides a good patient experience.

2.1.1 Harrogate and Rural Alliance Integrated Community Care

In September 2019 local health and social care providers came together, operating as the Harrogate and Rural Alliance (HARA), to provide adult service users with joined up community health and social care in Harrogate and Rural District.

This new approach brings colleagues in Primary Care, Harrogate and District Foundation Trust community service colleagues, social services provided by North Yorkshire County Council and mental health services provided by Tees Esk Wear Valley together in one place, along with a wider network of NHS, local government, voluntary and independent sector partners and people with lived experience to work together to support and care for our communities.

The Alliance allows for unified care to be delivered around individuals and their heath and care needs. Early intervention, prevention and sustained wellbeing are at the centre of our activities, with services being delivered at or close to home whenever possible, with hospital visits only when necessary.

2.1.2 Supporting Patient Discharge and Community Care

Our work with Harrogate District Hospital has maintained excellent performance against the Delayed Transfers of Care (DToC) target which is now consistently below the 3.5% national expectation.

A Supported Discharge Service (SDS) has been established and has achieved success working with patients, carers and care homes to enable patients to be discharged earlier than would otherwise be possible whilst continuing rehabilitation supported by a multi-disciplinary clinical team.

Enabling appropriate earlier discharge and preventing unnecessary hospital admissions is a core objective of the Harrogate and Rural Alliance. HARA coordinates care between health and social care to provide a more joined up service to patients to maintain patients in their own homes including residential care for as long as possible.

2.1.3 Diabetes Transformation

We have continued to work with Harrogate District Hospital and GP practices to increase referrals to diabetic structured education. All GP practices are making referrals to the programme and participate in the National Diabetes Audit which is a major national clinical audit, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and Quality Standards. At the end of October 2019, 367 HaRD patients had completed the Diabetes Prevention Programme which is a locally implemented national programme targeted to patients who are at risk of developing Diabetes.

2.1.4 Reducing Antibiotic Resistance

This remains a high priority for Harrogate and Rural district CCG and we have been working with West Yorkshire Research and development team who have rolled out the Lowering Antimicrobial Prescribing (LAMP) initiative to help support our practices to improve antimicrobial stewardship. All our practices have received regular reports on their antibiotic prescribing throughout the year and have supported practices to use a quality improvement methodology to audit their antibiotic prescribing practice. Our CCG prescribing of antibiotics continued to one of the lowest in the country and continued reduction in the prescribing of broad spectrum antibiotics.

2.1.5 Reducing opiate prescribing

There has been a focus at working with GP practices to focus on reducing the prescribing of opiate analgesics for management of chronic pain. The CROP project in conjunction with West Yorkshire R+D team has demonstrated an overall reduction of 9% in patients been prescribed an opiate analgesic which equates to 537 patients across the whole of the CCG and a saving of £42,000.

2.1.6 Crisis Support for Children

We have commissioned a new model of care for crisis support and intensive home treatment to support children and young people in a mental health crisis. A dedicated Children and Young Peoples Crisis Intensive Home Treatment service is now available in Harrogate and Rural District seven days a week from 10 a.m. to 10 p.m. Providers are working towards a 24/7 Crisis service across all of North Yorkshire for the future which should be operational by July 2020.

In response to the COVID-19 pandemic, providers Tees, Esk and Wear Valley (TEWV) are also responding to the national call for an all age 24/7 urgent care access telephone function which should be live by 15 April 2020.

2.1.7 Community Crisis Intervention Service

The service continued to September 2019 as it was only a pilot for a year. The service was designed to provide intensive support in an individual's home environment to help prevent a crisis inpatient admission and long stays in specialist psychiatric hospitals. Throughout the life of the service it treated over 40 individuals successfully and demonstrated that with the right support in the home environment we can dramatically increase quality of life both emotionally and physically by caring for people in their own homes.

Since then the CCG has been successful in bidding for some Mental Health and Learning Disability transformation money to develop a Intensive Support Service with the learning disability community team, the aim of the service is that people with a learning disability should be able to access specialist health support in the community on an intensive 24/7 basis when necessary.

There is a need to reduce inpatient admissions, reduce the length of stay of those people that are admitted and facilitate transfers to community settings for those people that have been in hospital for a long time.

The proposal is to develop a scaled down enhanced community team model (8am-8pm, 7 days a week) and the learning from the community crisis intervention service would be a key element to facilitate discharges, reduce future admissions and to realise the funding required to create a sustainable county wide Stepped Care model of intensive support. This is pilot in both Harrogate and York with the future intention to roll out across the whole of North Yorkshire and York.

2.2 Developing Primary Care

The focus of working with Primary Care in 2019/20 has been guided by the establishment of Primary Care Networks (PCNs). This national initiative aimed to increase capacity and resilience of GP practices and primary care services by providing additional funding for clinical roles and service specifications for the delivery of new patient focussed services. Within the CCG we have four PCNs:

Knaresborough and Rural 54,084	**Dr Chris Preece** Church Lane Surgery	Church Lane Surgery	Eastgate Medical Group
		Springbank Surgery	Beech House Surgery
		Nidderdale Group Practice	Stockwell Road Surgery
Heart of Harrogate 51,359	**Dr David Taylor** Dr Moss & Partners	Dr. Moss & Partners	Church Ave. Med Grp
		The Leeds Rd Practice	Kingswood Surgery
Mowbray Square 30,076	**Dr Ian Dilley** East Parade Surgery	The Spa Surgery	Park Parade Surgery
		East Parade Surgery	
Ripon and Masham 29,000	**Dr Richard Fletcher** Dr Ingram and Partners	North House Surgery	Ripon Spa Surgery
		Dr. Ingram & Partners	Dr. Akester & Partners

Each PCN covers a group of practices with the objective of working together, at scale, and sharing back office functions and clinical services where possible. Services established through PCNs in 2019/20 include Social Prescribers, Clinical Pharmacists working in GP practices, and First Contact Practitioners (FCPs). These are physiotherapists with extended skills providing

physiotherapy assessment and treatment closer to patients' homes and earlier diagnosis of musculoskeletal problems (see section 2.3.2).

Development of PCNs will continue over the next three to four years and will result in a significant increase in primary care staff and access to services.

2.3 Better Value Healthcare

2.3.1 Managing the CCGs Finances

The CCG's savings target for 2019/20 was £4.9m. A number of significant opportunities to help achieve this were identified across continuing health care, medicines management and joint working with Harrogate and District NHS Foundation Trust (Harrogate District Hospital). These opportunities resulted in confirmed plans to deliver £4.5m of savings and the CCG has delivered £3.8m savings.

2.3.2 Demand Management

Throughout 19/20 the CCG produced and regularly issued a 'GP Gatekeeper Bulletin' to all practices, which included information and comparisons on referrals and trends but also key updates on planned care projects and how they were progressing. These bulletin's encouraged peer review of referrals within practices and prompted several local audits concerning particular areas where referral activity may have significantly changed.

Demand management remains a standing agenda item at quarterly GP practice cluster meetings where variance and trends are discussed and feedback given.

Spinal Surgical Services

Several gynaecology, gastroenterology clinical pathways have been reviewed and improved to provide better guidance on when to refer but also improve access to direct to test pathways where this is appropriate this reduces unnecessary referrals whilst improving the patient journey when referral is required.

As part of the WY&H ICS clinical pathways programme, an in depth review of current spinal surgical services was carried out and identified significant variance within clinical pathways across the region. This lead to the development of a new spinal pathway with the aim of bringing local services in line with the National Lower Back Pain Pathway. This ensures that best practice guidance on the management of lower back pain is being followed and that patients access the right clinical services at the right time. This will significantly reduce inappropriate referrals for spinal imaging and reduce pressure on spinal surgical services.

Musculoskeletal First Contact Practitioner Pilot

The CCG has worked together with primary care colleagues and Harrogate District Hospital to pilot the delivery of a Musculoskeletal First Contact Practitioner (FCP) within two GP surgeries. This service ensures patients with musculoskeletal conditions are able to access expert advice at the start of their care pathway at their local GP practice. FCPs triage patients and provide a diagnosis and care plan, which may include advice on self-management or referral on for appropriate diagnostic tests or follow up treatment, including consultant opinion, where this is appropriate. The FCP role has had a positive response from service users and has developed excellent working relationships between primary and secondary care colleagues. The pilot has demonstrated a reduction in inappropriate referrals to secondary care services such as physiotherapy, orthopaedics and radiology and ensures that patients who do need ongoing treatment are seen by the right clinician, in the right place, first time.

Work is now being carried out to roll out the successful FCP model across all practices within the Harrogate and Rural District area as part of the development of additional roles scheme through the Primary Care Networks.

Faecal Immunochemical Testing

In December 2019, Faecal Calprotectin (FC) testing was introduced. As part of an integrated pathway with Integrated Faecal Immunochemical Test (FIT), it will assist early in the patient assessment when there is a clinical uncertainty as to the diagnosis of Irritable Bowel Syndrome (IBS) (which may not need referral to secondary care) or Inflammatory Bowel Disease (IBD).

2.3.3 Aligned Incentives Contract Between the CCG and Harrogate District Hospital

The CCG continued to apply an aligned incentive work to deliver new ways of working and support the CCG's financial recovery programme. A successful pilot of 'first contact practitioner' MSK service was jointly delivered providing the basis for a much wider roll-out in 2020/21 across the Harrogate area.

2.3.4 Gastroenterology

Following the successful implementation of the consultant-led triage of Gastroenterology referrals last year, the CCG and Harrogate District Hospital have worked together to enable the role out of consultant led triage across a number of other specialities. Consultants are able to feedback advice on the management of patients to GP's as well as ensuring that patients who are appropriate for a secondary care opinion are allocate to the most appropriate clinic or diagnostic test. This has had a number of benefits including: improving the patient experience, strengthening the links between primary and secondary care staff, increasing the spread of clinical knowledge across the system through good advice and guidance and reducing costs.

2.3.5 Tackling Medicine Waste

Each year continues to offer opportunities to enhance the quality, safety and cost effectiveness of local prescribing. Primary care prescribing data (available to December 2019) demonstrates continued control of the CCG's weighted prescribing costs as compared to the national trend. However, international manufacturing difficulties have increased the cost of many common medicines with resultant increases in prescribing spend across the whole NHS. There remains considerable commitment to improving cost efficiency across the country, and sustained efforts will continue to work on maintaining the CCG's weighted prescribing costs below national levels. By mid-March 2020 the CCG was well advanced in delivering its planned and target ambitions for efficiency savings in prescribing.

The Medicines Management Team working collaboratively with GP practices and care homes to promote on-line ordering of repeat prescriptions. This is improving time efficiency for GP practice and care home staff, reducing the risk of error and medicines waste. An audit in one local care home showed a reduction in waste of 57% following implementation of on-line ordering (see section 6.5.17).

2.3.6 Over the Counter Prescriptions

Our local programme to encourage the public to apply self-care, which is now being supported by national campaigning with the same purpose, encourages patients to seek professional advice from community pharmacists for minor conditions and not to expect medication with limited benefit or low 'over the counter' costs to be prescribed by their GP. Recent data analysis demonstrates reduced prescribing of these items in the CCG. (see section 6.5.17).

2.4 Well Governed and Adaptable Organisation

To be a well governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services using innovative approaches to meet the future healthcare needs of our population.

2.4.1 The CCGs Project Management Approach

The CCG's project management office (PMO) has worked closely with project teams in HRW, SR and Vale of York CCG to move to a standard approach across North Yorkshire and Vale of York CCGs.

2.4.2 Aligned Incentive Contract Delivery

To support the aligned incentive contract with Harrogate District Hospital two working groups were established to oversee the delivery of projects which help manage costs within the system. One group is focused on Unplanned Care and the second is

focused on Planned Care. The delivery groups are made up of staff from both organisations and include representatives from clinical, operational and management functions. To strengthen this approach a small executive joint group was established to maximise opportunities across the two programmes and make best use of limited resources.

2.4.3 Planning across the Three North Yorkshire CCGs

In preparation for the creation of the new North Yorkshire CCG a single planning group was established with representatives from the three North Yorkshire CCGs and the Vale of York CCG. Operational planning for 2020/21 was prepared by this group working jointly with NHS providers to create the first version of a system wide operational plan for North Yorkshire and York.

2.5 Health and Wellbeing

2.5.1 Self Care and Prevention

We have been actively promoting self-care and prevention to help keep people from getting unnecessarily ill and to ensure that money is spent within the health care system where it is most needed. We have been actively encouraging people to use community pharmacies first for advice on managing minor ailments and promoting self-care and prevention by providing people with information to help them stay well.

2.5.2 Loneliness Strategy

Strategy has been developed and consulted upon, and can be viewed here and we are now working with partners to consider the most effective way forward in terms of developing a plan to turn some of the recommendations from the strategy into action. In addition toolkits are under development to be used by community groups (both local and wider groups to develop community activities to address loneliness.

2.5.3 Mental Health

The CCG works in partnership around how mental health services are commissioned and delivered in conjunction with Tees, Esk and Wear Valleys (TEWV) Foundation NHS Trust who deliver the majority of mental health services across North Yorkshire.

These decisions, and local priorities, are made at the North Yorkshire Mental Health and Learning Disability Partnership Board, where North Yorkshire County Council are a key partner. During 2019/20 the North Yorkshire Mental Health Partnership Board focused on the following areas of work:

- Developed the key objectives and identified how this linked to the principles of North Yorkshire Partnership Mental Health and how they would be delivered:
  - Greater focus on prevention and early intervention
  - Provision of integrated care closer to home
  - Intervening and supporting people earlier and more effectively in their illness to reduce the number of admissions for inpatient treatment
  - Better use of resources across the whole pathway
  - Supporting people to achieve their self-determined health and well-being goals.
  - Delivery of comprehensive mental health and learning disability services, initially prioritising those in the NHS Long Term Plan and the TCP.

Building on the work of 2018/19, the partnership board had set a number of priorities for the 2019/20 year. These included addressing the sustainability of the Early Intervention Psychosis service and reviewing the treatment offer for patients who receive a diagnosis.

Early intervention in Psychosis (EIP)

In October 2019 all 3 localities were involved in a deep dive by NHS England helped us to understand the service delivery challenges and gaps against the national access and quality standards.

The merger of North Yorkshire and York mental health services has provided an opportunity to look at the structure from how EIP support is delivered across the whole locality; as we are challenged by geography, cross-cover, leadership and variation in patient experience.

In response, the North Yorkshire and York Early Intervention Teams came together through a Design Event to propose a revised service model which aims to meet the national access and quality standards and workforce requirements and so deliver improved patient outcomes.

Recommendations from the design event have recommended a 2 team model across North Yorkshire and York which would address the workforce challenges. This proposal requires investment, which will be proposed to the North Yorkshire mental health partnership group for consideration.

Individual Placement and Support (IPS) Services

Establish NY wide Individual Placement and Support (IPS) services to support people with severe and enduring mental illness into work.

Out of Area Placements (OAPs)

Working as a partnership to reduce the number of Out of Area Placements (OAPs) to ensure patients always receive care as close to home as possible.

A key priority has been to ensure that all packages of care that fall outside of the block mental health contract the CCGs have with TEWV are safe and effective, and are of the best care, for the best value, for the best benefit. Importantly, that these packages of care continue to be monitored and reviewed to ensure that value for money is achieved consistently.

The review process started in October 2019 with the TEWV reviewers working closely with the Vulnerable People's team for North Yorkshire. The initial scope has looked at high cost packages of between £10K to £50K and £50k plus per annum. A project group was also established to oversee the governance and assurance of this work. This has included establishing an information sharing agreement between TEWV and the CCG for access to the QA system and PARIS; establishing a weekly report out process to monitor and escalate issues identified through the review process, and the development of a financial tracker. The collaboration with the Vulnerable People's team has proved to be highly successful, and has enhanced the capacity and effectiveness of the team across North Yorkshire.

By 28th February 2020, out of a caseload of 81 people in receipt of packages of care of £50k or above, 60% of cases have had reviews completed. Out of a caseload of 40 people in receipt of packages of care between £10k and £50k, 58% have been reviewed. It was anticipated that by April 2020 all packages within scope would have been reviewed, but this work has been paused so resource can be used to address the Corvid 19 crisis; however positive changes have already been made to people's care following their reviews through the Partnership work, which this has been captured through patient stories, highlighting the person centred approach to this work.

Joint Commissioning Arrangements

Continue to develop joint commissioning arrangements with Local Authority colleagues to address factors that could safely avoid admission and remove obstacles to discharge from hospital.

As part of the transforming care agenda across North Yorkshire and York developed by an Adults Dynamic Support register and a Children and Young people's Register. The registers have interdependency with the local Joint Strategic Needs Assessment and

the Community Treatment Review/inpatient register. The dynamic registers identify the needs of the local population and continue to develop a dynamic model of prevention and proactive intervention to reduce the need for people to display challenging behaviour. The Transforming Care partnership is responsible for the developing of this register and commissioning activity in relation to it.

As part of the process we have developed TOR's and addressed IG issues re consent and sharing of information, to do this we have utilised the 'public task' approach SO we can eliminate the requirement for patient consent (in accordance with our IG team).

Crisis Care Plans

Progress crisis care plans and ensure that MH Liaison and Diversion services can meet the specific needs of all ages.

The CCG was successful in receiving additional transformation funding for Mental Health Crisis which contributes to developing a 24/7 telephone support service for adults, older people and children and young people.

Each locality was successful in securing transformation monies to develop Crisis cafes in each area. Harrogate Hospital now has a 24/7 Mental Health liaison service within its A&E department.

Operationalise the North Yorkshire Perinatal Mental Health service.

The North Yorkshire and York Perinatal Mental Health Specialist Team commenced service delivery in January 2019. The service model has been developed within Tees, Esk and Wear Valleys NHS Trust, and covers North Yorkshire and York locality.

The Service runs on a multi-hub model, with some staff (medical/psychology/peer support/ nursery nurses) working across the county or into clusters of hubs. Care co-ordinators work into one hub, based locally, and sharing office space with local teams, which fosters good local relationships and ensures practitioners are available and accessible in each area. This has also strengthened the working relationships with IAPT especially. Outpatient clinics and group work is available in each locality, with frequency being flexible and depending on need. Patients are seen in the community, antenatal clinics, CMHTs and GP practices. The service has a NYY single point of access and referrals are triaged by IAPT, CMHT and Primary Care daily with a perinatal duty worker assigned for second opinion if required. The focus of the service is on the prevention of severe episodes of illness, promoting recovery and supporting the parent-infant interaction.

All-age ADHD/Autism service redesign

ASD/ADHD remains a priority for the CCG which will continue to be a focus in 2020/21.

Autism Pathway: Children and Young People

Increasing numbers of referrals for children and young people's autism diagnostic assessment has continued to be a challenge as this has increased the waiting time from referral to assessment. The CCG has made this a key priority area throughout 2019/20 to reduce the waiting list.

Harrogate District NHS Foundation Trust (HDFT) provides the Children's Autism Diagnostic Service in both the Harrogate locality and Hambleton, Richmondshire and Whitby (HRW) locality. Following a Rapid Process Improvement Workshop in June 2019 led by HDFT, a new streamlined assessment model was introduced across both localities to clear the waiting list by July 2020. Despite experiencing some issues including staff sickness, turnover and an increase in the number of referrals, HDFT have reported they are on track to meet NICE guidance recommendation of 13 week wait from referral to first appointment by September 2020. We await the Q4 2019/20 performance data which will be available end of April 2020.

HDFT Q3 2019/20 performance is as follows:

- HRWCCG – average wait from referral to first appointment at 73 weeks
- HaRDCCG – average wait from referral to first appointment at 53 weeks

2.5.4 Promoting Access to IAPT

We have been working in partnership across the three North Yorkshire CCGs and with specialist mental health service provider Tees, Esk and Wear Valleys NHS Foundation Trust to promote access to talking therapies. This has included promoting the newly launched website, which makes it easier for people to access help and support, for instance through self-refer online without having to go through a GP. We have also been promoting Kooth[11], a website offering free online counselling and emotional wellbeing support for children and young people.

2.5.5 Compass BUZZ

Compass BUZZ is an innovative service which works with the whole school workforce and other key partners to increase the skills, confidence and competence of staff supporting children with emotional and mental health concerns. It also offers support for schools to deliver co-facilitated one to one or group sessions to children and young people.

[11] https://www.harrogateandruraldistrictccg.nhs.uk/index/news/?post=new-online-mental-health-support-for-young-people-in-north-yorkshire

Across North Yorkshire a total of 12,869 staff have been trained with 94% of all staff trained within Level 1 stating that they have received improved knowledge and 92% have increased confidence as a direct result of the training (for more information see section 6.5.14).

2.5.6 Buzz Us

BUZZ Us is a confidential texting service for young people (aged 11-18 years) across North Yorkshire and was launched to encourage more young people to access mental health support and advice more easily. By texting the free service young people can receive confidential advice, support and signposting from a wellbeing worker and the service continues to be exceptionally well used by young people across North Yorkshire (for more information see section 6.5.15).

2.5.7 Looking Out for Our Neighbours

We have been an active advocate of the West Yorkshire and Harrogate 'Looking out for our Neighbours' campaign which launched in 2019. The campaign now has over 350 supporters including the Jo Cox Foundation and #hello my name is and looks to help prevent loneliness in our communities by encouraging people to do simple things to look out for one another. You can find out more about the campaign and download resources online.[12]

2.5.8 West Yorkshire and Harrogate Suicide Bereavement Service

The West Yorkshire and Harrogate Suicide Bereavement Service was launched in December 2019. The new service is a response to the fact that people bereaved by suicide are more likely to suffer from severe depression or post-traumatic stress disorder, or even adopt suicidal behaviours themselves. There is now an enhance suicide bereavement support service across the region which includes peer support, practical advice and signposting to other much needed services, for example counselling or financial advice.

2.5.9 Healthy Hearts Initiative

A new initiative that was launched in April 2019 with the aim of reducing the number of heart attacks and strokes across Harrogate and surrounding areas is showing positive results. The first phase of the project focuses on hypertension (more commonly known as high blood pressure). Since its official launch an extra 250 people across Harrogate and Rural District have been added to the hypertension register and an extra 400 patients had their blood pressure controlled to safe limits under 140/90 or better.

[12] The Looking out for our Neighbours website can be found at https://ourneighbours.org.uk/

2.5.10 ICON

On 8 November, the Designated Nurses team in North Yorkshire and York launched a new innovative programme to prevent abusive head trauma injuries to babies caused by shaking. 'ICON – Babies Cry, You can Cope' (ICON) is an evidenced-based programme designed to help parents and carers understand the normal crying pattern of young infants and to help them develop successful coping mechanisms.

The ICON programme has been initially funded by the four North Yorkshire Clinical Commissioning Groups (CCGs) and delivers four simple messages before the birth and in the first few months of a baby's life which will be communicated by Midwifery and Health Visitor services:

I – Infant crying is normal;

C –Comforting methods can help;

O – It's OK to walk away;

N – Never, ever shake a baby.

These ICON messages have been demonstrated to help parents and carers manage the stresses which can be caused by normal infant crying. Midwives, Health Visitors and other professionals across the region have developed ICON expertise to help give parents and carers the tools they need to help keep their babies safe. They have also produced an information graphic around infant crying which can be found here.

2.6 Active and Meaningful Engagement

We work in close partnership with local people and organisations that commission or provide care for our population to embed meaningful engagement into the CCG's decision making processes.

This is particularly important as we work with our partners to achieve positive changes in healthcare which will better serve the needs of our local population. Listening to the experiences of patients and their families is a powerful lens on the services that are delivered to make sure quality is at the forefront of our mind.

2.6.1 Patient Partners

This year we have been working actively with our patient partners to ensure structured and sustained input into key CCG worksteams. Thirty partners from our local GP practices make up the CCG's Patient Partner Group. Our Patient Partners provide

structured input and constructive challenge into proposed projects and service development. Their work is a key element to us involving and engaging meaningfully with our public. Patient Partners also feedback on their work to GP patient participation group networks.

2.6.2 Working Across the Three North Yorkshire CCGs

The three North Yorkshire CCGs have been working collectively to maximise engagement opportunities as we prepare to become the North Yorkshire CCG on 1 April 2020 by using our resources differently, while ensuring we remain focused on delivering the best outcomes for the Harrogate and Rural District population.

2.6.3 Worked Closely with our Health and Social Care Partners

We have been working closely with our partners throughout the year to deliver the healthcare needs of today, while planning effective and sustainable delivery for the future. To learn more about our partners and our collective work please see sections 1.7, 1.8, 6.4.2, 6.4 and 6.6.6.

2.6.4 Engagement to Inform Service Specification

This year we have engaged widely with patients, users, providers and the broader population on services we commission in a number of key areas. This year we have engaged on community mental health services, dementia, prescribing, integrated community care for adults and medicine waste. For more detail on engagement work with local people on services please see section 6.6.

3 Our Financial Position

The CCG received a funding allocation of £236.9m in 2019/20 (£227.7m in 2018/19). In addition the CCG received a further non-recurrent £8m allocation called Commissioner Sustainability Funding (CSF) and a further non-recurrent support allocation of £7.4m. The CCG was able to access this additional funding because it achieved its 2019/20 financial plan. Some of this resource allocation is ring-fenced:

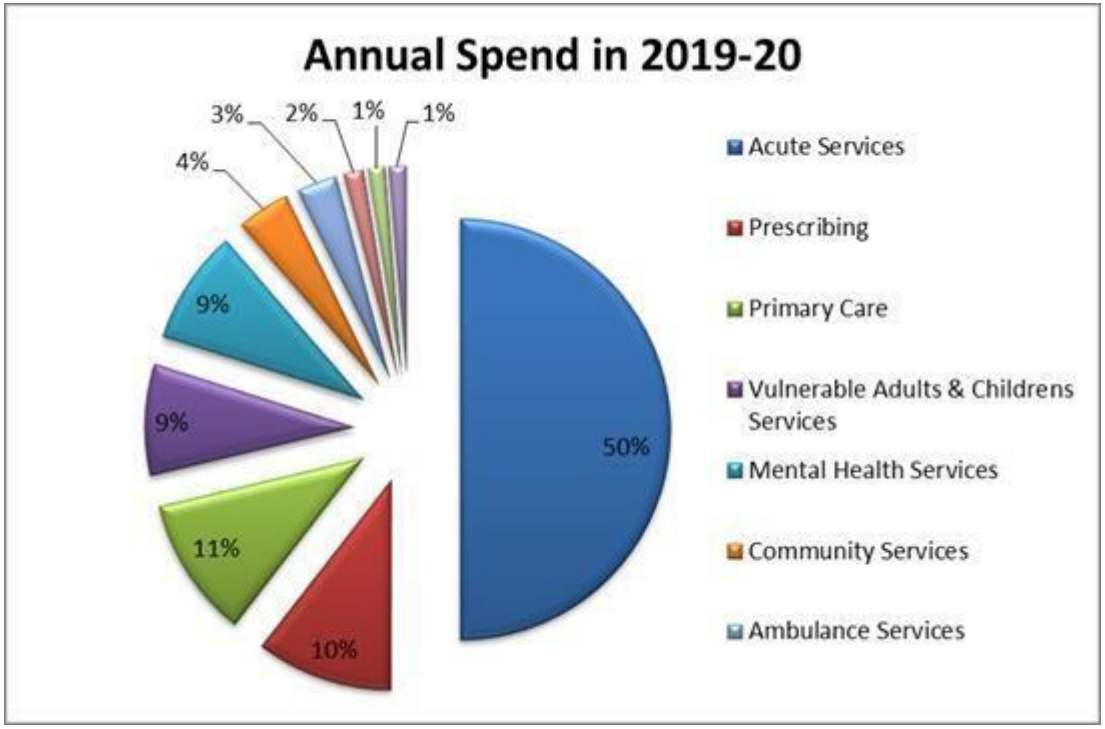
- £22m (£21m in 2018/19) is allocated specifically for primary medical care through delegated budget responsibility from NHS England;
- £3.5m (£3.4m in 2018/19) is allocated specifically to cover the administration costs of the CCG.

The CCG's financial plan for 2019/20 was to deliver a deficit of £8m (a £10m deficit was delivered in 2018/19). This was in line with NHS England business rules for deficit CCGs. In order to achieve this requirement the CCG set itself a challenging savings target, to be delivered through its QIPP schemes, of £4.9m.

During the year the CCG continued to experience growth in activity/cost in excess of the increase in funding allocation from NHS England, but within the planned financial deficit of £8m. The key areas of growth resulting in a continuing cost pressure for the CCG were:

- Acute hospital care: In 2018/19 the CCG entered into an Aligned Incentive Contract (AIC) with its main local acute provider, which continued into 2019/20. An AIC effectively fixes the income, within a set of parameters, to the acute provider to allow for wider system working to take place without affecting either organisations financial positions. Analysis against the standard charging mechanism of Payment by Results (PbR) shows that the resulting charge to the CCG would have been very similar to the AIC fixed income value.
- Continuing health care costs continue to increase (7% increase in cost from 2018/19) arising from both the cost of care packages and the number of people in receipt of a care package.
- In line with national expectations, the CCG continued to invest in mental health services at a higher rate than its funding allocation increase. This requirement is mandated to CCGs through the Mental Health Five Year Forward View (www.england.nhs.uk/mental-health/taskforce/).

Offsetting the cost pressures noted above, the CCG achieved a significant transactional element of its savings/efficiency (QIPP) programme. This has resulted in the CCG achieving its financial plan and statutory financial duties for 2019/20, delivering savings of £3.8m.



4 Risks

Our policy and approach to risk management is set out in detail in section 9.4 of the Annual Governance Statement. The risk management and assessment process underpins successful delivery of our strategy, achievement of our objectives and the management of our relationships with key partners.

We are committed to maintaining a sound system of internal control based on risk management and assurance. By doing this, we aim to ensure we are able to maintain a safe environment for patients through the services we commission, for staff and visitors, as well as minimise financial loss to the organisation and demonstrate to the public that we are a safe and efficient organisation.

4.1 Overview of Strategic Risks

In 2019/20 the Governing Body Assurance Frameworks (GBAF) across the three North Yorkshire CCGs were under review in preparation of the establishment of the new North Yorkshire CCG. The Audit Committee has been assured by the Director of Corporate Services, Governance and Performance that processes are in place to manage all risks effectively and it is expected that strategic risks will be aligned to the new GBAF and new Strategic Objectives in May 2020.

All risks are aligned to Committees which enables the CCGs to identify where there are risks associated with meeting statutory duties and the organisation's strategic objectives. The North Yorkshire CCGs also received an opinion of significant assurance in the management of risk for 2019/20.

All significant risks that have an impact of the CCG's strategic objectives are detailed within the risk management section of the Annual Governance Statement (see section 9.4).

5 The Look Ahead

From 1 April 2020 three existing North Yorkshire CCGs will begin operating as the North Yorkshire CCG.

In the year ahead we will continue to develop the new CCG, drawing on best practice from our predecessors and across the system. In developing the new North Yorkshire CCG we will harmonise our approach to commissioning healthcare to enable reductions in unwarranted variation and reduce inequalities. We will also work to eliminate any remaining duplication in our commissioning practices and reduce bureaucratic boundaries to work more efficiently together and with our partners.

As the North Yorkshire CCG we will develop our unified commissioning voice and work more strategically, on a larger footprint, with our local and regional partners. We will operate as a system leader to ensure we effectively amplify the combined impact of

our activities to enable better lives for local people. We will be a clinically led, responsive, organisation which actively listens to our local communities. This will ensure that our activities are fully aligned with local health and care needs.

In the years ahead will also keep a firm eye on the financial challenges both in healthcare and across all public services locally, as we maximise opportunities to work more efficiently together and deliver better outcomes for the people of North Yorkshire.

6 Performance Analysis

6.1 What are we measured against and how have we performed?

We assess performance against key local and national measures every month and report these to our Governing Body. Performance is not monitored in isolation, we also consider performance information alongside reports on the quality and safety of the services we commission and also patient experience of those services.

Our performance is measured by NHS England in a number of ways including analysis of the monthly performance data and face to face reviews with NHS England on a quarterly basis.

6.1.1 NHS Constitution Requirements

In 2019/20, we have continued to perform strongly against its key constitutional requirements. This success is due to clinically informed commissioning decisions and the continued hard work of our partners, including NHS provider trusts and local authorities.

We continue to build on strong partnership working to deliver both performance requirements and future service developments.

We are committed to meeting the requirements outlined within the NHS Constitution and taking action to make improvements where performance is below expectation.

In 2019/20, we have continued to perform strongly against our key constitutional requirements. These indicators are reported to, and monitored through, our Governing Body and some of its formal committees, the Finance, Performance and Commissioning Committee, the Quality and Clinical Governance Committee and the Primary Care Commissioning Committee.

For more information about our financial performance for the year please see sections 3, 10 and 11 or for more detail our annual accounts from page 142.

The performance standards of the constitution are split into the following main categories:

NHS Constitution	Target	Position 2019/20
Maximum 18 weeks from referral to treatment (RTT)	92%	**81.0%**
Maximum 6 weeks diagnostic test waiting times	≤1%	**9.2%**
A&E waits – 4 hours to assessment, treatment and discharge	95%	**91.1%**
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	92.8%
Maximum one month (31-day) wait from decision to treat to treatment for all cancers.	96%	97.9%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	85%	81.9%

* Due to the Covid-19 pandemic NHS England agreed the temporary suspension of performance reporting. However, the CCG has presented the data to March 2020, although performance is likely to be affected by the impact of Covid-19.

6.1.2 18 Week RTT

The main increases across North Yorkshire CCGs have been seen within Trauma & Orthopaedics, Ophthalmology and Neurology.

The standard continues to be a challenge both locally and nationally and Harrogate and Rural District CCG failed the target of 92% at 87.2% which is static.

The waiting list position was planned to be no higher than 10,628 by March 2020. The waiting list total had grown slowly throughout the year, but by March the waiting list position had a total of 10,325 waiters which was a decrease of 469 patients compared with March 2019.

Some speciality pathways at our tertiary centre continue to be a challenge and we continue to monitor the position closely to ensure patients who need to be seen more quickly are prioritised.

6.1.3 Diagnostics

Although the November position showed a return to under the 1% threshold at 0.7% the December performance has dropped again. In December there were 35 breaches in total covering 9 different diagnostic procedures and 9 trusts. This is the equivalent of 1.24% of total diagnostics waiting and above the 1% target. This is principally due to an increase in waits in Neurophysiology (6) and additional breaches from a range of providers other than HDFT, including Oxford and University College London. HDFT met the target at 0.8% (up to M9).

6.1.4 A&E Waits

Both Harrogate and Rural District CCG and Harrogate NHS FT coped well in the lead up to the Christmas and New Year period of 2019/20 although additional escalation bed capacity was opened ahead of plan. The A&E Delivery Board supported the 'Every Hour Matters' initiative at Harrogate and District NHS FT to support the Trust post-Christmas.

A&E performance is challenging nationally and Harrogate and District NHS FT remains in the top ten Trusts for performance and top two in the Yorkshire and Humber Region.

6.1.5 Cancer Waiting Times

28 Days (Faster Diagnosis Standard (FDS))

The new 28 day Faster Diagnosis Standard ensures that patients who are referred for investigation of suspected cancer can find out, within 28 days of referral, if they do or do not have a cancer diagnosis. The standard was introduced in April 2020 and whilst a 'national threshold' has not been determined, the CCG's main provider Harrogate District Foundation Trust (HDFT) achieved 79% in March 2020.

62 Days (from referral to first treatment)

During the course of the year (January 2019 – January 2020), 62 day performance across West Yorkshire and Harrogate Cancer Alliance has fluctuated between a minimum of 75% (January 2020) and 83% (April 19). Set against a national target of 85%, performance is not dissimilar to almost all Alliances in England against a backdrop of increased demand/ referrals and diagnostic/ treatment bottlenecks.

However, the performance of both the CCG and HDFT has improved over the latter half of the year and in generally achieving the 85% target.

Supporting implementation of the 2 week wait referral pathways has been the subject of focussed work between HDFT and the primary care cancer lead for the CCG.

In summary, the CCG has continued to work with local provider partners and the Cancer Alliance to deliver priority programmes of work to transform cancer pathways and improve the time to diagnosis and in turn to drive further improvement in the one year survival rates for our local population diagnosed with cancer.

6.2 The Quality Premium

In previous years, as part of the Quality premium, the CCG has been measured against a national set of quality indicators, as well as having to achieve financial gateway performance in order to qualify for addition quality premium funding. For 19/20 the quality premium is no longer operational and CCG organisations are now measured against wider set of indicators which forms part of the NHS CCG Oversight Framework.

6.3 NHS Oversight Framework

In recent years it has become increasingly clear that the best way to manage the NHS's resources to deliver high quality, sustainable care is to focus on organising health at both system and organisational level. NHS England and NHS Improvement are aligning their operating models to support system working and 2019/20 has been a transitional year to support local systems, with the new integrated approach from 2020/21.

The changes to oversight included:-

- NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations
- a greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals
- working with and through system leaders, wherever possible, to tackle problems
- matching accountability for results with improvement support, as appropriate
- greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The annual assessment of CCGs by NHS England will continue in 2019/20 and comprises a set of 60 indicators. It is a judgement, reached by considering a CCG's performance in each of the indicator areas over the full year and balanced against the financial management and qualitative assessment of the leadership of the CCG.

Scores across the indicator areas are combined to create an overall score within a range of 0-2, with performance towards 2 seen as higher performing and performance towards 0 seen as lower performing.

The CCG internal assessment is as follows but actual performance and ratings will be dependent on final published methodology and movement of other CCG as it based on relative CCG position in terms of achievement.

	Scarborough and Ryedale CCG	Hambleton, Richmondshire and Whitby CCG	Harrogate and Rural District CCG
New Service Models	0.133	0.179	0.208
Preventing Ill Health and Reducing Inequalities	0.143	0.208	0.208
Leadership and Workforce	0.15	0.167	0.156
Quality of Care and Outcomes	0.264	0.264	0.153
Finance and Use of Resources	0.321	0.25	0.307
Total	**1.012**	**1.068**	**1.032**

6.3.1 Cancer

Indicator	Data	Target	Position
Cancers diagnosed at early stage	2018	Nat Av 51.8%	53.4%
Max 62 day wait for first definitive treatment for cancer following an urgent GP referral for suspected cancer	2019/20 (Apr-Feb)	85%	81.9%
One year survival rate: % of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis	2017	Nat Av 72.8%	74.8%
National Cancer Patient Experience Survey	2018	Nat Av 8.80	9.17

The key ambitions in the NHS Long Term Plan for cancer, to be delivered by 2028 are:

- 55,000 more people each year will survive their cancer for five years or more;
- 75% of people with cancer will be diagnosed at an early stage (1 or 2).

In support of delivery of the CCG's contribution to the national ambitions the organisation has continued to develop an integrated approach to planning and operational delivery with its partners, via the Harrogate and Rural District Cancer Locality Group and all key stakeholders of West Yorkshire and Harrogate Cancer Alliance.

Each year in the CCG, circa 990 individuals are diagnosed with cancer and there are circa 420 cancer deaths.

Earlier cancer diagnosis is critical to meeting our survival ambition, as it means patients can receive treatment when there is a better chance of achieving a complete cure. Cancer Alliances are the driving force for change and to provide a dedicated focus and capacity to deliver localised improvements in cancer outcomes.

The Rapid Diagnostics Centre for Serious nonspecific symptoms is an early diagnosis initiative to support NHS England's national strategy for earlier and faster cancer diagnosis (28 day Faster Diagnosis Standard). It is envisaged patients coming through the new pathway will experience a rapid diagnostic one stop clinic approach involving a CT TAP and TNE scope and a results consultation all on the same day.

Rapid Diagnostic Pathways

The national ambition is to have full coverage of the Serious non Specific Symptom patients by 2024 and coverage of the majority of 2ww pathways during the same timeframe. Alliance wide 5 year plans have been submitted to national team at the end of January and show delivery of the national ask.

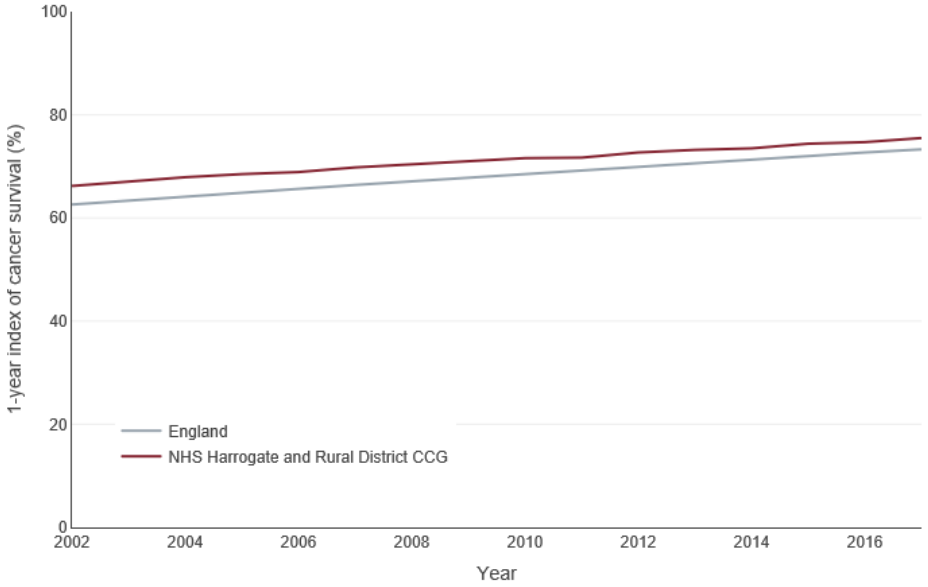
A Rapid Diagnostic Centre (RDC) for patients who have serious non-specific symptoms has been running since March 2019 and will achieve full coverage of the HaRD GP practices by the end of April 2020.

On average, patients have seen their GP 3 times prior to referral to the RDC and the median waiting time for the initial OP is 8 days (range 2-20 days) see section 6.5.8 for more information.

Improved Survival

Advances in diagnostics, treatment and care (including genomics testing and individualised treatments) are significant contributing factors to improve survival rates.

The chart shows the 1- year survival rate from cancer (2002 - 2017) has been consistently 2-3 percentage points above that of England.



Screening

Regular screening for breast, bowel and cervical screening provides an opportunity to identify (and treat) cancers at an early stage of development, detect and treat 'pre-cancer' disease (e.g. management of lower GI polyps). These appointments also provide an opportunity to identify and address if possible, behaviours which are not conducive to good health (e.g. smoking). In general the population of the CCG responds positively to the opportunities offered by the screening programme.

(2018/19)		HDFT CCG	England
Breast	Females aged 50-70 screened within the last 36 Months	77.5%	71.6%
Cervical	Females aged 25-64 attending within target period	77.9%	72.6%
Bowel	Adults aged 60-74 participating in the programme following invitation	65.4%	60.4

In 2019/20 there have been two changes which are and will continue to have an impact on the cancer screening programmes, namely:

- The introduction of an updated screening test (FiT) in the bowel screening programme has resulted in an increase in uptake following invite in addition to increasing the detection rate for bowel cancer following screening.
- The introduction of the HPV test as the primary test in the cervical screening programme will, as a result of increased sensitivity provide a longer protection of negative results and increased detection rates.

In addition, the introduction of the HPV vaccination in boys aged 12 -13 will reduce the numbers of HPV related cancers in the future.

Work will continue in 2020/21 to progress the ambition to increase the proportion of cancers diagnosed at stages 1 and 2 cancers diagnosed from 55.1%. In 2018 the proportion had risen slightly from 51.1% in 2017 to 51.9%.

6.3.2 Dementia

Indicator	Data	Target	Position
Dementia: Estimated diagnosis rate for people with dementia	Mar 2020	66.7%	75.0%
Dementia: Care planning and post- diagnostic support	2018/19	Nat Av 83.6%	83.3%

Improving access to receiving a timely and formal dementia diagnosis continues to be a priority for the CCG. A formal diagnosis helps ensure that people obtain the right help, support and advice they require as early as possible. The CCG works with GP Practices and other partners to improve early detection of dementia and therefore increase diagnosis rates. This includes identifying 'Dementia Leads' within each GP Practice in each locality to help provide the information people need to understand the importance of a dementia diagnosis and the support that is available to people living with dementia and/or their families and carers. Later in 2020, a comprehensive review of the Memory Assessment Service and post diagnostic support across the three localities is planned to identify gaps and develop the service so as to improve the patient and carer experience of receiving, and living well, with a dementia diagnosis.

Living well with dementia also includes helping to avoid unplanned hospital admissions, wherever possible, by ensuring individuals receive continuous care in familiar environments either at home or in community care home settings. The CCG is involved in delivering work programmes that help make sure advanced care plans are in place, and recorded in good time, for individuals when making choices about their future end of life care needs. Additionally, work is underway to provide training and support to health and care professionals to understand the signs and symptoms of delirium and/or manage the distressing behaviours that people with dementia sometimes experience during difficult times so as to help avoid a hospital admission.

The CCG works with North Yorkshire County Council, provider services and the voluntary sector to deliver the North Yorkshire Dementia Strategy – Bring Me Sunshine – by communicating the positive benefits of a dementia diagnosis, by mapping the wider support offer available for people living with dementia that goes beyond delivering health services alone, and by helping establish Dementia Friendly communities to make North Yorkshire a place where people can live well with dementia.

6.3.3 Diabetes

Indicator	Data	Target	Position
Diabetes patients that have achieved all the NICE-recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	Jan – Sep 2019	Nat Av 38.8%	39.9%
People with diabetes diagnosed less than a year who attend a structured education course	Jan – Sep 2019	Nat Av 13.2%	29.8%

To contribute to improving diabetes care for all patients, the CCG helped to establish multi-disciplinary team meetings between the specialist diabetes team and practice diabetes teams.

We have continued to work with Harrogate District Hospital and GP practices to increase referrals to diabetic structured education. All GP practices are making referrals to the programme and participate in the National Diabetes Audit which is a major national clinical audit, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and Quality Standards.

6.3.4 Mental Health

Indicator	Data	Target	Position
Improving Access to Psychological Therapies: Access	2019/20 to Feb	19%	13.7%
People with first episode of psychosis starting treatment with a NICE recommended package of care within 2 weeks of referral.	2019/20	56%	51.7%
Improving Access to Psychological Therapies: Recovery Rate	2019/20 to Feb	50%	58.0%
The proportion of people that waited 6 weeks or less from referral to their first IAPT treatment	2019/20 to Feb	No target	99.9%
Children and Young People's mental health service transformation	Jan-20	34%	**26.8%**

The core principle of the Mental Health partnership is to ensure parity of esteem and delivery of the mental health investment standard (MHIS).

Improving Access to Psychological Therapies: Prevalence

The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies.

Sustainable increases in access rates within IAPT services are achieved when new demand for services goes up accompanied by an increase in capacity to treat.

Improving Access to Psychological Therapies recovery rate: Standard 50%

The percentage of people who finished treatment within the reporting period:

- Who were initially assessed as “at caseness”,
- Have attended at least two treatment contacts and are coded as discharged,
- Who are assessed as moving to recovery.

The CCG has a launched an online self-referral portal to encourage more patients who would benefit from therapy to refer directly into IAPT. In 2019/20, the CCG will be working to maintain and improve IAPT recovery and waiting time performance, and develop an integrated IAPT pathway for people living with long-term health conditions and/or medically unexplained symptoms (MUS).

Changes to the qualification and training required has impacted on delivery against the access target, performance against the standard is expected to start to improve once training is complete.

Children’s and Young People’s Mental Health (CYP MH)

The Future in Mind Local Transformation Plan (LTP) was refreshed at the end of October 2019. Work is underway with key partners such as Local Authority, CAMHS and 3rd Sector providers, to review progress made and outline priorities for the coming year. The full Local Transformation Plan 2018/19 refresh document can be found on the CCG website[13].

HRW CCG have been successful in a funding bid for a North Yorkshire CYP MH support website, based on the Leeds CCG ‘Mindmate’ model which will help in integrating pathways. The virtual online Recovery College which provides a range of online resources to young people, parents and carers and teachers, and was developed with the involvement of children, young people, parents, carers and TEWV CAMHS staff, is now live.

[13] http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/children-and-young-people-mental-health/hard-ltp-refresh-oct-2018-final.pdf

Following feedback received from NHSE on the LTP quarterly updates, the NY CCGs arranged a meeting with NHSE to discuss gap between the reported expenditure and LTP allocation. It was agreed that the October 2019 refresh would include Autism funding which will positively impact on expenditure.

6.3.5 West Yorkshire and Harrogate Local Maternity System

In support of NHS England's National Maternity Review (February 2016) a West Yorkshire and Harrogate Local Maternity System (WY&H LMS) was established in 2017. In April 2018 the WY&H LMS was embedded into WY&H Health and Care Partnership and is a priority programme.

The WY&H LMS have co-produced a plan with women and staff. This has been submitted, for assurance, to meet NHS England Transformation Board reporting deadlines. These have been updated to incorporate the requirements of the Long Term Plan.

The programme trajectories were developed with stakeholders as per NHS England and Improvement planning guidance.

The WY&H LMS concentrated on the following areas of work during 2019/20:-

- Continuity of Carer
- Safer Maternity Care
- Digital Transformation
- Maternity Voices Partnerships
- Prevention

Key achievements in Harrogate:-

- As at February 2020 the number of women booked on a Continuity of Care Pathway was 31.8%. The target for the end of March 2020 was 35%
- A local Maternity Voices Partnership (MVP) Group has been established with which has a service user as the nominated chair. The LMS have provided support and funding to the group for volunteer expenses and promotion
- Fully compliant with Saving Babies Lives V1
- In January 2020 The Special Care Baby Unit (SCBU) at Harrogate Hospital received the UNICEF Baby Friendly Gold standard accreditation. They are the first SCBU in the country to achieve this standard.

The key priorities for 2020/21 will be a Local Maternity System approach for digitalisation, neonatal critical care transformation, improving postnatal care and peri-natal mental health. The LMS will also continue to have safety at the heart of any transformation.

6.3.6 Learning Disabilities

Indicator	Data	Target	Position
Reliance on specialist inpatient care for people with a learning disability and/or autism (per 18+ million population)	2019/20	30	33
Proportion of people with a learning disability on the GP register receiving an annual health check	2018/19	67.3%	**41.8%**
Completeness of the GP learning disability register	2018/19	Nat Av 50.0%	55.7%

The CCG is committed to improving care for this group of people and will continue to strive towards improvement of both their health and social care.

As we have previously reported, in October 2015 NHS England released plans of a three year programme to close inappropriate and outmoded inpatient facilities, and establish stronger support in the community for people with Learning Disabilities and/or Autism of all ages. Implementation timings for this plan were between April 2016 and March 2019, with the intention to reduce inpatient beds for people with a learning disability and/or autism and replace with Enhanced Community Services to ensure as many people as possible can lead their lives in their communities. The plan has now been extended by NHS England for a further two years until March 2021. The CCG is making good progress on these targets and will continue working closely and collaboratively with all partners to prevent inpatient admissions and to help facilitate discharge into new community services. The CCG is held to account by NHS England for any delays in discharge to suitable community settings.

People aged 14 years and above with a learning disability are entitled to receive an annual health check by their GP. Improving the uptake of those entitled to receive an AHC continues to be a priority area within the wider work programme surrounding Learning Disabilities. As part of the North Yorkshire Learning Disability Strategy – Live Well, Live Longer - the CCG works closely with colleagues from North Yorkshire County Council, community provider services, the voluntary sector and self-advocate groups, to communicate the importance and value of people with a learning disability receiving an annual health check, and identifies good practice from neighbouring CCGs, other Local Authorities and third sector organisations. The CCG monitors quarterly data closely

in order to encourage and lend support to GP Practices with the largest Learning Disability Registers to continuously improve the uptake of annual health checks within the local learning disability community. Please note that the 2019/20 position to date is only 6 month data (i.e. April 2019 – Sept 2019). Additionally, there are plans to have a section devoted to Learning Disabilities, with gold standard tools and easy-read support materials, on the newly developed North Yorkshire CCG website in 2020.

6.4 Sustainable Development

Our activities and decisions have potential to affect the resources available to us, the communities in which we serve, and the wider environment. Sustainability means recognising, measuring and managing the impact of our business activities, including commissioned services delivered by providers. We recognise that good maintenance and care of the environment contributes a great deal to the long term health of people, their social wellbeing and economic prosperity.

Our local strategy demonstrates the importance of sustainable development and our commitment to ensuring that we act now to promote initiatives which help us meet the challenges facing the NHS, including our legal duty to cut carbon emissions under the 2008 Climate Change Act.

The CCG has a Sustainability Development Management Plan (2018-2020) approved by its Governing Body. Kate Kennady, Lay Member for Patient and Public Engagement is appointed a Governing Body Sustainability Lead.

As described in our Sustainability Strategy, the world's first combined health, public health and social care carbon footprint for a national health system estimates the health and care system carbon footprint to be 32 million tonnes of carbon dioxide equivalent (MtCO2e). To protect the wellbeing of the UK population, the NHS, public health and the social care system has set an ambitious goal to reduce carbon dioxide equivalent emissions across building energy use, travel and procurement of goods and services by 34% by 2020. There are a number of carbon hotspots in the NHS and we are helping to reduce carbon emissions by:

Emissions	What are we doing?
Pharmaceuticals	• We have successfully campaigned to reduce pharmaceutical waste:
Energy	• We use smarter ways of working, making efficient use of our office space by hot desking, reducing the need for travel. • We have an office recycling programme in place to minimise the amount of waste we generate. • As part of an effort to minimise use of paper, we are moving towards Governing Body and senior management team members accessing documents on tablet computers where appropriate. This reduces the time and resources involved in production of meeting papers.

Emissions	What are we doing?
	• The buildings are well-used, and do not use heat or power unnecessarily. • Staff actively turn off lighting and heating when spaces are not in use. • Staff are regularly reminded to power off PCs and other electrical equipment at the end of the working day, or when not in use. The CCG has communicated to all staff the importance of conserving energy for example in reducing the volume of printing and photocopying which in turn saves on costs.
Travel and Transport	• Staff are encouraged to work from home and hot desk where appropriate. • Teleconferencing facilities are available in the CCG office and most staff have access to Skype reducing the need to travel to attend meetings. • Staff are encouraged to car share when attending meetings. • The CCG has a travel and expenses policy. The use of passenger rate encourages car sharing and there is also a mileage rate for pedal and motor cycle use. • The CCG offices have facilities available to encourage active travel such as cycle parking, showers that are accessible to staff and visitors alike.
Our People	• Staff have access to facilities to and support to their health and wellbeing including a staff room for rest, kitchen facilities • Our organisation and estate is totally smoke free and support is provided to staff wanting to use smoking cessation services. • The CCG has clear processes in place to manage our duty of care (e.g. health and safety) to all staff, contractors and third party personnel working on our sites or on our behalf • A Modern Slavery Statement for the CCG is published on our website and where appropriate we ask prospective suppliers to confirm that they comply with the Modern Slavery Act 2015. • The CCG commitments for the Governing Body are condensed, where possible, into one day a week to avoid unnecessary travel and improve efficiency of work patterns.

6.4.1 Procurement

The NHS is a major employer and economic force both in Harrogate and Rural District, and within the wider North of England region.

We recognise the impact of our purchasing and procurement decisions on the regional economy, and the positive contribution it can make to economic and social regeneration of Harrogate and the surrounding area. We are committed to the development of

innovative local and regional solutions and in 2019/20 have supported a sustainable local health economy, working with other public sector organisations to deliver innovative projects to the local population whilst developing the local supplier base.

6.4.2 Sustainable clinical and care models

We have created the Harrogate Transformation Leadership Executive to develop and monitor implementation of partnership approach to longer term sustainability with the health and social care system.

We are part of a wider the West Yorkshire and Harrogate Heath and Care Partnership Integrated Care System[14]. The leadership and staff of health and care organisations in West Yorkshire and Harrogate, in their role as part of Health and Wellbeing Boards, have existing plans to deliver ambitious improvements to health and social care services for people in Bradford, Airedale, Wharfedale, Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

These plans, alongside our West Yorkshire and Harrogate priorities, make up our West Yorkshire and Harrogate Health and Care Partnership draft plan. This work, managed in partnership, allows us to work together on good practice and shared solutions.

The CCG actively engages patients in service design so that care models are realistic, appropriate and aligned to the expectations of our patients, carers, their families and the community. This learning is captured and shared internally and externally, including our mistakes, to support care models in being future proof.

6.5 Improving Quality

The CCG complies with its responsibility to discharge its duty to improve quality under section 14R of the Health and Social Care Act 2006 (as amended). As an organisation at a time of increased financial pressures it is essential that quality remains at the forefront of everything we do to ensure the patient experience is the best it can be, whilst meeting the quality standards the CCG has set.

In liaison with Hambleton, Richmondshire and Whitby CCG (HRW CCG) and Scarborough and Ryedale CCG (SR CCG) the CCG has held a Joint Quality and Clinical Governance Committee (JQCGC) meeting which has provided assurance that commissioned services were being delivered in a safe and high quality manner.

To ensure effective governance, all potential new or changes to services have been subject to a Quality Impact Assessment (QIA) and if required an Equality Impact Assessment (EIA). These are completed as part of the commissioning cycle and were reviewed by the JQCGC to ensure that all commissioning decisions are also considering the quality perspective in addition to the

[14] You can read more about the West Yorkshire and Harrogate Health and Care Partnership in section 1.7.5 of this report.

performance and financial objectives. Moving forward as North Yorkshire CCG from 1 April 2020 the Quality and Clinical Governance Committee is a forum where different sources of intelligence in relation to patient concerns, patient experience, quality and safety are triangulated to provide a clearly articulated and accurate position statement.

Over the previous year, work has continued with the providers to seek assurance and the CCG attends the Clinical Quality Review Groups. This is an opportunity for clinicians, CCG and senior managers to have a productive dialogue regarding care provision, areas of improvement, lessons learned and new innovations.

6.5.1 Quality of Primary General Practice Services

The quality of General Practice primary care services has continued to be a key priority for the CCG and is overseen by the Primary Care Commissioning Committee, which in 2019/20 was chaired by a lay member of the CCG's Governing Body. The CCG has developed a range of methods to build a two-way dialogue with its seventeen member practices. All practices are engaged within clusters and information flows to and from the cluster teams. Primary Care Networks and Clinical Directors will be key to improving General Practice and Primary Care in the future.

6.5.2 Care Quality Commission (CQC) Inspection of GP Practices

All seventeen of our practices have been inspected by the Care Quality Commission (CQC). Currently two practices have an 'Outstanding' rating and the remaining 15 practices are rated as 'Good'. No practice has a rating below 'Good' for any of the five key lines of enquiry or the six population groups rated by CQC during their inspections. Patient satisfaction scores in respect to recommending their GP service to others are consistently above 90%.

6.5.3 Fast Track Packages for End of Life Care Patients

In the last few weeks or months of a person's life their condition can rapidly change. Some people require immediate support to manage a range of complex symptoms and receive care in the place of their choice. This support can streamline discharge from hospital, help to prevent unnecessary admissions to hospital, as well as enable someone to remain at home in the last weeks of their life.

Through listening to family feedback and health care staff in hospital and community, the CCG recognised that there was difficulty sourcing Fast Track packages of care for people in the last few weeks of life. The Fast Track process for end of life patients requiring residential or nursing care is fully operational throughout North Yorkshire CCG, this is managed through the Continuing Healthcare Team. In addition, following a successful pilot with Saint Michael's Hospice we have introduced an outreach health care assistant service which works alongside other community services, such as the support offered by district nurses and GPs to

deliver practical help and support to enable someone to remain at home. End of Life Co-ordination Services are now operating successfully within the former Hambleton, Richmondshire and Whitby, and Harrogate and Rural District CCG areas. We intend to look at the option of extending a similar model of this service in the Scarborough and Ryedale area in 2020.

6.5.4 Continuing Healthcare (CHC)

During the reporting year CHC has faced a number of challenges of which in the main have been caused due to the inability to recruit to vacant CHC nursing posts and changes to leadership at a senior level. Despite working in extremely difficult circumstances CHC team morale remains high and a number of achievements have been accomplished.

iQA is a software platform specifically designed for managing NHS-funded continuing healthcare. Following further system development and implementation it is now being used extensively by the CHC team for all aspects of CHC care management, finance and performance reporting. Further developments are in the pipeline for 2020 to extend the use to include Referral and CHC Panel portals.

Dedicated staff time and resource has also been employed to review standard processes for all areas of CHC activity allowing for consistent standards and practices. In Feb 20 an Internal Audit was carried out to provide assurance to senior management and the Audit Committee that the CCG has effective systems and processes in place to manage the data relating to Continuing Healthcare. It is pleasing to report that CHC received Significant Assurance on the effectiveness of the controls in place.

There are increasing numbers of CHC patients now accessing personalised care by means of a Personal Health Budget (PHB). In early 2020 this was extended to include Personal Wheelchair Budgets. CHC will also be looking at the options for further extending the PHB model to include S117 patients.

One of CHC's main targets is ensuring that CHC assessments are undertaken in a timely way (within 28 days of referral) and largely due to the reasons outlined above CHC have not always been able to meet these targets. However, CHC are in the process of developing a plan to focus on a roadmap for recovery that should include short term stabilisation, setting ambition for success and a migration path that addresses closer working relationships with the Local Authority. In addition CHC aim to look at the potential for the strategic recommissioning of services that it is hoped will achieve better efficiencies and outcomes.

6.5.5 Personalisation and Choice

We have been fortunate to be part of the West Yorkshire and Harrogate Personalisation Demonstrator site. This has enabled the CCG to gain greater understanding of all the components that contribute to people achieving greater personalisation and choice within their care and decision making.

We have made progress in creating the infrastructures for people in receipt of Continuing healthcare funding to have Personal Health Budgets (PHBs) which enable them to have more choice regarding their care delivery. In the last year the focus has been on offering PHBs as standard for all new care packages.

6.5.6 Diabetes Transformation

Diabetes Structured Education: We have continued to work with Harrogate District Hospital and GP practices to increase referrals to diabetic structured education. All GP practices are making referrals to the programme and participate in the National Diabetes Audit which is a major national clinical audit, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and Quality Standards. To contribute to improving diabetes care for all patients, the CCG helped to establish multi-disciplinary team meetings between the specialist diabetes team and practice diabetes teams.

Diabetes Prevention Programme: At the end of October 2019, 367 HaRD patients had completed the programme which is a locally implemented national programme targeted to patients who are at risk of developing Diabetes.

6.5.7 Sustaining Stroke Services and Improving Outcomes for Patients

During 2019/20 we have monitored the new hyper acute stroke pathway for patients to make sure that it is working well. The latest data suggests that 145 patients will have been directed to Leeds Teaching Hospitals NHS Trust (LTHT) for Hyper-acute Stroke (HASU) care. On average, patients have been repatriated to Harrogate and District NHS Foundation Trust (HDFT) within 2 days, with no reported delays in the process. The thrombolysis rate has been 11%, an increase in 1% on 2018/19 figures. A small number of patients have also been directed to HASU care at York, with no reported delays in the process.

6.5.8 Early Cancer Diagnosis

Rapid Diagnostic Pathways (RDC)

The national ambition is to have full coverage of the Serious Non-specific Symptom patients by 2024 and coverage of the majority of 2ww pathways during the same timeframe. Alliance wide 5 year plans have been submitted to the national team at the end of January and show delivery of the national requirement.

An RDC for patients who have serious non-specific symptoms has been running since March 2019 and will achieve full coverage of the Harrogate and Rural District GP practices by the end of April 2020.

On average, patients have seen their GP 3 times prior to referral to the RDC and the median waiting time for the initial outpatient appointment is 8 days (range 2-20 days).

The most common diagnostic tests being undertaken are CT and OGD and the average number of days to diagnosis is 32. There are ambitions to refine the booking processes to reduce the wait for an initial outpatient appointment and reduce the time to diagnosis to within 28 days where possible.

An initial cost analysis of the diagnostic tests has been undertaken and has shown that costs are similar to, but slightly less than, traditional pathways.

Discussions are underway regarding resources required to deliver an RDC approach for pancreatic and upper GI referrals.

Imaging

As a member of the Yorkshire Imaging Collaborative, HDFT have been involved in the successful launch of a technological solution (XEN) which allows connected sites to view each other's images and reports on a read only basis.

The longer term aspirations for this work programme will be to implement the roll out of a radiology workflow solution which will enable shared reporting capabilities across WYH Cancer Alliance, supporting more rapid turnaround of radiology reporting and access to specialist and second opinions.

Living With and Beyond Cancer

The NHS Long Term Plan for Cancer requires, where appropriate, every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

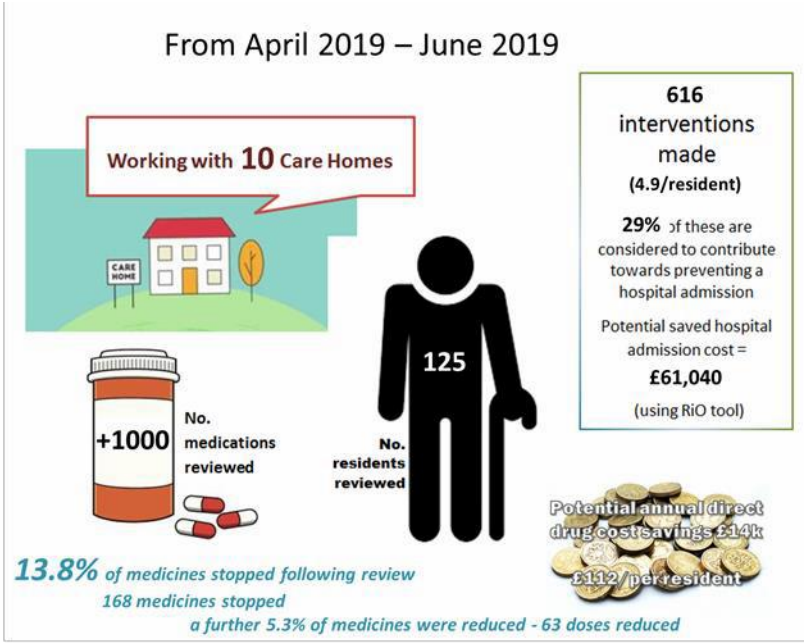
Personalised Stratified Follow Up Care: These pathways are in place for breast, prostate and colorectal patients.

6.5.9 Community Based Living Well Coordinators

We have worked with our partners in North Yorkshire County Council (NYCC) to establish Living Well co-ordinators within our GP Practices. Living Well coordinators are a central point to help people connect to community and voluntary sector services. They work with individuals and carers who are isolated, vulnerable, bereaved, lacking confidence, or perhaps on the borderline of needing health and social care services. Living well service users are helped to access their local community, and supported to find their own solutions to their health and wellbeing goals. This helps to reduce loneliness and isolation, and to prevent or resolve issues for people, including preventing hospitalisation. Appointments are now available within GP practices and appointments will be extended to all Primary Care Networks from 2019/20, making appointments within Primary Care settings available to all patients.

6.5.10 Care Homes

There are over 2,300 care home beds within the Harrogate and Rural District. While we do not commission services from care homes we recognise the significant contribution our care home providers make to the health and wellbeing of our local population and the importance of working together.



- Medicine Reviews – From June 2018 to June 2019 our Medicines Management Team undertook a pilot to review medications of residents within care homes. This involved discussing with individual residents any medicines they may no longer have taken or needed and those that may have caused them harm. This activity produced clear evidence of savings in prescribing costs, but most importantly reduced risks (quantified as reductions in hospital admissions) and improved quality of life for patients. This was supplemented by ongoing advice and guidance in the social care setting to support the ongoing safe and effective use of medicines.

- We have been working closely with North Yorkshire County Council's (NYCC) Quality Improvement Team to determine ways in which we can help support and improve approaches to quality of care. Collaborative provider engagement events have been held between NYCC and representatives from care providers (both domiciliary and care homes). These have provided opportunities for clinical updates and support in terms of Care Quality Commission requirements /updates.

6.5.11 Transforming Care Partnerships – Mental Health, Learning Disability and Autism

We have worked closely with key partners including health providers, the local authority, NHS England, families, children and young people to establish a North Yorkshire and York Transforming Care Partnership for children, young people and adults with a learning disability, autism or both. This includes making community services better so that people can live near their family and friends, and making sure that the right staffs, with the right skills, is supporting people.

We have developed joint commissioning arrangements with Local Authority colleagues to address factors that could safely avoid admission and remove obstacles to discharge from hospital.

The North Yorkshire and York Transforming care partnership have developed a Dynamic Support Register to help key partners identify those children and young people at risk of inpatient admissions and monitoring of Care and Treatment Reviews (CTR) to ensure that 90% are community based.

Indicator	Target 2019/20	Position 2019/20
Care and Treatment reviews compliance	90%	90%

6.5.12 The Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disability Mortality Review (LeDeR) programme was established in 2015 to drive improvements in the quality of health and social care for people with a learning disability and to help reduce premature mortality and health inequalities. Now, in 2020, the programme nationally provides the largest body of evidence on deaths of people with a learning disability at an individual level anywhere in the world.

In North Yorkshire there has been considerable progress made in 2019/20 in completing the backlog of reviews and we are developing a wealth of local knowledge of the lives of people with a learning disability. Key learning has highlighted the importance of attending annual health checks and accessing health screening and the benefits of good communication between all those involved in supporting someone with a learning disability.

With the support of a now well-established North Yorkshire and York multi-agency Steering Group the learning from reviews has been shared across a network of health and social care providers as well as to families; advocacy and self-advocacy groups. The learning has also been added to the training programme delivered to GPs and Primary Care practitioners. A separate annual report providing a more detailed account of the delivery of the programme is being produced by the LeDeR programme team and will be published when completed.

6.5.13 Community Crisis Intervention Service

The service was a one year pilot which ended in September 2019 and was designed to provide intensive support in an individual's home environment to help prevent a crisis inpatient admission and long stays in specialist psychiatric hospitals. Throughout the life of the service it treated over 40 individuals successfully and demonstrated that with the right support in the home environment we can dramatically increase quality of life both emotionally and physically by caring for people in their own homes.

Since then the CCG has been successful in bidding for Mental Health and Learning Disability transformation funding to develop an Intensive Support Service with the learning disability community team. The aim of the service is that people with a learning disability should be able to access specialist health support in the community on an intensive 24/7 basis when necessary. There is a need to reduce inpatient admissions, reduce the length of stay of those people that are admitted and facilitate transfers to community settings for people that have been in hospital for a long time.

The proposal is to develop a scaled down enhanced community team model (8am-8pm, 7 days a week) and the learning from the community crisis intervention service would be a key element to facilitate discharges, reduce future admissions and to realise the funding required to create a sustainable county wide Stepped Care model of intensive support. This pilot took place in both Harrogate and York with the future intention to roll out across the whole of North Yorkshire and York.

6.5.14 Compass BUZZ

Compass BUZZ is an innovative service which works with the whole school workforce and other key partners to increase the skills, confidence and competence of staff supporting children with emotional and mental health concerns. The service was launched in schools in September 2017 and offers 3 levels of training focusing on prevention and promotion, early identification of need and early help and intervention. It also offers support for schools to deliver co-facilitated one to one or group sessions to children and young people. In the Harrogate locality there are a total of 100 schools and of these schools:

- 100 schools received or booked Level 1 training;
- 93 schools received or booked Level 2 training;
- 87 schools received or booked Level 3 training.

Across North Yorkshire a total of 12,869 staff have been trained with 94% of all staff trained within Level 1 stating that they have received improved

knowledge and 92% have increased confidence as a direct result of the training.

6.5.15 BUZZ US

In January 2018 Compass BUZZ launched a confidential texting service for young people (aged 11-18 years) across North Yorkshire called 'BUZZ US'. The service was launched to encourage more young people to access mental health support and advice more easily, and at the right time, to help prevent problems escalating. By texting the free service young people can receive confidential advice, support and signposting from a wellbeing worker within one day via text. The service continues to be exceptionally well used by young people across North Yorkshire.

6.5.16 EPRR Assurance

The CCG has a responsibility to ensure it is able to respond appropriately if there is an emergency that affects the Harrogate and Rural District (or wider) area such as pandemic flu, floods, cyber-attacks, terror threats, etc. Our main role, as a category 2 responder under the Civil Contingencies Act, is to provide a support/coordination role for local health services. The CCG is an active member of the Local Health Resilience Partnership (LHRP).

The CCG has developed and adopted a business continuity plan, which sets out how the CCG will respond to any one or more of a range of key threats:

- loss of access to premises
- loss of key staff
- loss of key partners/stakeholders
- loss of key services

Business Impact Assessments have also been carried out on all CCG work streams and office sites. These have identified where the most significant risks are of an interruption to critical business operations as a result of a disaster, accident or emergency. Where vulnerabilities have been identified strategies have been developed to minimise the risks. These assessments are reviewed annually to reflect any changes to the CCG business.

In addition the CCG has a responsibility to ensure that it can continue working as an organisation (business continuity) as well as responding appropriately to any emergency situations. This process is called Emergency Preparedness, Resilience and Response (EPRR). To demonstrate this each year NHS organisations are required to complete an EPRR Assurance process. NHS England lead the process to gain assurance that NHS organisations are prepared to fulfil their Category 2 response, in their response to emergencies and are resilient in relation to continuing to provide safe patient care.

The review supports the CCG to assess itself against:

- A range of core standards around EPRR that all CCGs and health service providers have to deliver
- A specific topic of interest for 2019/20 which was severe weather.

The CCG submitted their EPRR assurance to NHSE in November 2019. The assurance rating is based on the percentage of Core Standards for EPRR against which the organisation has assessed itself as being 'fully compliant'.

The CCG self-assessed as demonstrating that it is 'substantially compliant' against the core standards.

An action plan has been developed and progress is already being made against the standards showing partial or no compliance.

In terms of Business Continuity it was found that the Covid-19 pandemic created an unprecedented situation, with Major Incident Plans being of limited value due to having been created around very different scenarios involving major trauma. Pandemic Flu Plans were also of limited value to the highly contagious nature of Covid-19, the rapidity of transmission and swift movement of the entire population into lockdown. However the establishment of command and control processes enabled rapid decision making with daily briefings and national guidance circulated to GP practices and key staff.

The leadership of the CCG acted quickly in sending all staff home to work remotely, providing laptops, equipment and secure VPN connections where required and phased the closure of the main CCG offices.

The rapid response of the CCG's digital technology provider was crucial in providing the digital tools to enable the organisation and GP practices to continue functioning and serving the population of the CCG. Our GPIT digital team acted quickly to get laptops out to GP practices to support home working and prioritised their vulnerable staff who were either pregnant or with underlying health conditions to work remotely. They also procured and rolled out a series of tablet devices to every care home in North Yorkshire to enable care homes to liaise with their GP practices regarding patients.

A lessons learned review has already been started and will be completed once the immediate response phase is over to implement any changes that are identified.

6.5.17 Medicines Management

Each year continues to offer opportunities to enhance the quality, safety and cost effectiveness of local prescribing. Primary care prescribing data (available to December 2019) demonstrates continued control of the CCG's weighted prescribing costs as compared to the national trend. However, international

manufacturing difficulties have increased the cost of many common medicines with resultant increases in prescribing spend across the whole NHS. There remains considerable commitment to improving cost efficiency across the country, and sustained efforts will continue to work on maintaining the CCG's weighted prescribing costs below national levels. By mid-March 2020, the CCG was well advanced in delivering its planned and target ambitions for efficiency savings in prescribing. Key areas of focus during 2019/20 have included:

- Our local programme to encourage the public to apply self-care, which is now being supported by national campaigning with the same purpose. This encourages patients to seek professional advice from community pharmacists for minor conditions and not to expect medication with limited benefit or low 'over the counter' costs to be prescribed by their GP. Recent data analysis demonstrates reduced prescribing of these items in the CCG.
- The Medicines Management Team working collaboratively with GP practices and care homes to promote on-line ordering of repeat prescriptions. This is improving time efficiency for GP practice and care home staff, reducing the risk of error and medicines waste. An audit in one local care home showed a reduction in waste of 57% following implementation of on-line ordering.
- Working with GP practices to focus on reducing the prescribing of opioid analgesics for management of chronic pain. In conjunction with the West Yorkshire Research and Development Team, the CROP project is demonstrating an overall reduction of 9% in the number of patients prescribed an opioid analgesic (537 patients) and this work is to be extended across all of North Yorkshire during 2020.
- Phase 1 of the West Yorkshire and Harrogate Healthy Hearts programme, which is also promoted in the 2019/20 prescribing incentive scheme. This has identified further (420) patients with hypertension, started their treatment and increase the proportion of patients (an extra 810) achieving NICE target blood pressure levels of 140/90mmHg. A new hypertension treatment pathway is also embedded. Over the next five years, this is expected to prevent:
  - 4 deaths
  - 7 strokes
  - 5 hearts attacks
- Joint project started between the local hospital trust, community pharmacies and the Yorkshire and Humber Academic Health Science Network in HaRD to expand the effective use of Transfer of Care Around Medicines scheme. This programme

improves patient safety and quality of care by providing targeted medicines support by community pharmacies following discharge from hospital.

- Antibiotic prescribing: partnership work with the West Yorkshire R+D team on a Lowering Anti-Microbial Prescribing project (LAMP) has ensured all GP practices have received regular reports on their antibiotic prescribing, heightening awareness of antibiotic stewardship and prompting practices to carry internal audits to reduce inappropriate antibiotic prescribing. This has resulted in further reductions in the use of antimicrobials overall and reduced use of broad spectrum antibiotics to well below national targets.
- Our local hospital Trust has achieved a successful switch of patients from the branded Humira to the biosimilar version adalimumab which has released over £900,000 worth of savings.
- A focus on increasing pharmacist led medication reviews, including for those with learning disability or autism and for residents in care home settings. To date the team has carried out 125 medication reviews which have resulted in 625 clinical interventions (of which 82% were accepted by GPs) and there were a total of 246 medicines stopped. 20% of interventions related specifically to STOMP medicines (Stopping Over Medication of People with a learning disability, autism or both).

Our Medicines Management Team continues to work closely with local partners as well as neighbouring organisations. This encourages new ideas and initiatives to be considered, debated and enhanced, resulting in a more assured Medicines and Prescribing Programme.

6.5.18 Serious Incidents

The CCG remains committed to commissioning services which provide safe care however we acknowledge that systems and processes can break down and lead to errors within the NHS. It is imperative that these are identified and managed appropriately with a robust systematic review. The governance process is supported by the North Yorkshire and York Serious Incident Team. The CCG receives all serious incident reports for review and closure and they attend the Serious Incident panel where all SI's are discussed and lessons learned are shared.

Our main provider, Harrogate and District NHS Foundation Trust (HDFT) has reported 75 incidents during 2019/20 compared to 88 in 2018/19 and 67 during 2017/18.

All providers of patient care continue to be monitored and the CCG has robust processes in place to manage Serious Incidents through the monthly Collaborative Serious Incident panel, which reviews each investigation report, assesses the robustness of the

action plan and provides feedback to providers to request assurance that lessons are learned and disseminated, and actions implemented.

6.5.19 HCA Infections

Organisations are required to meet national standards for reducing the number of infections from Clostridium Difficile (C.diff) and blood stream infections (BSI) from Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin sensitive Aureus (MSSA) and Escherichia coli (E.coli). The CCG and our provider organisation have an annual objective for each infection, which is subject to a collaborative reducing action plan and is monitored and reported upon quarterly to the Governing Body.

It is important to reduce the numbers of HCAI within our health and social care systems so as to avoid pain and discomfort for patients, reducing the need for prolonged treatments and reducing the burden of caring on families and carers. A HCAI often increases the length of hospital stay which is not in the best interests of the patient or the hospital.

In terms of C.diff infections, Harrogate and Rural District CCG has an annual objective of 31 cases, which is set by NHS Improvement. The position at the end of January 2020 is that we have recorded 8 CCG attributable cases. The acute provider has exceeded its annual C.diff objective of 19 by 10 cases with a total of 29 cases to the end of January 2020.

Clostridium Difficile (C-Diff)

The number of cases is shown below:

	Harrogate and Rural District CCG
Actual	8
Target	31

The medicines management team continue to work to with CCG and reduce inappropriate prescribing of antibiotics along with increased education from our infection control team.

There is a zero tolerance level against MRSA and to the end of January 2020 there have been zero MRSA bacteraemia cases recorded against Harrogate and Rural District CCG. There have been no cases of MRSA bacteraemia since 2013.

MSSA BSI cases continue to be reported as per Public Health England requirements. At the end of January 2020 Harrogate and Rural District CCG reported 28 cases, 6 hospital and 22 community cases. This is an improved position against the 2018/19 annual total of 36, 5 hospital and 31 community cases. From April 2017, a CCG objective for the reduction of Gram Negative

Blood Stream Infection (GNBSI) has been in place. To date we have been required to monitor rates of Escherichia coli, (E.coli) but this is likely to be extended to other GNBSIs in the future.

In 2019/20 the CCG have recorded 171 cases of E. Coli BSI of which 17 were hospital attributed cases, in 2018/19 there were 181 cases, 9 of which were hospital attributed cases. Data demonstrates that the majority of cases occur in primary care, which is reflective of the national picture.

The CCG have a GNBSI reduction plan in place, in collaboration with the acute provider and other stakeholders, which is reviewed and revised as required at the bi-monthly Infection Control Group. NHS Improvement have reviewed the reduction plan at the multi-agency Infection Prevention and Control Group and have offered support to the CCG in order to reduce the rates of GNBSI.

The CCG have been participating in the NHS Improvement Urinary Tract Infection collaborative with Vale of York CCG, York Foundation Trust and community providers. Three work streams were agreed with a focus on increasing hydration, catheter management and appropriate antibiotic prescribing.

During 2019/20 collaborative multi-agency infection prevention and control meetings across NHS Harrogate and Rural District CCG, NHS Vale of York CCG, local authorities and our main Acute Services Provider have been held bi-monthly. The group has Terms of Reference and actions are recorded and monitored via an action tracker.

6.5.20 Same Sex Accommodation

All providers of NHS funded care are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient. NHS organisations are required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation. This is published on the NHS England website. There were 4 breaches reported for the year up to February 2020.

6.5.21 Safeguarding Adults and Children

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, 2019; NHS E/I, 2019). 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.
- A Named GP for Safeguarding Children and Adults and, as part of collaborative arrangements with the three other North Yorkshire and York CCGs, a Nurse Consultant for Primary Care (Safeguarding Children and Adults). During 2019-20 the CCG increased this resource by recruiting to the new post of Named Nurse for Safeguarding in Primary Care.
- Regular reporting into the CCG Quality and Performance 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 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.

Work undertaken by the Designated Professionals Team during 2019/20 has included:

- Continued progress against assurance arrangements to monitor how our NHS provider organisations support vulnerable children and adults.
- Establishment of a safeguarding forum for safeguarding leads from private health care providers. This is aimed at supporting continued development of safeguarding arrangements within those organisations in line with national contractual and best practice requirements.
- Ongoing work with colleagues from the local authority in respect of strengthening the health offer for children in care, including the provision of timely health assessments.
- Working closely with Safeguarding Children Partners across North Yorkshire to identify learning arising from local and national case reviews, agreeing actions to address any identified practice issues and seeking assurance that such actions are embedded in practice.

- Development of a new system for more robust linking of Primary Care into domestic abuse processes to support improved information sharing and decision-making.
- Continued progress with Primary Care coding as 'Was Not Brought', and proactive follow up of missed appointments.
- Practice assurance processes further developed with support for completion of NHS E safeguarding self-assessment tool.
- 723 members of Primary Care staff trained including Level 3 Safeguarding training for Practice Nurses.
- Work with health provider organisations to agree a Development and Mentorship Programme which aims to support continuous professional development and succession planning in the highly specialist area of safeguarding children practice – this has been adopted by a number of other areas across the country.
- The implementation of 'ICON – Babies Cry, You Can Cope'. This is an evidence-based programme to support parents manage normal infant crying and to reduce the incidence of abusive head trauma in infants. The programme was successfully introduced across all provider organisations in North Yorkshire and the City of York.
- Establishing and embedding the new safeguarding children partnership arrangements with leads from the local authority and North Yorkshire Police in line with revised statutory guidance.
- Working with partners from military healthcare on developing safeguarding knowledge and expertise, and implementation of new assurance processes for military healthcare establishments.

6.6 Engaging People

Our work is all about getting the best possible health outcomes for the people we serve. To achieve this we need to talk with patients and the public. Many conversations have taken place this year across a range of healthcare topics to ensure that these views drive the decisions we make. Patient involvement has been central to many of the achievements featured in the report and we have used a wide variety of ways to work with our local community and make sure they can influence our work.

6.6.1 Participation Principles

Our participating principles, as set out below, are included in our constitution. These show how we will secure public involvement in the planning, development and consideration of proposals for change along with decisions affecting the operation of commissioning arrangements. It provides a framework to ensure that the views and needs of the public are obtained prior to making decisions about how the care provided to them is delivered through:

- Working in partnership with patients and the local community to secure the best care for them.
- Adopting engagement activities to meet the specific needs of the different groups and communities.
- Publicising opportunities to engage with us.
- Involving the local population in the planning of commissioning arrangements within the CCG.
- Clearly communicating and explaining any changes to service delivery and impact on the population.
- Clearly communicating the impact of engagement and influence upon our commissioning decisions
- Publishing up to date information about health services on the group's website and through other media.
- Developing feedback mechanisms and encouraging and acting on feedback.
- Delegating responsibility to the group's Governing Body to ensure that effective public involvement mechanisms are designed, developed and implemented.
- Requiring the Governing Body to report to and provide assurance to the group on how public involvement has been secured and influenced the decision making.
- Including in the published annual plan evidence that this involvement has occurred.

Communications and Engagement Strategy

"How we will listen to you, learn from your experiences and use this insight to guide what we do"

6.6.2 Patient Partner Group

Our thirty patient partners provide structured input into projects and service development. This year we have been concentrating on working effectively with our patient partners through close alignment of patient partner activity with key CCG work streams, including integrating community health and social care and efficient prescribing. Patient partners provide valuable insight and constructive challenge throughout our plans and development activities to improve our work on behalf of the Harrogate and Rural District population. The Patient Partner Group also serves as a 'reader panel' for documents and other material we develop and provides constructive challenge and insight.

6.6.3 HaRD Net

We have built a network of people with a particular interest in local health services. ‘HaRD Net’ is a key tool in enabling us to reach our local communities and a resource for feedback on services and our plans for the future. The group is made up of about 130 self-nominated members of the public and local partners who have an interest in our work. We continue to promote the network through a social media campaign, promotion at events we attend and by encouraging existing members to help us to spread the word. We will also continue to contact local community groups and ask for their support and representation on the network. We have but in place mechanisms to ensure a consistent conversation with our local network as we become the North Yorkshire CCG from 1 April 2020.

6.6.4 GP Practice Patient Participation Groups

Our GP Practices have established Patient Participation Groups. These groups consist of patients within the practice who are actively involved in providing either personal feedback or actively seeking others feedback regarding quality of care and services provided within their respective GP Practice. Our aim is to ensure we have a representative from all Practice Participation Groups within the CCG’s Patient Partner Group.

6.6.5 Social and Digital Media

We make proactive use of digital platforms to reach more local residents. These spaces have helped us reach out to additional audiences to encourage participation in consultation exercises and public events and in promoting health and wellbeing campaigns.

6.6.6 Harrogate and Rural Alliance – integrated health and social community care

Extensive engagement took place this year to support launch of an integrated community health and social care service for adults in Harrogate and Rural District on

31 September 2019. This included conversations with staff, a wide range of local partners, and people who use our services to help develop the service model. We want the model to be owned by colleagues who work in primary, community and social care and influenced by people who receive health and social care services. We have also been working with local people to get their views on how we can best involve them in service developments as integrated care matures.

6.6.7 Engagement with Children and Young People (CYP) and their families

Throughout 2019/20 a great deal of local engagement work has been undertaken by the Children and Young People's Commissioning/Continuing Care Team for North Yorkshire CCGs to ensure that the voice of children, young people and their families are represented in all stages of the commissioning cycle. The team records its engagement activities against the 'ladder of engagement' which demonstrates and informs the use of different levels of patient and public involvement. This information will inform the team's engagement strategy in 2020/21 and will help to increase co-production. A summary of key highlights is:

- The team attended the Harrogate and District NHS Foundation Trust (HDFT) 5 day Autism Rapid Process Improvement Workshop for Children's Autism Assessment Service in June 2019, which resulted in the Trust and CCG agreeing to implement a transformational sustainable service model with a streamlined pathway across both the Harrogate and Hambleton, Richmondshire and Whitby localities.
- The Head of Service attended ADHD Parent/Carer event for the Scarborough and Ryedale locality in January 2020. This was hosted by the Provider Tees, Esk and Wear Valleys NHS Foundation Trust and included an information session on the service and opportunity for parent/carer feedback. Attendance numbers on the day were low, however enquires following the event have significantly reduced.
- Following the meeting with the Head of Service and Flying High in January 2019, and also the restructuring of North Yorkshire County Council (NYCC) engagement, the team is continuing to link in with this group via the NYCC Youth Voice and Creative Engagement Officer and to develop and work together in 2020/21 and beyond.
- The team attended the NYCC Youth Voice conference in 2019 and was part of the Question and Answers Panel.
- The team has attended 'Young Mind Combined' events in December 2019 and February 2020 and is utilising the feedback to design the 'Go To' website e.g. design of website chosen by CYP (signposting the website to Children's and Young People's Mental Health services). The 'Go To' Website to be launched in March 2020.
- Young Minds Combined has representatives from various North Yorkshire youth groups e.g. HDFT Youth Forum and North Yorkshire Youth Voice Executive.

- The team regularly attend (and also attended the Young Persons MH Summit in July 2019) to ensure that CYP voice is heard and represented in commissioning decisions
- The team are developing an Engagement Tool to invite parent/carers to be involved with co-production which will be finalised by year end.
- Head of Service is linking with the new Chair of North Yorkshire Parent/Carer's forum at North Yorkshire County Council.

6.6.8 Mental Health

Last year we made key decisions about future provision of the mental health services for adults and older people in Harrogate and Rural District. Our decisions were firmly grounded in what we heard from the community, service users, their carers and families, health and care professionals and partners in the volunteer and community services sector. We had regular meetings with service users and their carers and service users were active members of the transformation steering group.

In summer 2019, in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), our specialist mental health providers, we conducted a public conversation across Harrogate and Rural District about what future community mental health provision should look like. We spoke with over 200 people and their input has helped us develop the model of future care[15].

6.6.9 Medicine Waste Campaign

This year we have continued our medicine waste and self-care campaigns. Colleagues have taken information into healthcare settings and the community to help promote. This comprehensive campaign, started in 2018, is designed to help support our strategic objectives of reducing medicine waste to release more resources to invest into other health services. We are using a wide range of approaches to get our messages out, particularly going into the community to ensure we achieve the broadest reach possible. We have:

- Created promotional materials, a display stand for events and displays boards for the outpatient waiting areas at Harrogate District Hospital and in waiting areas in GP practices, to raise awareness and give information to the general public.
- Worked with local acute hospitals to raise awareness of medicine waste to patients and staff members.

[15] https://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/mental-health/mht-2018-survey-results-for-web-publication.pdf

- Made use of social media to post key messages and engage the public to change behaviour around their medicines.
- Worked with social care settings to provide waste education and medicine management and ordering to staff.
- Explored collaborative working with the district nurses and supportive discharge service to sign post patients who may need further assistance with their medicines.
- Worked closely with the CCG Patient Partner Group and GP practices Patient Participant Group to help deliver our key messages.

6.6.10 Developing maternity care

We are part of the new West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) website platform for teams of women and their families, commissioners and maternity staff who are working together to develop local maternity care. This is consistent with the NHS national Better Births strategy and the Local Maternity System (LMS) action plan, Maternity Voices Partnerships (MVPs) are working groups that operate locally across the region. People are invited to get involved by becoming volunteers to help with work such as asking for feedback at meetings, which they attend on behalf of their local MVP. All volunteers are fully supported and expenses are paid.

6.6.11 Looking out for our neighbours

We worked in partnership with colleagues across the West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) to further develop and deliver the 'Looking out for our neighbours' campaign. This included a winter campaign, amplified through the involvement of the Northern Powergrid. The campaign looks to stimulate community spirt and encourage people to look out for the vulnerable in their neighbourhoods. The hope is this will benefit general health and emotional wellbeing and that with this support from neighbours; we can prevent ill health in vulnerable people and help them live in their own homes, keeping them out of hospital, for longer. The campaign, which launched in Spring 2019 has attracted hundreds of supporter organisations and continues to develop momentum across the WY&HHCP.

6.6.12 Winter communications

We worked together across the Harrogate District health care system to support people in their health care through our communications channels this winter. We used all of our communications channels to deliver messages aligned to our winter health objectives, such as encouraging flu vaccinations, making best use of NHS111 and encouraging mental health wellbeing over the holidays, and ensuring people knew which local health facilities were open over the Christmas and New Year holidays.

6.6.13 Community Engagement

Across the CCG we are committed to being active members of the community we serve. The CCG is an active participant in the Mental Health and Wellbeing Network in Harrogate and welcomes the opportunity to hear about current issues across the district and share news from the CCG. In September 2019 we attended the Nidderdale Show in partnership with Dementia Forward to speak with people about dementia issues, care and support. We have also taken part in engagement throughout the district to discuss changes to primary care with the introduction of primary care networks in England from next business year and the new integrated approach to health and social care for adults across Harrogate and Rural District.

6.6.14 Handling Complaints and Parliamentary Affairs

NHS Harrogate and Rural District CCG is committed to dealing with complaints about the services provided by the CCG and the services we commission. The CCG takes complaints seriously and ensures that complaints, concerns and issues raised by patients, relatives and carers are properly investigated in an unbiased, non-judgemental, transparent and timely, and appropriate manner.

In 2019/20, 17 complaints were received and responded to during 2019/20 of which 2 are pre-investigation and awaiting a formal outcome. No complaints were received by the Parliamentary Ombudsman,

The CCG received and responded to 14 letters from local MPs between 1 April 2019 and 31 March 2020.

6.7 Reducing Health Inequality – making sure we consider everyone's needs

Health inequalities are the unfair differences in health outcomes that are caused by the difference in where people live or their social and economic circumstances. Whilst the locality has a backdrop of relative affluence, there are pockets where the proportion of children living in poverty is near or above the national average. We have a legal duty to ensure that patient access to health services and the outcomes achieved is not affected as a result of inequality of access. We want to ensure there is equality of access and treatment for all the services we commission both as a matter of fairness and as part of our commitment to reduce

health inequalities and improve health and wellbeing. We ensure our staff receive training to understand equality and diversity in commissioning service provision and we consider equality and diversity in all our commissioning. We do this by carrying out a quality and equality impact assessment for all the services we commission or where a service change is being considered. We consider the needs of particular communities when making decisions about local health services. Whilst we have a statutory duty to do this, we also know that it's the right thing to do. Whenever we consider a change to an existing NHS service we look at the impact this may have on particular groups in the Harrogate and Rural District locality. We are committed to ensuring that all patients are able to access the services they need, when they need them, and for them to be provided in the most suitable way. This means that everyone in Harrogate and Rural District should have equal access to NHS information and services. We want to remove any barriers to this, particularly those that may be due to factors such as age, race, disability, or gender. We know people may access services in different ways and we take steps to help support those who may have difficulties. We are committed to ensuring that health services in Harrogate and Rural District are culturally sensitive, inclusive, accessible, and appropriate for our residents.

We have implemented the Equality Delivery System (EDS2) and undertake an annual assessment to enable us to assess our equality performance and generate information to assess the compliance with the Public Services Equality Duty arising from section 149 of the Equality Act 2010. This self-assessment sits alongside the Equality and Diversity Strategy. The self-assessment shows we are maintaining the level achieved in the 2018/19 assessment; however the need for continued work is acknowledged and included in our action plan for the standards.

Better health outcomes			**Improved patient access and experience**			**A represented and supported workforce**			**Inclusive Leadership**		
	2019/20	2018/19		2019/20	2018/19		2019/20	2018/19		2019/20	2018/19
1.1			2.1			3.1			4.1		
1.2			2.2			3.2			4.2		
1.3			2.3			3.3			4.3		
1.4			2.4			3.4					
1.5						3.5					
						3.6					

6.7.1 Health profile

There is a high proportion of people aged over 65 (21.9%) in the Harrogate and Rural District area compared with the national average (17.3%) ('national average' for this section refers to England). In contrast, the proportion of people aged 5-14 (11.1%) is slightly lower than the national average (11.6%). The age profile shows a lower proportion of the population in age groups 0-49 years and a higher proportion in age groups 50-95+, compared with both England and the Yorkshire and the Humber region.

The locality also has a higher life expectancy at birth that the national average at 81 for males and 85 for females. This equates to a higher percentage of men and women in the 85+ age group than the national average. This leads to the district having a higher than average percentage of the population coping with frailty in various forms which will often limit mobility and/or cognitive skills. In addition, advanced age poses an increased risk of sight and/or hearing impairment that the district must take into account. The challenges of a population where 1 in 5 residents are 60+ are key to take into consideration when developing or transforming services.

The district has lower levels of people with a physical disability (15.5%) than the national average. However, this still equates to 24,470 people in the district. Approximately 36%, or 8,800, are estimated to have limited mobility potentially affecting their ability to access public transportation.

Around 3000 adults (2.4%) are estimated to have a learning disability across the district. This is similar to national estimate.

Disease Prevalance

North Yorkshire County Council (NYCC) has published the annual report for 2019/20 which demonstrates that the CCG practices managed to invite 22.8% (n=5295) of the eligible population for the NHS Health Check programme this is marginally higher than North Yorkshire average (22.5% n= 33094). Of those offered an NHS Health Check 44.5% (n=5295) of patients received the Health Check, this is lower than North Yorkshire (50.4% n=16691) and the North Yorkshire 50% set target. This is also well below the nationally aspirational target of 75%.

19.2% (n=1018) of those who received an NHS Health Check across HaRD were identified as having a 10% or more CVD risk score. This is higher than the national target and therefore suggest of those who do attend, more are found to be at risk of developing a heart or circulatory problem in the next ten years.

The CCG is working alongside NYCC and practices to support the delivery of the NHS Health Check.

6.7.2 Homelessness Services

We continue to provide this service and it performs well in delivering essential services to this disadvantaged population.

6.7.3 Learning Disability Annual Health Checks

Work continues to support GP Practices in their role to increase the number of people with learning disabilities who attend for an Annual Health Check. 2019 training events were well attended in the Harrogate, Hambleton Richmondshire and Whitby, and Scarborough and Ryedale localities. Education has been provided to Practice Nurses regarding the benefits of health checks for this patient group in reducing health inequalities, and how to improve the experience and outcome from a patient perspective. People with a learning disability are always involved in the training to help demonstrate to health care professionals in primary care the difference between a 'good' health check and a 'bad' one.

6.7.4 The LeDER Programme

The Learning Disability Mortality Review (LeDeR) programme was established in 2015 to drive improvements in the quality of health and social care for people with a learning disability and to help reduce premature mortality and health inequalities. Now, in 2020, the programme nationally provides the largest body of evidence on deaths of people with a learning disability at an individual level anywhere in the world.

In North Yorkshire there has been considerable progress made in 2019/20 in completing the backlog of reviews and we are developing a wealth of local knowledge of the lives of people with a learning disability. Key learning has highlighted the importance of attending annual health checks and accessing health screening and the benefits of good communication between all those involved in supporting someone with a learning disability.

With the support of a now well-established North Yorkshire and York multi-agency Steering Group the learning from reviews has been shared across a network of health and social care providers as well as to families; advocacy and self-advocacy groups. The learning has also been added to the training programme delivered to GPs and Primary Care practitioners. A separate annual report providing a more detailed account of the delivery of the programme is being produced by the LeDeR programme team and will be published when completed.

6.7.5 Special Educational Needs and Disabilities (SEND)

The Health SEND Network is a network of key stakeholders for SEND and has been developed to support the CCGs in meeting their duties under the Children and Families Act 2014. A key priority of the Health SEND Network is to improve the patient journey from children's services to adult services. We started with a Task and finish group across North Yorkshire to develop a seamless

North Yorkshire and York Pathway. However, due to a number of different Providers, systems and process across the patch this proved exceptionally difficult to create. It was decided that the Designated Clinical Officer (DCO) will work with each provider to set up a simple pathway and local contact guidance to support the local demographic. This will allow for a more responsive and quality approach to the children and families of each area.

Health Providers have a statutory duty to respond to health information requests to support Education Health and Care Plans (EHCP) within 6 weeks. There is a requirement that 90% of these requests should be returned within the 6 weeks. The CCG Children's Commissioning have worked with our North Yorkshire County Council partners and paediatric services to improve processes. Performance of EHCPs are as follows:

- Harrogate and Rural District CCG: Annual 2019/20 performance at 80% (although considerable improvement was made within Q3 at 93%, the performance within Q4 dropped to 66%)
- Hambleton, Richmondshire and Whitby CCG: Annual 2019/20 performance at 91% (with strong performance within Q3 at 100% and within Q4 at 87%)
- Scarborough and Ryedale CCG: Annual 2019/20 performance at 99% (strong performance throughout the quarters)
- North Yorkshire overview: Annual 2019/20 performance at 89%.

EHCP performance continues to be monitored at the quarterly North Yorkshire and York Health SEND Network meeting. The Designated Clinical Officer (DCO)continues to challenge the providers and working on smoother process of a complex network of communication. There has been CCG agreement to recruit for a 3 day a week band 8a DCO to support the development of the SEND agenda.

The Health SEND Network is a network of key stakeholders for SEND and has been developed to support the CCG in meeting its duties of the Children and Families Act 2014. The Health SEND Network has reviewed its Terms of Reference and membership attendance recently, and will re-launch with the new Parent Carer Forum Lead. Within this a key focus over 2020/21 will be around setting up a local Pathway for a child's journey into adult services. This will be a joined up process with Providers, Local authority and the Parent Carer Forum Lead'.

6.8 North Yorkshire Health and Wellbeing Board

The North Yorkshire Health and Wellbeing Board (HWB) is a partnership between CCGs, North Yorkshire County Council and a number of other stakeholders to improve health and wellbeing across the district. It brings together partners to encourage

integrated working and commissioning between health and social care to deliver the right care, in the right place at the right time for people in Harrogate and Rural District CCG.

The Accountable Officer of the CCG is the Vice-Chair of the HWB and is working with the HWB to ensure that joint priorities are delivered across the Harrogate and Rural District footprint.

This year's work has included:-

- contributing to continued implementation of the Joint Health and Wellbeing Strategy, including on-going implementation of Strategies for Dementia; Healthy Weight, Healthy Lives; Learning Disabilities and Young and Yorkshire;
- playing a positive role in the development and implementation of the Better Care Fund and the quarterly performance reporting undertaken;
- contributing effectively to the development of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment by participation in the respective working groups.
- working on Board identified priorities around Digital, Housing and Mental Health.

In terms of the Board identified priorities, referred to above, work this year has included:-

- **Focus on digital solutions**: A Digital Strategy has been approved by the Board, which will be launched for consultation. The CCG contributed to the development of the Strategy as a member of the Reference Group and is involved in the development of the Local Health Care Record (exemplar) which is the shared care record for Yorkshire and Humber.
- **Mental Health**: Contributed to continued implementation of the Action Plan approved by the Board, following the Mental Health Summit held in 2018.

  The CCG has also been a key player in the Mental Health and Learning Disabilities Partnership, which comprises Harrogate and Rural District, Hambleton, Richmondshire and Whitby and Scarborough and Ryedale Clinical Commissioning Groups, Tees, Esk and Wear Valleys NHS Foundation Trust, and North Yorkshire County Council. Achievements so far include a Children's Attention Deficit Hyperactivity Disorder Service in Scarborough; enhanced perinatal mental health services; and "Kooth", (see section 2.5.4) the online counselling service for young people. Future intentions include exploring further integrated Health and Social Care work.

  The CCG has also been involved in the development of the Go To website (see section 6.6.7), which provides information to help signpost young people, families and professionals to the right information and services available for mental health and

wellbeing across North Yorkshire. The website has been developed in conjunction with young people, professionals and parents and carers.

The CCG also undertook an annual refresh of the Local Transformation Plan for Children and Young People's Emotional and Mental Health in North Yorkshire and York.

- **Housing and health**: As part of the Joint Strategic Needs Assessment, the CCG are contributing have contributed to a dedicated section of housing and health. The main outcome from this is the agreement that agencies working within North Yorkshire continue to collaborate to improve joint working arrangements across health, social care, planning and housing and jointly provide effective solutions to housing issues, thereby improving health outcomes.

The key document produced by the HWB is the North Yorkshire Joint Health and Wellbeing Strategy, which sets out the vision of the Board in improving people's health and wellbeing within the county. The current strategy is a five year plan up to 2020.

The Accountable Office has been active in leading the Board and shaping the agenda to address the 5 themes across the strategy. These are:

- **Start well** - to support families to receive the help they need from birth to maximise their life changes.
- **Live well** - supporting those people with conditions that can be prevented or delayed, for example heart disease and stroke.
- **Age well** - to provide care and support to older people through services working together and for people to take ownership of their own care.
- **Dying well** - we want to make sure that people receive the best possible care at the end of their life.
- **Connected communities** – helping people feel part of a strong, vibrant community and ensure a stronger link between work programmes across health and social care.

The Accountable Officer is the sponsor for the Live Well theme.

We have had regular conversations with the HWB about our collective delivery of the strategy, both in formal board business and via Board workshops, as well as through extensive work with broader partners.

The CCG is also aligned to the HWB strategy to jointly deliver the Better Care Fund and Improved Better Care Fund schemes. The focus is on reducing delayed transfers of care, non-elective admissions, re-admissions and admissions to care homes. This is in partnership with Harrogate and District Foundation Trust, North Yorkshire County Council, Mental Health, Tees, Esk and Wear

Valleys NHS Foundation Trust, Continuing Healthcare and voluntary sector partners. There are a number of voluntary sector schemes supporting patients with an agreed care plan when discharged from hospital to keep them safe at home. The package of support includes escorts with shopping, preparing meals and completing daily tasks such as washing.

Building on partnership working, the CCG has been jointly working with local partners to progress with developing an integrated model of health and social care via the Harrogate and Rural Alliance (HARA) (see section 2.1.1). This is a partnership involving the NHS, the County Council and GPs designed to deliver an integrated operating model that brings together community health and social care services for adults in Harrogate.

HARA commenced in October 2019 and is bedding in well.

The ambition for the integrated model is it will:

- Have prevention as the starting point;
- Develop a new model, anchored in primary care, based on prevention, planned care, unplanned care, optimising all available resource;
- Provide care at home wherever possible;
- Focus on population health as opposed to organisations; where possible, be a GP practice centre model;
- Include GP daily involvement and commitment, and
- Have active involvement from people who use services and carers.

Harrogate and Rural District Clinical Commissioning Group

Accountability Report - Corporate Governance

7 Members Report

7.1 The Governing Body

Governing Body Members	
	**Dr Alistair Ingram** **Clinical Chair (Voting) – April 2013 to March 2020** Alistair qualified at Nottingham Medical School in 1989. After finishing his general practice training in Lincolnshire he became a partner at Dr Fletcher and partners in Ripon in 1993.The practice shares the responsibility with the other Ripon practices for the medical cover to the in-patient beds and minor injuries unit at Ripon Community Hospital. He has been a trainer for General Practice trainees on the Northallerton Vocational Training Scheme since 2000. Alistair has previously been Chair of the Masham and Ripon Consortium for Health and Chair of the Harrogate and Rural District Practice-based Commissioning Group.
	**Amanda Bloor** **Accountable Officer, North Yorkshire CCGs (Voting) – April 2013 to March 2020** Amanda was appointed as the Accountable Officer for the three North Yorkshire CCGs (Hambleton, Richmondshire and Whitby, Harrogate and Rural District and Scarborough and Ryedale) in December 2018. Prior to this she served as Accountable Officer for Harrogate and Rural District CCG since it was established in 2013. Amanda is a strong advocate of prevention, self-care and supporting our population to lead healthy lives. She is passionate about mental health services and working in partnership to help achieve the best health outcomes for the people who live in our area. When not working Amanda enjoys yoga and running and spending time walking in the Yorkshire countryside with her family and two dogs.
	**Dr Sarah Hay** **GP Governing Body Member (Voting) – April 2013 to March 2020** **Lead for Quality, Governance, Urgent and Emergency care, Cancer and End of Life** Sarah qualified in 1995 from St Mary's Hospital, Paddington. She moved to Yorkshire in 1999 to train as a GP. As a GP Registrar she was the Yorkshire representative at the BMA. Sarah is a part-time partner in a small practice in Harrogate, her interests include Information Technology, GP Appraisal and her clinical interest is palliative care, having worked in three hospices over the years. Prior to joining her practice she worked as both a locum and salaried GP in Leeds and Harrogate and also spent a year working as a GP in New Zealand. In addition to being a partner she does regular

	sessions at the out-of-hours service in Harrogate and also works as a GP Appraiser. This is her first post in Clinical Management.
	**Dr Bruce Willoughby** **GP Governing Body Member (Voting) – September 2014 to March 2020** **Lead for Planned Care and Primary Care** Bruce qualified from Newcastle University in 1993 and went on to become a GP in Northumberland. After a number of years of working with the Primary Care Group on stroke improvement, he left General Practice and trained as a specialist in public health across the North East including working in a variety of PCTs, a Care Trust, Government Office for the North East and a hospital trust. In 2008 he moved to his native Yorkshire and took up a consultant post in Public Health Medicine in North Yorkshire and York PCT. In 2012, after feeling he was in need of getting back to the coal face and missing patient contact, he returned to General Practice. He has worked since then as a GP at a number of practices within Harrogate and the surrounding area and now is part of Sterling Medical Chambers which provides GP locum services to local practices.
	**Dr Ian Woods** **Secondary Care Doctor (Voting) – January 2018 to March 2020** Ian qualified in Medicine in 1979, and after specialist training became a Consultant Anaesthetist in 1988. His special interests included Intensive Care and also Patient Safety, he became the Specialty Advisor at the National Patient Safety Agency. During the latter part of his clinical career he was Medical Director of a Foundation Trust for 4 years, and now at the CCG sits on the Audit Committee in addition to the Governing Body. Ian lives with his family in North Yorkshire, and enjoys walking and photography.
Governing Body Lay Members	
	**Sheenagh Powell** **Lay Member (Voting) – January 2018 to March 2020** **Vice Chair and Chair of the Audit Committee** Sheenagh has many years' experience of working in the NHS including roles as a board member, finance director and chief executive. Sheenagh's career crosses NHS organisations including Primary Care Trusts, an NHS Foundation Trust and NHS England.

Kate Kennady
Lay Member (Voting) – February 2018 to March 2020
Patient and Public Involvement

Kate Kennady is one of two lay members with responsibility for patient and public involvement. Kate is retired having spent her working life in the NHS latterly as a senior nurse and has worked in a number of acute hospital trusts. Her last post was as Director of Quality at the Mid Yorkshire Hospitals Trust. Kate then worked for the Royal College of Nursing as a Professional Learning and Development Facilitator for the Yorkshire & Humber and Northern regions. Kate is a registered nurse and undertook her training in Liverpool. She also has a Master Degree from the University of Leeds in Health Service Studies.

Lance Gilroy
Lay Member (Voting) – February 2018 to March 2020
Public and Patient Involvement

Lance Gilroy is one of two lay members with responsibility for patient and public involvement. Lance is a retired Police officer and has lived in the Harrogate area for most of his life. Currently Lance works as a case manager in the criminal justice sector. He has considerable experience in engaging with challenging service users, particularly those with mental health and substance misuse issues.

Governing Body Executive Members

Wendy Balmain
Director of Strategy and Integration, North Yorkshire CCGs – November 2016 to March 2020

Wendy was appointed Director of Strategy and Integration for the three North Yorkshire clinical commissioning groups in June 2019.

Wendy previously served as Director of Transformation and Delivery for NHS Harrogate and Rural District CCG where she was responsible for delivering health care commissioning for the CCG and led work to integrate community and adult social care services. Wendy brings extensive experience across health and social care both at a national and local level to the role.

As Director of Strategy and Integration she is responsible for primary care transformation and commissioning, including implementation of primary care networks, working closely with partners across North Yorkshire to expand integrated service models.

	**Simon Cox** **Director of Acute Commissioning, North Yorkshire CCGs – June 2019 to March 2020** Simon Cox has worked in the NHS for over 31 years. Initially he worked as an Operating Department Practitioner in the operating theatres at Leeds General Infirmary. Simon moved into NHS management, firstly as a theatre manager, before developing into broader general management in both healthcare provider and commissioner roles. Simon was Chief Officer of NHS Scarborough and Ryedale CCG from its inception until 2018. From June 2019 he has been operating as Director of Acute Commissioning for the three North Yorkshire CCGs.
	**Dilani Gamble** **Chief Finance Officer (Voting) – July 2014 to June 2019** Dilani is a qualified accountant and an associate member and fellow of the Association of Chartered Certified Accountants (ACCA). Dilani has had 22 years of NHS experience with over 15 years in senior management roles. During this time, her career has spanned finance, contracting, business intelligence and performance, holding a number of senior management positions including Head of Finance at NHS England (North Yorkshire & Humber Area Team), Associate Director of Contracting and Information at East Riding of Yorkshire PCT and Senior Commissioning Accountant at North Lincolnshire PCT.
	Iain Dobinson **Interim Chief Finance Officer – July 2019 to October 2019** Iain has worked in the NHS for over thirty years holding Director of Finance roles in both provider and commissioning organisations in the North East and Yorkshire. He lives in Newcastle and was in Harrogate and Rural District CCG on an interim basis.
	**Jane Hawkard** **Chief Finance Officer, North Yorkshire CCGs (Voting) – November 2019 to March 2020** Jane joined the team as Chief Finance Officer in November 2019 after six years as Chief Officer of East Riding CCG. Jane qualified as a chartered accountant with KPMG and worked as a financial accountant at Yorkshire Bank in their store card, leasing and central office divisions before joining the NHS in 1994. Since joining the NHS Jane has worked for mental health, community, acute trusts and the former North East Yorkshire and North Lincolnshire (NEYNL) Strategic Health Authority. She has worked at a senior level in finance, contracting and strategy prior to her Chief Officer role. Jane was also a Director on the East Riding of Yorkshire Council senior management team.

	In her role as Chief Finance Officer Jane is committed to ensuring a sustainable financial future for the North Yorkshire health economy working with trusts, local authorities and CCG partners.
	**Joanne Crewe** **Director of Quality and Governance / Executive Nurse (Voting) – September 2016 to May 2019** Joanne qualified as a registered general nurse in 1986 and went on to complete an MSc in Nursing Practice. Joanne worked at Dewsbury and District Hospital as a respiratory specialist nurse and with North Kirklees PCT as lead nurse for clinical development and innovation. She then moved on to lead a team responsible for transformational redesign and commissioning services, including large-scale programmes for long-term conditions, intermediate tier services, frail elderly, palliative and end of life care. Prior to joining the CCG, Joanne worked as an Operational Director at Harrogate and District NHS Foundation Trust.
	Sue Peckitt **Chief Nurse, North Yorkshire CCGs (Voting) – June 2019 to March 2020** Sue was appointed Chief Nurse for the three North Yorkshire CCGs in June 2019. She is a registered nurse with more than 30 years' NHS experience in a wide variety of nursing and clinical quality roles in both secondary care organisations and clinical commissioning groups. Sue worked as Deputy Chief Nurse level for six years prior to her current appointment and holds an MSc in Health Sciences and a post graduate diploma in management. Sue is responsible for clinical quality and safety, safeguarding of adults and children, and patient experience. Sue is committed to working closely with colleagues across the health and social care system in North Yorkshire in order to reduce health inequalities and improve the quality of care for our population.
	Julie Warren **Director of Corporate Services, Governance and Performance – June 2019 to March 2020** Julie was appointed Director of Corporate Services, Governance and Performance for the three North Yorkshire CCGs in June 2019. She has worked in the NHS for more than 26 years in different organisations across Yorkshire and the Humber including setting up one of the first Surestart programmes for 0-5 year olds and their families and carers. Qualified in health promotion, Julie strongly promotes being proactive in raising awareness and self-care. She is committed to ensuring local priorities are delivered learning from best practice across the country.

7.2 Council of Members

Chaired by the Clinical Chair of the Governing Body, the Council of Members is made up of the Lead Commissioning GPs from each of the 17 GP Practices who each signed a mandate detailing who would be attending from within their Practice. Each Practice is responsible for working with the Governing Body and GP Commissioning Leads to engage in the commissioning, monitoring and improvement of service in the area. Members of the Senior Management Team (SMT) attend to support the work of the group, and bring items to the meeting for discussion and approval, such as new commissioning projects and services. SMT also provides the Council of Members with updates of ongoing work within the CCG and gives members the opportunity to ask questions directly to the SMT. It also provides an opportunity to keep the Practices informed of the financial position.

The composition of the Council of Members throughout 2019/20 and up to the signing of the Annual Report and Accounts is as follows:

GP Practice	Representative Member	GP Practice	Representative Member
Beech House Surgery	Dr Claire Keenleside	Leeds Road Practice	Dr Peter Banks
Church Lane Surgery	Dr John Crompton	Nidderdale Group Practice	Dr John Hain
Dr Akester & Partners	Dr Gareth Roberts	North House Surgery	Dr Peter Johnson
Church Avenue Medical Group	Dr Naveen Rajagopal	Park Parade Surgery	Dr Victoria Finnan
Dr Ingram & Partners	Dr Alistair Ingram (Chair)	Ripon Spa Surgery	Dr Charles McEvoy
Dr Moss & Partners	Dr Ben Millar	Spa Surgery	Dr Mark Hammatt
Eastgate Medical Group	Dr Chris Walsh	Springbank Surgery	Dr Angela O'Donoghue
East Parade Surgery	Dr Ian Dilley	Stockwell Road Surgery	Dr Matt Travis
Kingswood Surgery	Dr Ruth Kirby		

7.3 Members Practices of the CCG

As listed above.

8 Clinical Commissioning Group Committees

8.1 Register of Declarations of Interest

All CCG staff, must declare interests and conflicts, as required by Section 140 of the National Health Service Act 2006 (as amended). Declarations of Interest made by the CCG's decision makers, are updated regularly and are published on the CCG website at: https://www.harrogateandruraldistrictccg.nhs.uk/publications/conflict-of-interest/

8.2 Personal Data Related Incidents

I can confirm that NHS Harrogate and Rural District CCG have not reported any personal data related incidents to the Information Commissioners Office in 2019/20.

8.3 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.

8.4 Modern Slavery Act

NHS Harrogate and Rural District CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2020 is published on our website at https://www.harrogateandruraldistrictccg.nhs.uk/publications/

8.5 Statement of the Accountable Officer's Responsibilities

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

To the best of my knowledge and belief, and subject to the disclosures set out below (eg. directions issued, s30 letter issued by internal auditors), I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

- No Disclosures issued

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.
- 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.

Amanda Bloor

Accountable Officer

23 June 2020

9 Annual Governance Statement 2019/20 by the Chief Officer as the Accountable Officer of the Harrogate and Rural District Clinical Commissioning Group (03E)

9.1 Introduction and context

NHS Harrogate and Rural District Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2019, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

9.2 Scope of responsibility

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

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

9.3 Governance Arrangements and Effectiveness

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

As such I have considered how the CCG applies the principles in order to deliver our strategic aims for patients, carers and the public.

9.3.1 Constitution

The CCG maintains a Constitution and associated Standing Orders, Prime Financial Policies and a Scheme of Reservation & Delegation, all of which have been approved by the CCG's membership and have previously been certified as compliant with the requirements of NHS England.

The Scheme of Reservation & Delegation defines those decisions that are reserved to the Council of Members and those that are the responsibility of its Governing Body, the clinical commissioning group's committees, individual officers and other employees.

The CCG is made up of 17 member practices across Harrogate and Rural District (at 1 April 2019). The Council of Members is comprised of one GP representative from each member practice.

The Constitution includes:

- Membership and the area we cover
- Our Mission, Values and Aims
- Functions and Duties
- Decision Making
- Roles and Responsibilities
- Standards of Business Conduct and Managing Conflicts of Interest
- The CCG as an Employer
- Transparency and Ways of Working
- Standing Orders, Scheme of Reservation and Delegation and our Prime Financial Policies.

The Constitution was updated once in 2019/20 in line with NHS England's process.

In November 2019, changes were made to the constitution in order to make changes across the three North Yorkshire CCG Constitutions in order to establish Joint Committees and to remove disestablished Committees of the Governing Bodies. The Standing Orders were also aligned across the three North Yorkshire CCGs for consistency and to ensure decisions can be made at the appropriate level and by the appropriate people, in line with the new single management structure across the three North Yorkshire CCGs. These amendments were agreed by the member practices and submitted to NHS England for approval in November 2019. NHS England sent a formal notification of approval of these changes to the CCG in November 2019.

The Scheme of Reservation & Delegation was updated once during 2019/20. These amendments were agreed by the member practices in November 2019 where authority was delegated to the Governing Body to approve amendments to the Scheme of Reservation and Delegation. The amendments were submitted to NHS England for approval in November 2019. NHS England sent a formal notification of approval of these changes to the CCG in November 2019.

9.3.2 Governing Body and Committee Structure

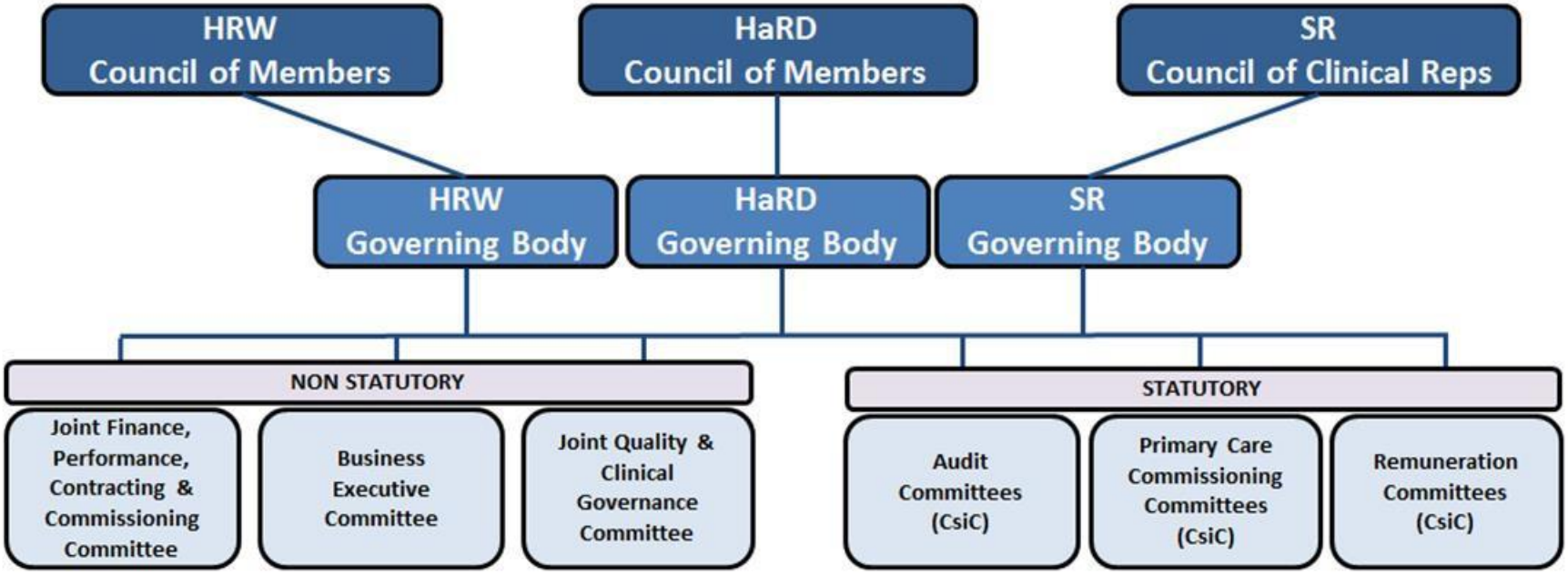
The Governing Body is responsible for the functions conferred on it through the constitution. In summary these are:

- To ensure arrangements are in place to exercise its functions effectively, efficiently and economically
- To lead the setting of the vision and strategy
- To approve the commissioning plans
- To monitor performance
- To provide assurance of the management of strategic risks.

The Governing Body comprises a diverse range of skills from Executive, Clinical and Lay members. There is a clear division of the responsibilities of individual's with no one individual having unregulated powers of decision.

The Governing Body has responsibility for leading the development of the CCG's vision and strategy, as well as providing assurance to the Council of Members with regards to achievement of the CCG objectives. It has established five committees to assist in the delivery of the statutory functions and key strategic objectives of the clinical commissioning group. It receives regular opinion reports from each of its committees, as well as the minutes from the statutory Committees. These, together with a wide range of other updates, enable the Governing Body to assess performance against these objectives and direct further action where necessary.

During early 2019/20, the three North Yorkshire CCGs (NHS Hambleton, Richmondshire and Whitby CCG; NHS Harrogate and Rural District CCG; and NHS Scarborough and Ryedale CCG) agreed to merge. This led to the disestablishment of all non-statutory Committees by the Governing Body and the establishment of three Joint Committees by the Council of Members / Council of Clinical Executives. The structure across the CCGs for the majority of 2019/20 was as follows:



Committee / Meeting	Role
Council of Members / Council of Clinical Representatives	The Council of Members / Clinical Representatives includes the Lead Commissioning GP from each of the GP Practices. Each Practice is responsible for working with the Governing Body and GP Commissioning Leads to engage in commissioning, monitoring and improvement of service in the area. Executive Directors also attends to support the work of the group, and bring items to the meeting for discussion and approval if necessary, eg new commissioning projects, services etc. Directors also provide updates on work that is on-going within the CCG and gives members the opportunity to ask questions directly. It also provides an opportunity to keep the practices informed of the overall financial position. The CCG recognises the potential for interests of members to conflict with the business of the CCG; consequently the CCG has embedded in its governance documents, policies, protocols and processes to ensure that conflicts are recognised, managed and that decisions are made only by those who do not have a vested interest.

Committee / Meeting	Role
Governing Body	Chaired by the Clinical Chair, the Governing Body has the following functions conferred on it by sections 14L (2) and (3) of the 2006 Act, inserted by Section 25 the 2012 Act, together with any functions connected with its main functions as may be specified in regulations of in the constitution. The Governing Body has responsibility for: • Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function); • Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006, inserted by Schedule 2 of the 2012 Act; • Approving any functions of the group that are specified in regulations; • Leading the setting of vision and strategy; • Approving commissioning plans; • Monitoring performance against plans; • Providing assurance of strategic risk.
Committees Published report *NY CCGs Governing Bodies Committees Annual Report 2019/20*, provides a detailed evidence on matters relating to the year 2019/20 and includes attendance records: http://www.northyorkshireccg.nhs.uk/about-us/	
Audit Committee (Committees in Common)	Chaired by the Vice-Chair of the Governing Body / Lay Member for Governance, the Audit Committee has delegated responsibility from the Governing Body for oversight of integrated governance, information governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and financial reporting.
Remuneration Committee (Committees in Common)	Chaired by the Lay Member for Patient and Public Involvement of the Governing Body, the Remuneration Committee has delegated responsibility from the Governing Body for advising the Governing Body on all aspects of salary not covered by Agenda for Change, arrangements for termination of employment, monitoring and evaluating the performance of individual Governing Body Members, and approving human resources policies and procedures.

Committee / Meeting	Role
Joint Quality and Clinical Governance Committee (JQCGC)	The JQCGC provides oversight on any quality, safety or equality impact relating to all commissioned services through its review and monitoring of quality surveillance metrics that may indicate an adverse impact on quality or safety and therefore require further mitigation to be considered. It provides assurance to the Governing Body that any risk to equality and quality has been appropriately mitigated and how continuous improvement will be monitored. It also monitors safeguarding.
Joint Finance, Performance, Contracting and Commissioning Committee (JFPCCC)	The JFPCCC monitors and reviews the overall financial position of the CCGs, activity information, provider contract positions and issues, deliverability of QIPP, and risks in achieving its forecast out-turn at the end of the year. It provides members with greater clarity on the CCG's financial and contracts position by holding budget holders to account for delivery, risks and mitigation. It also provides assurance to the Governing Bodies on the CCG's financial position, flagging concerns and issues for further discussion.
Joint Business Executive Committee (JBEC)	The JBEC ensures executive and clinical directors have clear oversight and grip on the transformation and efficiency programme in the CCGs. The Committee ensures financial sustainability whilst improving patient experience and outcomes through transforming care. The Committee monitors programmes and transformation plans that seek long term solutions to financial challenges across care systems. The Committee receives investment opportunities and business cases, advises committee members on their implications and makes decisions in line with the CCGs' operational scheme of delegation. If the investment or business case exceeds the committees approval limit the committee makes recommendations and highlights key factors to the Governing Body to assist them to make a decision.
Primary Care Commissioning Committee (Committees in Common)	The Primary Care Commissioning Committee meets in public bi-monthly and provides assurance on the delegated arrangements from NHS England to HaRD CCG for primary care commissioning. The Committee members make collective decisions on the review, planning and procurement of primary care services under delegated authority from NHS England. The Committee focuses on quality, efficiency, sustainability, productivity and new models of primary care.
West Yorkshire and Harrogate Health and Care Partnership and the Joint Committee	The Joint Committee is part of the West Yorkshire and Harrogate (WY&H) Health and Care Partnership ('the Partnership'). The Committee enables the WY&H Clinical Commissioning Groups to work together across the area – making sure that when it makes sense, work is done once and is then shared across WY&H.

Committee / Meeting	Role
	The Committee has delegated authority from the CCGs to take collective decisions on agreed priorities. As well as taking formal decisions, the Committee also makes recommendations to the CCGs when a joint approach will help achieve better outcomes across WY&H. The Members of each CCG agree the Committee's Terms of Reference and its work plan, which sets out the decisions for which it is responsible. Further detail of responsibilities and records of attendance can be found on the West Yorkshire and Harrogate Joint Committee website: http://www.wyh-jointcommiteeccgs.co.uk/

9.3.3 Council of Members Effectiveness

The responsibilities of the member Practices are:

- to work constructively with the Governing Body and GP Commissioning Leads to engage in the commissioning, monitoring and improvement of services in the area. This will include considering and addressing, where appropriate, identified areas of variation and sharing referral, admission and prescribing data;
- to participate in and deliver at practice level, and in partnership with other practices where appropriate, the clinical and cost effective strategies agreed by the CCG;
- to follow the clinical pathways and referral protocols agreed by the CCG (except in individual cases where there are justified clinical reasons for not doing this); and
- to nominate a commissioning lead GP.

The Council of Members has met regularly throughout 2019/20. The meeting is an opportunity for all members to discuss wider strategic issues affecting all practices. Following these meetings, members meet in their localities to collectively commission new services and share best practice. This has been particularly important in 2019/20 for sharing ideas on how best we can manage our budgets, whilst ensuring quality is a fundamental part in all commissioning decisions made.

Having direct contact with patients' means that the Members can ensure that the feedback received can directly influence the decisions made by the CCG. This means the CCG can commission services for local residents that better meet their needs.

The Council of Members is committed to reviewing its own performance and in light of the establishment of the new North Yorkshire CCG will undertake a review of its own performance as a combined approach in 2020.

The Council of Members is subject to statutory training in the management of conflicts of interest.

9.3.4 Governing Body Effectiveness

The CCGs constitution sets out the composition of the Governing Body and identifies certain key roles and responsibilities required. There is also a formal competency based assessment process for appointments of Governing Body Members.

All members of the Governing Body are able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and have established credibility with all stakeholders and partners. Especially important is that the Governing Body is in tune with its member practices and secures their confidence and engagement.

The Governing Body membership is subject to statutory/mandatory training. Additional training and development is provided on a group basis through Governing Body workshops and through individual need as identified through appraisals.

The Governing Body is provided with a range of strategic information covering finance, performance, strategy, policy, risk and quality assurance at all meetings.

The Governing Body is committed to reviewing its own performance and in light of the establishment of the new North Yorkshire CCG will undertake a review of its own performance at a mid-year point in 2020. The results of the survey will be reviewed by the new Governing Body and an action plan will be developed.

The Governing Body met individually and as part of the NY CCGs Committees in Common throughout 2019/20 and a record of attendance was produced which demonstrated that meetings were quorate and that there was a high level of attendance from all Governing Body Members throughout 2019/20.

The Governing Body and the Committees in Common continued to provide strong leadership and oversight to the CCG. The Governing Body has been instrumental in consistently reinforcing the focus of the CCG on quality and meeting its statutory duties in relation to its finances.

The Governing Body agenda is structured to provide an opportunity for the Lay Member for Engagement to provide a formal update on communication and engagement activities and any feedback is discussed. The Governing Body places particular emphasis on quality and safety and discusses any quality and safety issues identified in its comprehensive set of data presented at the formal meeting or raised as part of the feedback received from the chair of the Joint Quality and Clinical Governance Committee.

In 2019/20, Patient Stories were a feature on Governing Body agenda's. These stories enable the CCG to hear about the experiences and needs of people accessing health services in the local area, allows the Governing Body to think about sharing good practice as well as making changes to improve people's experience and access to health care.

In 2019/20, the Governing Body received a number of questions from members of the public.

There have been a number of development sessions held for the Governing Body in 2019/20 and the areas covered at these sessions is shown below.

Governing Body Workshop	Governing Body Workshop Topic
April 2019	• North Yorkshire CCGs – Joint Governance Arrangements ○ Capsticks LLP provided a presentation around the legal implications on the journey to merger ○ Discussed and supported the decision to make a recommendation to the CCG Council of Members/Representatives to approve a merger request in June 2019 to NHSE for the 3 CCGs to be operational as one NY CCG from April 2020. ○ Made a commitment that the Governing Bodies will work together to help determine the transitional arrangements and to support the development of the operating and governance model during 2019/20.
June 2019	• North Yorkshire CCGs – Joint Governance Arrangements ○ Discussed and approved the NY CCGs Interim Governance Structure and destabilised previous ways of working as single CCGs (with the exception of statutory committees and the Governing Body who were determined to meet as Committees in Common where possible). ○ Discussed and supported the decision to make a recommendation to the CCG Council of Members/Representatives to approve a merger request in June 2019 to NHSE for the 3 CCGs to be operational as one NY CCG. • Financial Recovery Plan
September 2019	• North Yorkshire CCGs – Joint Governance Arrangements
October 2019	• North Yorkshire CCG – Joint Governance Arrangements • Finance Update – Spending Approach

Governing Body Workshop	Governing Body Workshop Topic
November / December 2019	• North Yorkshire CCGs – Governing Body Appointment update • Integrated Care System • Patient and Public Engagement • Finance Update – Spending Approach
January 2020	• North Yorkshire CCG – Joint Governance Arrangements • Finance Update – Spending Approach • Patient and Public Engagement Approach • Staffing Update – Consultation • Case for Additional Financial Support - Scarborough Hospital
February 2020	• Strategic Objectives • Vision, Values and Behaviours • Financial Update and Financial Governance
April 2020	The following workshops were postponed due to Covid-19. Any business was conducted through the Finance, Performance, Contracting and Commissioning Committee in early April. The following workshops will be scheduled as soon as practically possible in 2020. • Cyber Security • Risk Management, Assurance and Governance • Governing Body Assurance Framework

9.3.5 UK Corporate Governance Code

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

For the financial year ended 31 March 2020, and up to the date of signing this statement, the CCG has aligned with the provisions set out in the UK Corporate Governance Code as demonstrated in the table below.

Leadership

The strategic and operational management of the CCG is led by the Governing Body. The CCG has in place an effective Governing Body comprised of Clinical Leads, Executive Directors and Lay Members, plus other attendees. The Governing Body has a clear delegation of responsibilities to its formal Committees and its Officers; a clear process for decision making; and a Clinical Chair responsible for leadership of the Governing Body.

Individual members of the Governing Body bring different perspectives, drawn from their different professions, roles, background and experience. These differing insights in to the range of challenges and opportunities facing the CCG, together, ensure that the CCG takes a balanced view across the whole of its business.

Accountability

The CCGs Audit Committee is chaired by the Lay Member for Audit and Governance. The CCG has a series of financial controls in place, including the Prime Financial Policies and Scheme of Reservation and Delegation (SoRD) set out in the Constitution, Operational Financial Policies and Procedures and the Operational Scheme of Delegation (OSD). The OSD was reviewed by the Joint Finance, Performance and Commissioning Committee and approved by the Governing Body in July/August 2019.

The CCG has a Risk Management Strategy that has been approved by the Governing Body. In April 2020, Internal Audit completed an audit of the CCG's risk management and governance arrangements and provided an opinion of significant assurance.

The CCG has a Conflict of Interest Policy and Standards of Business Conduct Policy which have been approved by the Governing Body.

The Audit Chair held the position of Conflicts of Interest Guardian throughout 2019/20 and has been supported by the Corporate Team in the day to day management of managing conflicts of interest throughout 2019/20. In February 2020, Internal Audit completed an audit of how the CCG manages conflicts of interest and provided an opinion of high assurance.

The CCGs Information Governance Steering Group, reporting into the Audit Committee, has overseen the improvements required to ensure the CCG achieves its information governance goals.

The CCG appointed Internal Auditors, Audit Yorkshire. External Auditors, Mazars LLP, were appointed independently on behalf of the CCG. Both Internal Audit and External Auditors report to Audit Committee.

Remuneration
The Remuneration Committee, which is accountable to the Governing Body, makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Remuneration Committee does not include Members that are fulltime employees or individuals who claim a significant proportion of their income from the CCG. Conflicts of Interest are managed so that no individual is involved in deciding their own remuneration.
Relations with Shareholders
The Governing Body and Primary Care Commissioning Committee (PCCC) meetings provide an opportunity for members of the public and stakeholders to submit questions and receive a response from the Chair and other members of the Governing Body and PCCC. In return, this provides the Governing Body with an opportunity to understand public opinion in order to develop a balanced understanding of the issues and concerns of patients. The CCGs constitution clearly details the decision making process and voting rights. Minutes of the meeting are recorded and published on the CCG website. All Governing Body and PCCC papers are made available on the website in accordance with agreed terms of reference. The CCG uses its Annual General Meeting to communicate with stakeholders and the general public and encourage their participation. At the AGM, the Chair, and members of the CCGs Governing Body including the Chairs of the Audit Committee and Remuneration Committee are available to answer questions. The CCG publicises the AGM in order to attract interest. It is vital that the CCG has developed strong working relationships with a range of health care partners in order to be successful commissioners within the local system. These relationships provide CCGs with on-going information, advice and knowledge, to help them make the best possible commissioning decisions.

9.3.6 Discharge of Statutory Functions

In light of the 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.

9.4 Risk Management Arrangements and Effectiveness

The CCG has an agreed Risk Management Strategy in place and is committed to the continued development and maintenance of a positive culture of risk management throughout the organisation. In 2019/20, the CCG, where possible, has sought to minimise risk and has demonstrated its commitment to the active management of preventing risk by continuing to develop and maintain a positive culture of risk management throughout the organisation.

Risk Management is integral to the CCG's decision making and management processes and is embedded at all levels across the organisation.

The Risk Management Strategy demonstrates the approach to risk management and ensures there is a system for monitoring the application of risk management within the CCG, and that actions are taken in accordance with the risk matrix guidance.

The CCGs risk management system is designed to support the delivery of safe and effective health services for service users, staff and wider stakeholders. The CCG believes that risk management is not about risk elimination; it is about encouraging appropriate risk-taking, ie those risks that have been evaluated and which are understood as well as is possible with currently available information. It is recognised that only through appropriate risk-taking will the CCG be able to ensure high quality healthcare services are commissioned. Successful organisations are by their nature successful risk takers and aware of their risk appetite.

CCG Governing Body and Committee forward plans are influenced by key priorities and the Governing Body Assurance Framework (GBAF) to ensure that any risks are being mitigated through robust and timely action plans.

The CCG has identified risks during the year as described in the Risk Management Strategy following input from operational groups and formal meetings.

In 2019 the North Yorkshire CCGs combined their risk registers in preparation for the establishment of the North Yorkshire CCG in 2020. The CCGs manage risks through a North Yorkshire Corporate Risk Review Group, led by the Director of Corporate Services, Governance and Performance. Combined risks are contained within the Directorate Risk Register (containing risks not deemed significant) and Corporate Risk Register (containing risks deemed significant).

The GBAF is the key source of evidence that links the CCG Strategic Objectives to risks. The GBAF provides the Governing Body with a comprehensive method for the effective and focused management of risks that arise in meeting our strategic objectives and

provides assurance in relation to how significant risks are being mitigated against and monitored via the system of internal controls established within the CCG.

In 2019/20 the Governing Body Assurance Frameworks across the three North Yorkshire CCGs were under review in preparation of the establishment of the new North Yorkshire CCG. The Audit Committee has been assured by the Director of Corporate Services, Governance and Performance that processes are in place to develop the GBAF and it is expected that risks will be aligned to the new GBAF and new Strategic Objectives at the first quarterly report in May 2020.

All risks are aligned to Committees which enables the CCG to identify where there are risks associated with meeting statutory duties and the organisation's strategic objectives.

The CCG has identified risks during the year as outlined in the Risk Management Strategy. Each risk is evaluated in a consistent way using the risk matrix. Risks are analysed by combining estimates of likelihood and consequence. By ensuring all risk assessments follow the same process of evaluation and calculation the Governing Body can be assured that a continual, systematic approach to all risk assessments is followed throughout the organisation.

The CCG seeks to reduce the risks in all aspects of its work. All policies and programmes are the subject of an Equality Impact Assessment which helps to identify and minimise risk. The CCG has approved policies on conflicts of interest, standards of business conduct and whistleblowing to encourage transparency and encourage reporting of incidents. The CCG works with a local Counter Fraud specialist and Internal Audit to reduce the risks of fraud. The Governing Body receives yearly training on counter fraud in order to refresh learning on what NHS fraud is; the consequences of it; the role of NHS counter fraud and the individual in protecting the NHS and how to report fraud.

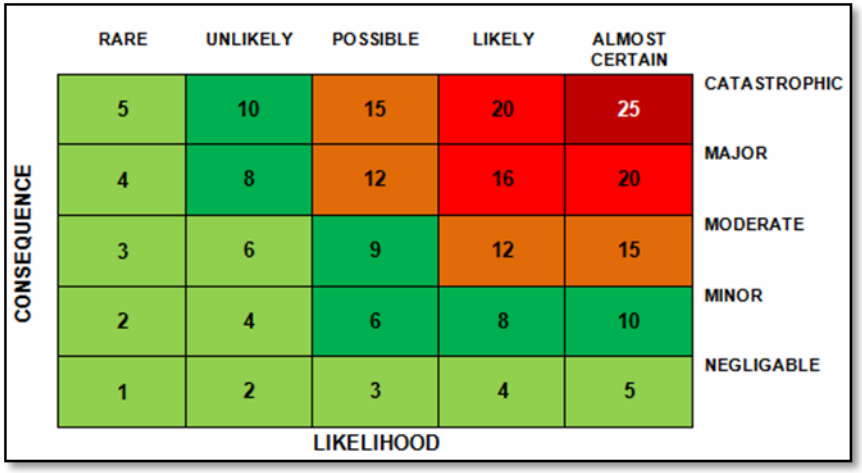
All committee and Governing Body papers carry a specific section within the executive summary page to identify high level risks arising from the area under discussion.

The Governing Body has considered its risk appetite and has determined that those risks identified as low or moderate in accordance with the risk matrix can be regarded as acceptable risks which are managed through the Directorate Risk Register.

Those risks both clinical and non-clinical identified as being in the high or above categories are regarded as significant risk and where the Committee cannot immediately introduce control measures to reduce the level of risk to an acceptable level. Any significant risks relating to the CCG's operational business risks are managed through the Corporate Risk Register.

Each individual risk has its own risk appetite. This is an important tool in determining actions that need to be completed in order to mitigate against the risk and reducing the risk score to an acceptable level.

The CCG uses the New Zealand 5x5 risk matrix, consistent with most of the NHS to determine risks.



1 – 5	Low
6 –11	Medium
12 –15	High
16 –20	Serious
25	Critical

The CCG endeavours to involve partner organisations in all aspects of risk management, as appropriate. A number of strategic meetings with partner organisations hold their own risk registers and manage risks through the meetings.

The CCG works closely and collaboratively with a wide range of partner organisations and has controls in place to identify risk and ensure that risks are properly managed and afforded an appropriate priority within the risk action plan.

The Clinical Commissioning Group embeds risk management through:

- the Governing Body Assurance Framework;
- Directorate Risk Register and Corporate Risk Register;
- Integrated Impact Assessments, including Equality Impact Assessments;
- Policies and procedures;
- Standing Financial Instructions and Standing Orders;
- Joint risk registers with external partners;
- Counter Fraud Policy and awareness campaigns;
- Individual performance management process; and
- Staff induction.

9.4.1 Capacity to Handle Risk

The following Committees and Officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2019/20 and have managed risks assigned to them.

Governing Body

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

- approval of the group's risk management arrangements
- receives and monitors the Governing Body Assurance Framework
- understanding any risks that may impact on the CCG's achievement of its strategic objectives
- approves and reviews strategies for risk management where required
- receives regular monthly updates from the Chief Officer, that identify any new significant risks
- demonstrates leadership, active involvement and support for risk management
- Where the CCG makes arrangements with NHS England or other CCGs to enter into collaborative commissioning, the Governing Body will oversee how risk will be managed and apportioned between parties.

As part of the process of bringing together the governance arrangements of the 3 CCGs a review of the risk register took place in July 2019. An internal risk group met monthly to oversee the delivery of the merger. The CCGs had mitigating actions against all these areas and the Governing Bodies and Audit Committees received regular updates.

The Governing Body also seeks assurance of the effectiveness of its Committees through an annual review of effectiveness of each committee and an annual report covering all its Committees (see section 9.3.4).

Audit Committee

Audit Committee is responsible for providing an independent overview of the arrangements for risk management within the organisation, with specific responsibilities for financial risk management. The Committee submits it minutes to the Governing Body from all of its meetings. It undertakes its own self-assessment of its effectiveness and reviews Internal and External Audits, the Governing Body Assurance Framework and financial governance reports. The Committee produces an annual report which forms part of the Annual Governance Statement.

The Audit Committee has received reports at each of the meetings regarding the development of a one system approach for the management of risk and is assured that processes are in place to manage risk effectively throughout this time of transition to a North Yorkshire CCG.

Joint Quality and Clinical Governance Committee

As the Committee with overarching responsibility for clinical risk management, it provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. The Quality and Clinical Governance Committee also covers areas including safeguarding, infection control, quality in contracts, incidents and medicines management. The Committee provides a bi-monthly report to the Governing Body of key outcomes from all of its meetings. The Committee undertakes its own annual self-assessment of its effectiveness and produces an annual report which forms part of the Annual Governance Statement.

The Joint Quality and Clinical Governance Committee receive quarterly reports which details any significant risks aligned to it.

Joint Finance, Performance, Contracting and Commissioning Committee

This Committee reviews financial performance and delivery of the CCG's QIPP programme. It is also responsible for providing the Governing Body with greater clarity and more information about the CCG's financial performance and helps shape its financial strategy. The main services commissioned by the CCG are reviewed by this Committee which also receives commissioning proposals and business cases. The Committee provides a bi-monthly report to the Governing Body of key outcomes from all of its meetings. The Committee undertakes its own annual self-assessment of its effectiveness and produces an annual report which forms part of the Annual Governance Statement.

The Finance, Performance and Commissioning Committee receive quarterly reports which details any significant risks aligned to it.

Joint Business Executive Committee

This Committee delivers transformation programmes including: Integration, Primary Care Networks, Population Health Management, QIPP Schemes, resulting in financial sustainability whilst improving patient experience and outcomes. The Committee interprets the North Yorkshire strategy and develop operational plans to deliver the vision. The Committee monitors QIPP programmes and transformation plans that seek long term solutions to financial challenges across care systems. The Committee provides a bi-monthly report to the Governing Body of key outcomes from all of its meetings. The Committee undertakes its own annual self-assessment of its effectiveness and produces an annual report which forms part of the Annual Governance Statement.

The Joint Business Executive Committee receives quarterly reports which details any significant risks aligned to it.

Primary Care Commissioning Committee

This Committee provides assurance on the delegated arrangements from NHS England for primary care commissioning. The Committee members make collective decisions on the review, planning and procurement of primary care services under delegated authority from NHS England. The Committee focuses on quality, efficiency, sustainability, productivity and new models of primary care. The Committee submits minutes to the Governing Body from all of its meetings. The Committee undertakes its own annual self-assessment of its effectiveness and produces an annual report which forms part of the Annual Governance Statement.

The Primary Care Commissioning Committee receives reports throughout 2019/20 which detailed any significant risks aligned to it.

Corporate Risk Review Group

The Corporate Risk Review Group is accountable to the Senior Management Team and is chaired by the Director of Quality/Governance. The CRRG is responsible for ensuring that the Corporate Risk Register and Directorate Risk Register are regularly reviewed and updated by risk owners. The group provides a level of scrutiny and challenge to the process of identifying and measuring risk, culminating in a cycle of continuous monitoring and review.

The Corporate Risk Review Group meets on a monthly basis to review the risk registers.

Chief Officer

As Accountable Officer for NHS Harrogate and Rural District CCG, the Chief Officer is responsible for achieving the organisational objectives in the context of sound and appropriate business processes and reporting risks to the Governing Body.

Chief Finance Officer

As Senior Responsible Officer for NHS finances across the North Yorkshire CCGs, the Chief Finance Officer is responsible for ensuring that the organisation complies with the Standing Financial Instructions to achieve financial balance and reports financial risks to the Governing Body. The Chief Finance Officer is the SIRO for the organisation.

Chief Nurse

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a Registered Nurse on the Governing Body, this person brings a broader view, from their perspective as a Registered Nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care. The Executive Nurse is the Caldicott Guardian for the organisation.

Other Directors / Heads of Department

Other Directors and Heads of Department are responsible for ensuring that risks have been properly identified and assessed across all their work areas, paying particular attention to cross-cutting risks. They are responsible for agreeing the Risk Register entries for their work areas and for ensuring that they are actively addressing the risks in their area and escalating risks to the Corporate Risk Review Group, where risks are reviewed.

Employees

All staff are expected to follow the risk management arrangements set out in the Risk Management Strategy.

Any risks identified by individuals are managed by the 'risk owner' who identified the risk. The 'risk owner' will discuss the risk with the Directorate Lead and Governance Lead before adding the risk to the Directorate Risk Register and if the risk is scored 12 or above the risk will be escalated through the appropriate channels.

9.4.2 Risk Assessment

The CCG's risk identification involves examining all sources of risk, both internally and externally and though a variety of sources.

The Governing Body Assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise achievement of its strategic objectives and to map out key control that should be in place to manage those risks effectively.

All significant risks that have an impact of the CCG's strategic objectives are managed through the Governing Body Assurance Framework and for 2019/20 are detailed below:

- Operational challenges including capacity issues in services commissioned by the CCG and provided in the community may impact on the timeliness of assessment, quality of services and support for vulnerable people in their own home.
- The scale of QIPP required to support delivery of the Financial Recovery Plan could impact on capacity and opportunity to develop and implement achievable service change.
- The CCG financial plan will not be delivered resulting in deterioration in the in-year financial position.
- Slippage in the delivery of the CCGs recovery plan resulting in the deterioration of the CCGs longer term financial sustainability.
- Strategic planning of partner organisations could impact on the opportunities and pace needed to transform the way services are commissioned for the local population and therefore may not fully align with the principles of a strategic system plan.

- The expectation of the public, patients or other stakeholders could impact on the CCGs strategy to improve health and wellbeing, promote and implement co-production and develop the shift in culture that would support more effective self-care and self-management.

All identified risks have key controls, how assurance will be given, gaps in assurance, action plans to address gaps and detail the risk leads. All risks are also aligned to a Committee and reports are received quarterly detailing changes in scoring.

In 2019/20 the Governing Body Assurance Frameworks across the three North Yorkshire CCGs were under review in preparation of the establishment of the new North Yorkshire CCG. The Audit Committee has been assured by the Director of Corporate Services, Governance and Performance that processes are in place to develop the GBAF and it is expected that risks will be aligned to the new GBAF and new Strategic Objectives at the first quarterly report in May 2020.

During 2019/20 the CCG has maintained sound risk management and internal control systems as described in the risk management section of this statement.

In April 2020, Internal Audit completed an audit of the CCG's risk management and governance arrangements and provided an opinion of significant assurance.

Covid-19 Risks

At the end of 2020, the CCG developed a Covid-19 risk register to manage risks related to the pandemic. The CCG established a robust process to manage risks through:

- Developing a risk register that ensures all risks had a designated Executive Risk Owner and a Risk Lead and all risks are being mitigated effectively.
- A weekly Covid Risk Register Group led by the Director of Corporate Services, Governance and Performance and managed by the Senior Governance Manager, to review and to provide a level of peer to peer review and support.
- A bi-monthly Quality and Clinical Governance Committee (QCGC) to provide overview and scrutiny of significant risks and non-significant by exception. Other Sources of Assurance.
- Reporting all significant risks through to the Governing Body and developing a heat map to provide a quantitative analysis of those risks.

Risk relating to Covid-19 will continue to be monitored as above until a business as usual plan is implemented and integrated into the risk management processes.

9.5 Other Sources of Assurance

9.5.1 Internal Control Framework

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

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

The CCG has a number of internal control measures in place monitored by the Governing Body and Audit Committee, these include: the risk management strategy, scheme of reservation and delegation, operational scheme of delegation, physical controls, management controls, security controls, accounting controls, policies, and mandatory training.

In addition the Governing Body Assurance Framework (GBAF) is the key document which provides an overview of the controls and assurances in place to ensure that the CCG is able to achieve its strategic objectives and manage the principle risks identified.

The governance structure within the CCG provides the control mechanism through which monitoring and mitigation of risks are managed and escalated to the Governing Body (as described in the previous section).

Each Committee produces an annual report which provides the Governing Body with a summary of the work done and in particular how Committees have discharged their responsibilities in supporting the CCG's Annual Governance Statement and Assurance Framework.

9.5.2 Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016 and revised in June 2017) 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 has carried out their annual internal audit of conflicts of interest which confirmed that the CCG has put in place arrangements to manage conflicts of interest that comply with the statutory guidance issued by NHS England in June 2017. The CCG can demonstrate a positive approach and culture towards the management of conflicts of interest.

The audit has not identified any areas on non-compliance or partial compliance that the CCG should declare in its Annual Governance Statement.

Internal Audit offered an opinion of High Assurance that the CCG has in place arrangements to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on managing conflicts of interest for CCGs.

9.5.3 Data Quality

The Governing Body and its committees receive monthly performance and quality reports which contain a significant range of data which officers ensure is the most up to date available and from reliable sources such contract data sets, nationally published data etc.

The Governing Body as part of the monthly discussions on all reports seek assurance on the accuracy and timeliness of the data and have found it acceptable.

9.5.4 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.

The CCG places 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 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, involving breaches of confidentiality and Data Protection Legislation.

The Clinical Commissioning Group completed the Information Governance Toolkit. In seeking further assurance of the quality of evidence provided, Internal Audit carried out an assessment of the evidence supporting the Information Governance Toolkit return and provided significant assurance in respect of this return.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG's Chief Finance Officer is the Senior Information Risk Owner (SIRO) and the Chief Nurse is the Caldicott Guardian. The CCG has an Information Governance Steering Group that reports to the Audit Committee and addresses information governance matters for the CCG.

EMBED was the CCG's main business intelligence provider in 2019/20.

Other primary data sources such as human resources information and financial data are managed via national systems.

9.5.5 Business Critical Models

In the Macpherson report 'Review of Quality Assurance of Government Analytical Models', published in March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance framework is in place and is used for all business critical models. Business critical models were deemed to be analytical models that informed government policy. The CCG can confirm that in 2019/20 it has not developed any analytical models which have informed government policy.

9.5.6 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 payroll services from 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 eMBED. Assurance is gained through regular contract monitoring and review meetings where outstanding issues are raised and resolved and future improvements are discussed and agreed.

9.6 Control Issues

In the Month 9 Governance Statement return, the CCG reported that for 2019/20 that it will meet its financial statutory duty. The position has been reported throughout the year to our regulator NHS England, our Council of Members, our Governing Body and various internal committees. As previously described, the CCG continues to demonstrate strong leadership and is has received an internal audit opinion of significant assurance on its Financial Governance and Reporting.

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

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance.

The CCG closely monitors budgetary control and expenditure. The annual budget setting process for 2019/20 was approved by the Governing Body and was communicated to all budget holders within the CCG. The Governing Body receives a Finance and Contract Report from the Chief Finance Officer at every Governing Body meeting. The Chief Finance Officer is the SIRO and a member of the Governing Body and is responsible for supervising the financial and control systems.

The Audit Committee will have the opportunity to scrutinise in detail the CCG's financial statements for 2019/20 at its meeting in May 2020, together with the report from external audit, before these are presented to Governing Body. The CCG has received an internal audit report giving significant assurance on the controls in place for ensuring good governance of its financial systems.

The Audit Committee, which is accountable to the Governing Body, provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with the laws, regulations and directions governing NHS bodies. The CCG develops its control framework based on the opinion and recommendation of Internal Audit and External Audit during the year and ensures that controls operate effectively and continuously identify areas for improvement. Audit action plans are monitored and implementation reviewed by the Directors and reported to the Audit Committee. Internal Audit plans, approved by the Audit Committee at the outset of the year, are linked to the CCG's governing body assurance framework with a particular focus on financial and corporate governance.

The Governing Body receives regular reports from the Audit Committee and Joint Finance, Performance, Contracting and Commissioning Committee. The Governing Body forward plan and agenda provides an opportunity for the Chair of each Committee to report at each meeting and raise any matters of concern.

The CCG recently undertook a self-assessment against the NHS England Quality of Leadership indicator for 2019/20 and submitted a rating of 'green to NHS England.

9.7.1 Delegation of Functions

The Governing Body has approved delegation of powers through the Scheme of Reservation and Delegation and terms of reference for committees.

As described above the Governing Body monitors this through regular reports from the CCG's Officers and its committees. These reports cover use of resources and responses to risk.

As previously described, processes are in place which includes risk assessment, management and monitoring in relation to collaborative commissioning. This is part of the overall framework of risk management of the CCG. In addition, where delegated arrangements are in place these are supported by:

- Governing Body Assurance Framework
- Corporate Risk Register and Directorate Risk Register
- Corporate Risk Review Group, accountable to Senior Management Team
- Memoranda of Understanding
- Joint Committee Reports to Council of Members
- Monthly reporting through Committees of the Governing Body
- Monthly reporting through management board arrangements

In the context of commissioning support services, services are supported by robust service specifications and formal contract management arrangements.

9.7.2 Counter Fraud Arrangements

The CCGs have a team of accredited Counter Fraud Specialists (LCFS) that are contracted to undertake counter fraud work proportionate to identified risks. In January 2020, NHS Counter Fraud Authority issued Standards for commissioners – fraud, bribery and corruption to LCFSs and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. The work plans for 2019/20 followed the format of the previous iteration of the standards and described the tasks and outcomes that informed anti-fraud activity during 2019/20.

The standards are as follows:

- **Strategic governance** – this sets out the requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-crime measures are embedded at all levels across the organisation.
- **Inform and Involve** – this sets out the requirements in relation to raising awareness of crime risks against the NHS, and working with NHS staff and the public to publicise the risks and effects of crime against the NHS.
- **Prevent and Deter** – this sets out the requirements in relation to discouraging individuals who may be tempted to commit crime against the NHS and ensuring that opportunities for crime to occur are minimised.

- **Hold to Account** – this sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes, and seeking redress.

The Chief Finance Officer for each CCG is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

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

The CCGs' Audit Committees – and more recently – Audit Committees in Common review and approves an annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report for each CCG and regular progress reports for the review and consideration of the Chief Finance Officer and Audit Committees.

The Counter Fraud Team also completes an annual self-assessment of compliance against the NHS Counter Fraud Authority Standards for commissioners: fraud, bribery and corruption, which is reviewed and approved by the Chief Finance Officer and – from April 2019 – the Audit Committees' Chairs prior to submission to NHS Counter Fraud Authority. The 2019/20 assessments were completed and submitted in April 2020 with an overall assessment of green.

9.8 Head of Internal Audit Opinion

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

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP FOR THE YEAR ENDED 31 MARCH 2020

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 (AGS) is an annual statement by the Accounting Officer, on behalf of the Governing Body, setting out:

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

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

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting 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 in turn assist the Governing Body in the completion of its AGS.

My opinion is set out as follows:

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

My **overall opinion** is that

- **Significant assurance is given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.**

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

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

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

Unless explicitly detailed third party assurances have not been relied upon.

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

The design and operation of the Assurance Framework and associated processes

An audit of the risk management framework was conducted in 2019/20 for which Significant Assurance opinion was awarded.

HaRD CCG has good processes in place to support risk management especially during this transitional year when all Risk Registers and GBAF's are being merged into one, ready for the creation of the new North Yorkshire CCG from 1st April 2020. To support this transition HaRD's Risk Management Strategy has been used to inform the Risk Management processes across the three North Yorkshire CCGs during 2019/20. This Strategy had been awarded High assurance in a previous audit report for its comprehensiveness and dynamic approach to risk management.

During this transition year, all committees have been operating using a "Joint Committee model". Our audit work confirmed that risk management arrangements have been contained within all Terms of Reference relating to all Joint Committees. Testing also identified that the Governing Body has sight of the key risks throughout Committee Reports and Papers, with discussion of key risks evident. The CCG's have combined their Corporate and Directorate Risk Registers with oversight by a newly formed Joint Corporate Risk Group.

The new Risk Management Strategy will be presented to the Governing Body on 25th June 2020 for approval whilst a new GBAF is currently being created and will be approved by the Governing Body in due course. Progress on this during 2019/20 has been hampered by Covid-19.

An audit on Conflicts of Interest was also completed during 2019/20 for which High Assurance opinion was awarded. Testing identified that HaRD CCG can demonstrate that effective arrangements are in place to manage conflicts of interest and that best

practice guidance from NHSE/I is being followed. In addition HaRD CCG is compliant with the NHSE Oversight Framework 2019/20 CCG Metrics Technical Annex.

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

Internal Audit work is planned using an Audit Needs Assessment (ANA). Such an assessment is undertaken every three years and generates a Strategic Audit Plan for those three years. The Audit committee approved the ANA and three year plan at the start of 2019/20. Annually the ANA is reviewed to provide an updated plan that takes into consideration the changing risk profile of the CCG. Both the three year plan and the annual plan are derived from a combination of the risks highlighted in the Assurance Framework and from a separate audit needs assessment undertaken in consultation with the Governing Body and the Audit Committee. This ensures that an audit plan is developed that is targeted towards the areas of greatest risk and allows Internal Audit to discharge its duties effectively.

Where variances from the plan have occurred these have been undertaken with the approval of the Chief Financial Officer and the Audit Committee. Whilst the impact of Covid-19 has resulted in some audits being deferred into 2020/21, no departures from the 2019/20 plan that are material for the purposes of this opinion have occurred.

Internal Audit reports are generated from the work highlighted in the plan. These reports are issued to Directors and to the Audit Committee. Progress in implementing agreed recommendations is reported to the Audit Committee by the CCG and internal audit undertakes an independent verification exercise to confirm their implementation.

Internal Audit reports carry one of four possible opinions. These give the recipient an indication of the level of assurance that can be taken that the processes of control within the area audited are adequate. The four opinions are “High Assurance”, “Significant Assurance”, “Limited Assurance” and “Low Assurance”. A report containing either a “High” or “Significant” opinion would generally be seen as satisfactory.

The outcome of the audit reports from the 2019/20 audit plan are summarised below, which confirms the final position for all audits planned in the year.

Audit Area	Assurance Level
QIPP Plans	Significant
QIPP Schemes	Significant
Risk Management	Significant

Audit Area	Assurance Level
Combined Governance Assurance	On hold – Covid 19
Business Continuity Planning	Significant
Equality & Diversity	Significant
Quality Strategy & Assurance Processes	Deferred to 2020/21 – due to change in priorities with the merger of NY CCG.
Primary Care Commissioning	Substantial
Contract Management	Significant
Handling Complaints	Significant
Hosted Services	High
Contract Management (HaRD CCG and HDFT)	Significant
Budgetary Control and Key Financial Systems	Significant
Budgetary Management Processes	On hold – Covid 19
Recovery Plan	HIgh
Conflicts of Interest	High
CQUIN	Deferred to 2020/21 – due to change in priorities with the merger of NY CCG.
Data Security & Protection Toolkit	Significant

Limited Assurance Opinion Reports 2019/20

Attention is drawn to the fact that NO final reports have been issued in 2019/20 with a “limited assurance” opinion.

Prior Year Limited Assurance Reports

During 2018/19 two audit reports were awarded a limited assurance opinion, one related to Data Cleansing within the Continuing Heathcare System, whilst the other related to numerous risks present within the Continuing Heathcare System as a whole. These risks, as described in the previous year’s Head of Audit Opinion, were as follows:

- Information held on the QA system may contain data that breaches the new GDPR requirements;

- Business Continuity risk as only 1 member of staff currently has a full working knowledge of the QA system. Pressure points are therefore felt when she is on leave and work is not addressed until her return. Internal Audit therefore has concerns on the ability of the service to continue whilst maintaining the integrity of the information held with the QA system during these absences;
- The absence of risk and control entries contained within the Risk Register even though all audit reports to date have provided limited assurance on the control environment in place;
- The QA system and SystmOne are not reconciled, which could open the CHC system up to fraudulent entries;
- Lack of Segregation for one member of staff who is able to add, delete and amend budgets and care home providers whilst also approving payments.

During 2019/20 follow up work has been undertaken on both of these reports and we are now satisfied that:

- The introduction of the new iQA system resulted in data being cleansed before it was transferred across to the new module. Using IDEA (an audit data interrogation tool) during our follow up work identified no data cleansing issues were present and that data did not breach GDPR requirements;
- Additional resource is now in place to support the use of the QA system during absences;
- CHC issues are now considered within Operational and Corporate Risk Registers and are being managed via the Joint Finance, Performance, Contracting & Commissioning Committee;
- Reconciliation checks between SystmOne and QA are being undertaken as well as reconciliations between budget and expenditure extracts from QA;
- The access rights of this individual have been reconsidered and amended to ensure adequate Segregation of Duties exists within the System.

We are therefore satisfied that the risks contained within the two original 2018/19 limited assurance audit reports are now being controlled.

Looking Ahead

We have managed to complete the majority of the 2019/20 Internal Audit Plan and are able to provide an opinion on that basis. In the main, this work was completed prior to Covid-19 beginning to impact. It is however, important to make reference to Covid-19 in your final formal Opinion.

NHS Organisations have had to move quickly to put measures in place to enable them to respond to Covid-19 and we fully appreciate that staff who we would usually engage with for planned work have been focused on service delivery, and our focus in this respect has been on supporting this response in any way we can.

NHS organisations are facing unprecedented levels of risk as a result of COVID-19 and many business critical controls are under massive pressure as the response to the coronavirus (COVID-19) emergency situation requires NHS organisations to operate differently to normal business.

Audit Yorkshire has provided support including offering staff for re-deployment and has issued a number of publications as well as sharing and incorporating NHSE/I guidance, NHS Counter Fraud Authority and HFMA briefings. We also developed and shared a document on Governance in the context of COVID-19 to support our Members and Clients in reviewing their governance arrangements in this time of national emergency. The document provides an easy to consider checklist of key guidance that has been issued in recent weeks and allows for self-assessment in considering key risks presented by COVID-19, helping to highlight those areas being managed well or not so well. We intend to follow up on the results of this assessment early in 2020/21.

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
June 2020

9.9 Review of the Effectiveness of Governance, Risk Management and Internal Control

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

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

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

- The Governing Body
- The Audit Committee
- Primary Care Commissioning Committee
- The Joint Quality and Clinical Governance Committee
- Joint Finance, Performance, Contracting and Commissioning Committee
- Executive Directors Meetings
- Corporate Risk Review Group
- Internal Audit and External Audit

This report describes in detail the CCG's approach to its governance structure, risk management and the systems of internal control.

- The Governing Body and Audit Committee have provided regular feedback on the completeness and effectiveness of the systems of internal control though the reports.
- Internal controls are subject to review and have been included in the Internal Audit Plan for 2019/20.
- The terms of reference for each Committee have been reviewed and refreshed during 2019/20.
- The Constitution has been reviewed and refreshed in 2019/20 to ensure governance arrangements are both compliant with the latest recommendations and are effective.
- The Governing Body have attended development sessions throughout the year and are committed to an early review of effectiveness following the establishment of the new North Yorkshire CCG on 1 April 2020.
- All Committees have carried out self-assessments of their effectiveness. Action plans have been produced if required and will be monitored throughout 2020/21.
- All Committees produced an annual report for 2019/20. The annual report was approved by the Committees and form part of the Annual Governance Statement.

- The Governing Body and all Committees have an annual forward plan based on the CCG's work plan and the Scheme of Reservation and Delegation.
- The Governing Body and Primary Care Commissioning Committee met regularly in public in line with statutory requirements.

Conclusion

I am assured, by the detail in this Annual Governance Statement and by the Head of Internal Audit statement, that in 2019/20 the CCG has operated within a robust system of internal control and no significant internal control issues have been identified.

Amanda Bloor
Accountable Officer
June 2020

Harrogate and Rural District Clinical Commissioning Group

Remuneration and Staff Report

10 Remuneration and Staff Report

10.1 Remuneration Committee

Details of the Remuneration Committee and activity is available in section 9.3.2.

10.2 Policy on the Remuneration of Senior Managers

Very Senior Managers' pay rates are set taking into account guidance received from NHS England. Other senior managers are paid in accordance with Agenda for Change Terms and Conditions of service.

10.2.1 Senior Managers Performance Related Pay (not subject to audit)

No performance related pay was paid to any senior manager of the CCG in 2019/20.

10.2.2 Senior Managers Service Contracts (not subject to audit)

No senior managers for the CCG have been engaged under service contracts in 2019/20.

10.3 Policy on the Remuneration of Very Senior Managers 2019/20

The CCG has continued to set pay rates for its Very Senior Managers' taking into account guidance received from NHS England. Other senior managers are paid in accordance with Agenda for Change Terms and Conditions of service.

The CCG will continue to follow appropriate guidance on setting remuneration levels for Very Senior Managers and will take into account the prevailing financial position of the wider NHS and the need for pay restraint. Performance of Very Senior Managers will be monitored in line with the organisation's objective setting and appraisals processes.

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

10.4 Senior Manager Remuneration 2019/20 (subject to audit)

2019-20 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Dr A Ingram Clinical Chair/GP	50-55	0	0	0	0	50-55
Mrs S Powell Vice Chair	10-15	0	0	0	0	10-15
Mrs A Bloor Chief Officer (see note a)	55-60	0	0	0	57.5-60.0	110-115
Mrs D Gamble Chief Finance Officer 1/4/19 - 30/6/19	20-25	0	0	0	5.0-7.5	30-35
Mr I Dobinson Chief Finance Officer 1/7/19 - 31/10/19 (see note b)	10-15	0	0	0	0	10-15
Mrs J Hawkard Chief Finance Officer 1/11/19 - 31/3/20 (see note c)	20-25	0	0	0	35.0-37.5	55-60
Mrs W Balmain Director of Strategy and Integration 1/4/19-30/4/19 1/5/19-31/3/20 (see note d)	 5-10 40-45	 0 0	 0 0	 0 0	 2.5-5.0 10.0-12.5	 10-15 50-55
Mr S Cox Director of Acute Commissioning (see note e)	45-50	0	0	0	15.0-17.7	60-65
Mrs J Crewe Director of Quality and Governance/ Executive Nurse 1/4/19-7/8/19	30-35	0	0	0	25.0-27.5	55-60

2019-20 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000)** **£000**	**(b) Expense payments (taxable) to nearest £100** **£00**	**(c) Performance pay and bonuses (bands of £5,000)** **£000**	**(d) Long-term performance pay and bonuses (bands of £5,000)** **£000**	**(e) All pension related benefits (bands of £2,500)** **£000**	**(f) Total (bands of £5,000)** **£000**
Mrs S Peckitt Chief Nurse 28/6/19-31/3/20 (see note f)	25-30	0	0	0	50.0-52.5	75-80
Mrs J Warren Director of Governance and Performance 15/7/19-31/3/20 (see note g)	25-30	0	0	0	0	25-30
Dr S Hay GP	55-60	0	0	0	55.0-57.5	110-115
Dr B Willoughby GP	85-90	0	0	0	40.0-42.5	130-135
Mr L Gilroy Lay Member	5-10	0	0	0	0	5-10
Mrs K Kennady Lay Member	5-10	0	0	0	0	5-10
Dr I Woods Secondary Care Doctor	15-20	0	0	0	0	15-20

Notes

Several of the following notes make reference to post-holders working across the 3 North Yorkshire CCGs. These individual organisations are:

- NHS Harrogate and Rural District CCG
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Scarborough and Ryedale CCG

The figures disclosed the in table above for this period represent NHS Harrogate and Rural District CCG's proportional share of the total cost.

a) Mrs A Bloor was Chief Officer for the 3 North Yorkshire CCGs: In total Mrs Bloor's salary falls within the bands of £145,000 to £150,000 and her pension related benefits fall within the bands of £152,500 to £155,000.

b) Mr I Dobinson was Chief Finance Officer for the 3 North Yorkshire CCGs between 1st July 2019 and 31st October 2019. For this period, in total, Mr Dobinson's salary falls within the bands of £30,000 to £35,000. Mr Dobinson did not contribute towards a pension.

c) Mrs J Hawkard was Chief Finance Officer for the 3 North Yorkshire CCGs from the 1st November 2019. For this period, in total, Mrs Hawkard's salary falls within the bands of £50,000 to £55,000 and her pension related benefits fall within the bands of £95,000 to £97,500.

d) Mrs W Balmain was employed solely by NHS Harrogate and Rural District CCG until the 30th April 2019, and then was Director of Strategy and Transformation for the 3 North Yorkshire CCGs. For this period, in total, Mrs Balmain's salary falls within the bands of £105,000 to £110,000 and her pension related benefits fall within the bands of £30,000 to £32,500.

e) Mr S Cox was Director of Acute Commissioning for the 3 North Yorkshire CCGs. In total Mr Cox's salary falls within the bands of £115,000 to £120,000 and his pension related benefits fall within the bands of £40,000 to £42,500.

f) Mrs S Peckitt was Chief Nurse for the 3 North Yorkshire CCGs from the 28th June 2019. For this period, in total, Mrs Peckitt's salary falls within the bands of £70,000 to £75,000 and her pension related benefits fall within the bands of £132,500 to £135,000.

g) Mrs J Warren was Director of Governance and Performance for the 3 North Yorkshire CCGs from the 15th July 2019. For this period, in total, Mrs Warren's salary falls within the bands of £70,000 to £75,000 and her pension related benefits are nil.

10.5 Senior Manager Remuneration 2018/19 (subject to audit)

2018-19 Salaries and Allowances						
Name and Title	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long-term performance pay and bonuses (bands of £5,000)**	**All pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
Dr A Ingram Clinical Chair/GP	50-55	0	0	0	0	50-55
Mrs S Powell Vice Chair	10-15	0	0	0	0	10-15
Mrs A Bloor Chief Officer 1/4/18-30/11/18 1/12/18-31/3/19 (see note a)	 80-85 15-20	 0 0	 0 0	 0 0	 72.5-75.0 12.5-15.0	 165-170 30-35
Mrs D Gamble Chief Finance Officer	95-100	0	0	0	35.0-37.5	120-125

2018-19 Salaries and Allowances						
Name and Title	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) to nearest £100** **£00**	**Performance pay and bonuses (bands of £5,000)** **£000**	**Long-term performance pay and bonuses (bands of £5,000)** **£000**	**All pension related benefits (bands of £2,500)** **£000**	**Total (bands of £5,000)** **£000**
Mrs W Balmain Director of Transformation and Delivery	90-95	0	0	0	32.5-35.0	245-250
Mrs J Crewe: Director of Quality and Governance/ Executive Nurse	85-90	0	0	0	35.0-37.5	150-155
Dr S Hay GP	55-60	0	0	0	102.5-105.0	70-75
Dr R Sweeney GP (see note b)	25-30	0	0	0	0	25-30
Dr A O'Donoghue GP (see note c)	0	0	0	0	0	0
Dr B Willoughby GP	80-85	0	0	0	42.5-45.0	115-120
Mr L Gilroy Lay Member	5-10	0	0	0	0	5-10
Mrs K Kennady Lay Member	5-10	0	0	0	0	5-10
Dr I Woods Secondary Care Doctor	15-20	0	0	0	0	15-20

Notes

a) Mrs A Bloor was Chief Officer only for NHS Harrogate and Rural District CCG to the 30th November 2018. The figures disclosed in the table above for this period are in full. From the 1st December Mrs Bloor was appointed Chief Officer for the 3 North Yorkshire CCGs, namely:

- NHS Harrogate and Rural District CCG
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Scarborough and Ryedale CCG

The figures disclosed the in table above for this period represent NHS Harrogate and Rural District CCG's proportional share of the total cost.

For this period, Mrs Bloor's total salary falls with the bands of £45,000 to £50,000 and her pension related benefits fall within the bands of £42,500 to £50,000.

b) Dr R Sweeney left the CCG on the 1st October 2018.

c) Dr A O'Donoghue left the CCG on the 26th August 2018.

10.6 2019/20 Pension Benefits (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2019 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2020 £000	(h) Employers Contribution to partnership pension £000
Mrs A Bloor Chief Officer	5.0-7.5	10.0-12.5	55-60	130-135	933	122	1,099	0
Mrs D Gamble Chief Finance Officer	0.0-2.5	(0.0-2.5)	25-30	55-60	479	(7)	515	0
Mrs J Hawkard Chief Finance Officer	0.0-2.5	0.0-2.5	40-45	95-100	748	26	848	0
Mrs W Balmain Director of Strategy and Integration	0.0-2.5	0.0-2.5	15-20	35-40	346	22	392	0
Mrs J Crewe Executive Nurse	0.0-2.5	0.0-2.5	30-35	75-80	609	4	649	0
Mrs J Warren Director of Governance and Performance	(0.0-2.5)	(7.5-10.0)	35-40	80-85	713	(35)	698	0
Mrs S Peckitt Chief Nurse	2.5-5.0	12.5-15.0	35-40	110-115	653	106	823	0
Mr S Cox Director of Acute Commissioning	2.5-5.0	0.0-2.5	45-50	60-65	669	38	740	0
Dr S Hay	0.0-2.5	2.5-5.0	35-40	75-80	563	38	624	0

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2019 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2020 £000	(h) Employers Contribution to partnership pension £000
GP								
Dr B Willoughby GP	0.0-2.5	(0.0-2.5)	40-45	95-100	686	24	739	0

Further Pension Declaration Notes

a) Certain staff members of the CCG do not receive pensionable remuneration therefore there are no entries in respect of pensions noted above. For this CCG it applies to the posts of Vice Chair, Secondary Care Doctor and Lay Members.

b) Dr Ingram no longer contributes into the NHS pension scheme.

c) Mr Dobinson did not take up the option of contributing into a pension scheme

d) Whilst several Officers and Directors were appointed and working across 3 CCGs (as noted above), the figures reflected in the pensions table account for their pension benefits in full.

e) The above pension disclosure figures for General Practitioners relates only for their employment at the CCG (as advised by NHS Pensions). It does not portray to represent the overall NHS pension contributions and accrued benefits for the individuals from other positions held in other organisations which come under the collective umbrella of the NHS.

10.7 Cash Equivalent Transfer Values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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.

Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgement.

The method used to calculate CETVs has changed to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If an individual was entitled to a GMP, this will affect the calculation of the real increase in CETV which has been reported. This is more likely to affect individuals who are members of the 1995 Section and 2008 Section of the NHS Pension Scheme.

10.7.1 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 pension scheme or arrangement).

10.8 Compensation on Early Retirement or for Loss of Office (subject to audit)

No payments have been made to any senior managers of the CCG for loss of office in 2019/20.

10.9 Payments to Past Members (subject to audit)

No payments have been made to any past senior managers of the CCG in 2019/20.

10.10 Pay Multiples (subject to audit)

Reporting Bodies are required to disclose the relationship between the remuneration of the highest paid director/member (based on comparing full time equivalent remuneration regardless of the actual hours worked at the CCG) in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director/member of the Governing Body in the clinical commissioning group in the financial year 2019-20 was £175,000 - £180,000 (2018-19 was £175,000-£180,000). This was 4.05 times (2018-19 4.2 times) the median remuneration of the workforce, which was £43,772 (£42,823 in 2018-19).

In 2019-20, no (2018-19, nil) employees received remuneration in excess of the highest-paid director/member of the governing body.

Remuneration ranged from £21,089 to £177,286 (2018-19, £18,038-£178,952).

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 calculation is also based on the annual full time equivalent remuneration for all employees of the clinical commissioning group regardless of starter and leaver status throughout the year. The median remuneration rose slightly from £42,823 to £43,772 between 2018-19 and 2019-20. This increase of 2.2% falls within the NHS pay award for 2019-20 for staff employed on Agenda for Change terms and conditions of 1.7% with an additional 1.1% lump sum in April 2019 for those staff who have reached the top of their pay-scale. The highest paid director/member of the Governing Body was not employed on Agenda for Change terms and conditions and therefore their pay did not increase in 2019-20, remaining static at the 2018-19 rates.

11 CCG Staff Information

11.1 Number of Senior Managers (subject to audit)

Pay Band (annual salary range)	Number	Pay Band (annual salary range)	Number
GP pay-scale	4	Band 8c (£61,777 - £72,597)	3
VSM (£95,000 - £150,000)	5	Band 8b (£52,306 - £60,983)	3
Band 9 (£89,537 - £103,860)		Band 8a (£44,606 - £50,819)	
Band 8d (£73,936 - £86,687)	1		

At the end of the financial year, the number of senior managers by pay band can be broken down as follows in the table above.

Please note that the annual salary information declared in this table is per whole time equivalent. Where staff work less than full time hours they have been included in the table at a rate relevant to working full time.

Please also note that only 8 members of the governing body are included as senior managers. The other 4 posts are lay members or independent members.

11.2 Staff Numbers and Costs (subject to audit)

On the 31 March 2020 the CCG employed 64 directly employed staff. This includes 1 independent secondary care consultant, 1 independent audit committee chair and 2 Governing Body lay members. This equates to 50.69 full-time equivalents of directly employed staff.

Since 1st January 2016 the CCG has been the host organisation for the regional medicines management team. Since 1st April 2017 the CCG has also been the host organisation for the regional adult mental health commissioning team. Since 1st April 2019 the CCG then became the host organisation for the regional human resources (HR) team. All of these teams are included in the staffing figures noted above as employees of the CCG but a proportion are subsequently recharged to other local CCGs according to the memorandum of understandings in place. On the 31st March 2020 there were 21 individuals employed within the medicines management team, of which 4.3 whole time equivalents relate to the work of this CCG. For the adult mental health commissioning team it was 3 employees, of which 0.75 whole time equivalents relate to the work of this CCG, and for the HR team it was 4 employees, of which 0.65 whole time equivalents relate to the work of this CCG.

The CCG also benefits from hosting arrangements undertaken by other local organisations. The most significant is the Partnership Commissioning Unit (PCU) which is hosted by NHS Scarborough and Ryedale CCG (SR CCG). SR CCG recharged this CCG for 16.15 whole time equivalents. Because these staff are not directly employed by this CCG they are not included in the staffing figures noted above.

Further staffing information, including the breakdown of staff between ‘permanently employed’ and ‘other’, please see the CCG’s statutory accounts note 4.

11.3 Staff Composition

At the end of the financial year, the number of people by sexual orientation employed at the CCG can be broken down as follows:

Staff Group	Male	Female	Transgender	Total
Governing Body	4	7	0	11
Council of Members (not employees of the CCG)	12	5	0	17
Other Senior Managers	4	4	0	8
All other staff	11	33	0	44

11.4 Sickness Absence Data

The CCG continues to apply the Policy for Management of Attendance and its systems and processes to record, monitor and manage absence with the support of the Workforce Team and Occupational Health.

The average level of absence for the last 12 months for employees of the CCG is 1.42%. This equates to approximately 261.38 Full Time Equivalent days lost. Absence continues to be proactively managed.

11.5 Staff Policies

The CCG has a suite of policies which provide guidance and processes on ensuring full and fair consideration is given for the application, employment and ongoing training and development of disabled persons and these include:

- Equality and Diversity Policy
- Learning and Development Policy
- Recruitment Policy

All the CCG's policies are published on the CCG website: https://www.northyorkshireccg.nhs.uk.

11.6 The Trade Union (Facility Time Publications Requirements)

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require organisations to declare certain information if they employ trade union representatives and employ more than 49 whole time equivalent staff. NHS Harrogate and Rural District CCG does not employ any trade union representatives, nor employs more than 49 whole time equivalent.

11.7 Other Employee Matters (not subject to audit)

11.7.1 Social Partnership Forum

Recognising the benefits of partnership working, the CCG is a member of the North Yorkshire, Humber and Leeds CCGs 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.

The CCG continues to use the Social Partnership Forum to approve policies as and when they are finalised by the CCG.

During 2018/19 The CCG, in conjunction with NHS Hambleton, Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG undertook a formal consultation to appoint a single Accountable Officer. A further consultation commenced to appoint a single executive leadership team across the three CCGs.

11.7.2 Obtaining Staff Opinions

As the CCG continued with its plan to merge with the two other North Yorkshire CCGs in 2019/20, two staff consultations were undertaken.

Consultation for the Proposed Appointments to a Shared Clinical Leads Structure – November 2019

A consultation was undertaken in November 2019 to appoint a shared clinical leads structure across NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG. This structure will transfer to the new North Yorkshire CCG from 1 April 2020.

Consultation on Restructure and Transfer of Staff to NHS North Yorkshire CCG – January 2020

In January 2020 the CCG consulted with staff on:

- The proposed transfer of staff from NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG to a single organisation that will be known as NHS North Yorkshire CCG, effective from 1 April 2020 in accordance with the legal transfer process of The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) and following the principles of the Cabinet Office 'Staff Transfers in the Public Sector' Statement of Practice (COSOP)/NHS Staff Transfer Scheme guidance.
- Appointments to a proposed single organisation structure for NHS North Yorkshire CCG and the proposed ways in which staff will be transitioned to them.

Staff Away Day

In November 2019, the CCG held a Staff Away Day for staff across the three CCGs to gain input from staff on the vision, values and behaviours they envisaged for the North Yorkshire CCG (established 1 April 2020) and to promote closer working relationships.

11.7.3 Disabled Employees

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

The CCG also supports staff and offers occupational health support and adjustments that may be required within the role in which they are employed. As an employer, the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. It actively works to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in recruitment, training, performance management and development practices.

11.8 Expenditure on Consultancy

During 2019-20 the clinical commissioning group spent £115,000 (£25,200 in 2018-19) on consultancy through 3 companies. This consultancy work was related to system sustainability, analytical review, and contract advice and guidance.

11.8.1 Expenditure on Agency Staff (not subject to audit)

During 2019-20 the clinical commissioning group spent £299,000 on agency staff (£185,000 in 2018-19). This was for 6 different posts, from 7 different agencies, covering a total of 208 weeks, at an average weekly cost of £1,438.

In addition to this, the CCG net accounts for the hosted PCU costs recharged to the CCG from NHS Scarborough and Ryedale CCG. This recharged included £225,000 relating to expenditure on agency staff (£121,000 in 2018-19).

11.9 Off-payroll Engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, clinical commissioning groups must publish information on their highly paid and/or senior off-payroll engagements.

The CCG had six off-payroll engagements during 2019/20 where it paid more than £245 per day and that lasted longer than six months. Details of these engagements are:

- In August 2016 the CCG engaged the services of a GP with a special interest in prescribing, as the CCG's lead for prescribing. This GP remained employed by their practice and invoiced the CCG accordingly for their time spent undertaking this role.
- In June 2017 a service manager was seconded to the CCG from the local NHS hospital to assist in delivery the care quality agenda. The service manager remained employed by the local NHS hospital and invoiced the CCG accordingly for their time spent undertaking this role. This secondment ended in October 2019.
- In March 2018 a project accountant was engaged by the CCG to work on several capital and revenue projects, both within the CCG and across the wider North Yorkshire programmes. This engagement ended in June 2019.
- In August 2018 a data analyst was engaged by the CCG to develop business intelligence reporting systems and embed data processing arrangements.
- In December 2018 a development manager was engaged by the CCG to strategically develop the Adult Mental Health Commissioning arrangements for North Yorkshire. This engagement ended in August 2019.
- In July 2019 a project manager was engaged by the CCG, on behalf of North Yorkshire and York CCGs, to actively progress the discharge of patients under the national directive of the Transforming Care Programme (TCP) for people with learning difficulties.

	Number
Number of existing engagements as of 31 March 2020	3
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	

	Number

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	2
Of Which:	
No. assessed as caught by IR35	-
No. assessed as not caught by IR35	2
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	-
No. of engagements reassessed for consistency / assurance purposes during the year.	-
No. of engagements that saw a change to IR35 status following the consistency review	-

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-
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	13

11.10 Exit Packages (subject to audit)

One employee of the CCG was made redundant in 2019/20 and received redundancy pay in line with NHS terms and conditions. Please note that the CCG’s statutory accounts (note 4.4) only disclose an exit payment of £54,333. This arises as the 3 North Yorkshire CCGs have made joint decisions in the development of a single management structure and therefore shared equally any costs incurred.

Please note that the CCG’s statutory accounts include a second exit package cost of £15,556. This does not arise from an employee of the CCG but again arises as the 3 North Yorkshire CCGs have made joint decisions in the development of a single management structure with costs incurred shared equally. This exit package relates to an employee of NHS Scarborough & Ryedale CCG.

12 Parliamentary Accountability and Audit Report (subject to audit)

NHS Harrogate and Rural District 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 starting at page 138. An audit certificate and report is also included in this Annual Report below.

13 Independent Auditor's Report to the Governing Body of NHS Harrogate and Rural District Clinical Commissioning Group

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Harrogate and Rural District Clinical Commissioning Group ('the CCG') for the year ended 31 March 2020, 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 Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, 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 2020 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 2019/20; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Conclusions relating to going concern

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; 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.

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 2020.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of the 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 review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the members of the Governing Body of NHS Harrogate and Rural District 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 Harrogate and Rural District CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Signature: 
Mark Kirkham (Jun 23, 2020 17:06 GMT+1)

Email: mark.kirkham@mazars.co.uk

Mark Kirkham, Partner

For and on behalf of Mazars LLP

5th Floor

3 Wellington Place

Leeds

LS1 4AP

23 June 2020

ANNUAL ACCOUNTS

Amanda Bloor

Accountable Officer

23 June 2020

NHS
Harrogate and Rural District
Clinical Commissioning Group

Financial Accounts
For the Year Ended
31 March 2020

NHS Harrogate & Rural District CCG - Annual Accounts 2019-20

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(1,211)	(912)
Other operating income	2	-	-
Total operating income		**(1,211)**	**(912)**
Staff costs	4	2,911	2,840
Purchase of goods and services	5	250,467	235,638
Depreciation and impairment charges	5	32	-
Provision expense	5	-	-
Other Operating Expenditure	5	112	94
Total operating expenditure		**253,522**	**238,572**
Net Operating Expenditure		**252,311**	**237,660**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**252,311**	**237,660**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**252,311**	**237,660**
Other Comprehensive Expenditure			
		-	**-**
Comprehensive Expenditure for the year		**252,311**	**237,660**

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Current assets:			
Trade and other receivables	10	2,025	1,556
Cash and cash equivalents	12	76	5
Total current assets		**2,101**	1,561
Total assets		**2,101**	1,561
Current liabilities			
Trade and other payables	13	(17,443)	(15,984)
Total current liabilities		**(17,443)**	(15,984)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(15,342)**	(14,423)
Assets less Liabilities		**(15,342)**	(14,423)
Financed by Taxpayers' Equity			
General fund		(15,342)	(14,423)
Total taxpayers' equity:		**(15,342)**	(14,423)

The notes on pages 22 to 23 form part of this statement

The financial statements on pages 3 to 6 were approved by the Audit Committee on 23rd June 2020 and signed on it's behalf by:

J Hawkard

Jane Hawkard
Chief Finance Officer
23rd June 2020

Amanda Bloor
Chief Accountable Officer
23rd June 2020

NHS Harrogate & Rural District CCG - Annual Accounts 2019-20

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	General Fund £'000	Total Reserves £'000
Changes in taxpayers' equity for 2019-20		
Balance at 01 April 2019	(14,423)	**(14,423)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(14,423)**	**(14,423)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20		
Net operating expenditure for the financial year	(252,311)	**(252,311)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(252,311)**	**(252,311)**
Net funding	251,392	**251,392**
Balance at 31 March 2020	**(15,342)**	**(15,342)**

	General Fund £'000	Total Reserves £'000
Changes in taxpayers' equity for 2018-19		
Balance at 01 April 2018	(13,497)	**(13,497)**
Transfer of assets and liabilities from closed NHS bodies	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(13,497)**	**(13,497)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Impact of applying IFRS 9 to Opening Balances	0	0
Impact of applying IFRS 15 to Opening Balances	0	0
Net operating costs for the financial year	(237,660)	(237,660)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(237,660)**	**(237,660)**
Net funding	236,734	236,734
Balance at 31 March 2019	**(14,423)**	**(14,423)**

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(252,311)	(237,660)
Depreciation and amortisation	5	32	0
(Increase)/decrease in trade & other receivables	10	(469)	(147)
Increase/(decrease) in trade & other payables	13	1,459	977
Increase/(decrease) in provisions	14	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(251,289)**	(236,830)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	9	(32)	0
Net Cash Inflow (Outflow) from Investing Activities		**(32)**	0
Net Cash Inflow (Outflow) before Financing		**(251,321)**	(236,830)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		251,392	236,734
Net Cash Inflow (Outflow) from Financing Activities		**251,392**	236,734
Net Increase (Decrease) in Cash & Cash Equivalents	12	**71**	(96)
Cash & Cash Equivalents at the Beginning of the Financial Year		**5**	101
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**76**	5

The notes on pages 19 to 22 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

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

1.2 **Accounting Convention**

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

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 and accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

· The assets the clinical commissioning group controls;
· The liabilities the clinical commissioning group incurs;
· The expenses the clinical commissioning group incurs; and,
· The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

· The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
· The clinical commissioning group’s share of any liabilities incurred jointly; and,
· The clinical commissioning group’s share of the expenses jointly incurred.

1.4.1 *Pooled Budgets - Better Care Fund*

On the 1st April 2015 NHS Harrogate & Rural District Clinical Commissioning Group entered into a Section 75 contractual arrangement, with North Yorkshire County Council as the host entity, for a pooled budget arrangement as part of the NHS 'Better Care Fund' national policy initiative. The following organisations are the other members of this pooled budget;

- NHS Airedale, Wharfedale & Craven Clinical Commissioning Group
- NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group
- NHS Scarborough & Ryedale Clinical Commissioning Group
- NHS Vale of York Clinical Commissioning Group
- North Yorkshire County Council

Consideration has been given as to whether IFRS 10 - Consolidated Financial Statements applies to this pooled budget arrangement, but has been deemed irrelevant as no individual organisation has sole control over the fund.

Consideration has been given as to whether IFRS 11 - Joint Arrangements applies to this pooled budget arrangement, and as a consequence it has been deemed a 'jointly controlled operation'. NHS Harrogate & Rural Clinical Commissioning Group has therefore applied the required disclosure in these accounts.

Consideration has been given as to whether IFRS 12 - Disclosure of Involvement with Other Entities applies to this pooled budget arrangement, and has been deemed relevant. NHS Harrogate & Rural Clinical Commissioning Group has therefore applied the required disclosure in these accounts.

1.4.2 *Pooled Budgets - Continuing Healthcare*

In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31st March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims. This annual contribution ceased on 31st March 2017.
The CCG was advised that HMRC had conducted a review of the CHC redress guidance, issued initially by the Department of Health and Social Care and more recently by NHS England, and has asserted that the indexation element of these redress payments constitutes yearly interest for income tax purposes. For this type of interest there is a requirement for the paying organisation (the CCG) to deduct 20% income tax before making the payment. HMRC intend to seek retrospective tax settlements from CCGs for tax amounts not deducted, starting with the tax year 2013/14.

NHS England have disputed this assessment on behalf of CCGs and have accounted for the potential liability up to and including March 2018. The CCG has accounted for the tax liability in 2019/20 and has paid over tax due to HMRC in respect of previously unassessed periods of care that have been settled during 2019/20.
The CCG has considered whether any post PUPoC claims would give rise to a liability in 2019/20 and has determined, using the NHS England methodology that any potential non PUPoC liability would be immaterial in nature.

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

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

1.5.1 *Critical Judgements in Applying Accounting Policies*

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

- Arrangements for obtaining the use of property have been the characteristics of operating leases under IAS17 and have been accounted for as such

1.5.2 *Key Sources of Estimation Uncertainty*

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

- The re-imbursement for dispensing drugs prescribed by general practitioners occurs two months in arrears. The NHS Prescription Services (part of NHS Business Services Authority) undertake the monitoring of activity and associated costs on behalf of all clinical commissioning groups. Based on the information they have provided, NHS Harrogate & Rural District Clinical Commissioning Group has made an informed calculation on accounting for a £4.278million accrual in these accounts.

- Continuing Care - An estimation has been included for patients currently awaiting a full assessment. Data is available regarding the number of patients currently awaiting a full assessment. Assumptions around the number of patients ultimately requiring a package and the anticipated price of such packages are derived from current information in the patient database, or from information provided by the clinical team where data is not available. This has been provided by NHS Scarborough and Ryedale CCG who host the service.

1.6 **Revenue**

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

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

1.7 **Employee Benefits**

1.7.1 *Short-term Employee Benefits*

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

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

1.7.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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.

1.8 **Other Expenses**

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

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 *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.

1.10.2 *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.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are 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.

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

1.10.3 *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.

1.10.4 *Depreciation, Amortisation & Impairments*

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

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

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

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

1.11 **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.

1.11.1 **The Clinical Commissioning Group as Lessee**

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.13 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.5% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.55% (2018-19: 1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.14 **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 clinical commissioning group.

1.15 **Non-clinical Risk Pooling**

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

1.16 **Climate Change Levy**

The Climate Change Levy is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

Please note that NHS Harrogate & Rural District Clinical Commissioning Group does not currently participate in such carbon reduction commitment schemes.

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 *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.

1.18.2 *Financial assets at fair value through other comprehensive income*

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.18.3 *Financial assets at fair value through profit and loss*

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.18.4 *Impairment*

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, 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, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
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 DHSC 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.

Please note that NHS Harrogate & Rural District Clinical Commissioning Group does not have any financial assets.

1.19 **Financial Liabilities**

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

1.19.1 *Financial Liabilities at Fair Value Through Profit and Loss*

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.2 *Other Financial Liabilities*

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

Please note that NHS Harrogate & Rural District Clinical Commissioning Group does not have any financial liabilities.

1.20 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

1.23.1 **Continuing Healthcare / Funded Nursing Care / Vulnerable People**
NHS Scarborough & Ryedale Clinical Commissioning Group host the clinical management and administration of continuing healthcare services, funded nursing care and vulnerable people services, on behalf of NHS Scarborough & Ryedale CCG, NHS Harrogate and Rural District CCG and NHS Hambleton Richmondshire & Whitby CCG. All payments relating to these services are transacted through NHS Scarborough & Ryedale CCG's ledger and expenditure is recharged to the other CCG parties on either an actual cost or a risk share basis. The staff employed by Scarborough & Ryedale Clinical Commissioning Group are apportioned between CCGs as follows:

NHS Harrogate & Rural District CCG - 43% (£650,097)
NHS Hambleton, Richmondshire & Whitby CCG - 37% (£573,160)
NHS Scarborough & Ryedale CCG - 14% (£214,317)
Vale of York CCG - 6% (£90,074)
Total - £1,527,648

1.23.2 **Adults & Children's Safeguarding:**
NHS Scarborough & Ryedale Clinical Commissioning Group host the regional children's safeguarding team on behalf of NHS Scarborough & Ryedale CCG, NHS East Riding of Yorkshire CCG, NHS Harrogate and Rural District CCG, NHS Hambleton Richmondshire & Whitby CCG and NHS Vale of York CCG. All payments relating to these services are transacted through NHS Scarborough & Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 22% (£142,514)
NHS Hambleton, Richmondshire & Whitby CCG - 19% (£122,211)
NHS Scarborough & Ryedale CCG - 16% (£106,246)
NHS Vale of York CCG - 43% (£288,420)
Total - £659,391

1.23.3 **Primary Care Safeguarding:**
NHS Scarborough & Ryedale Clinical Commissioning Group host the regional primary care safeguarding team on behalf of NHS Scarborough & Ryedale CCG, NHS East Riding of Yorkshire CCG, NHS Harrogate and Rural District CCG, NHS Hambleton Richmondshire & Whitby CCG and NHS Vale of York CCG. All payments relating to these services are transacted through NHS Scarborough & Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 21% (£27,073)
NHS Hambleton, Richmondshire & Whitby CCG - 18% (£23,863)
NHS Scarborough & Ryedale CCG - 15% (£19,960)
NHS Vale of York CCG - 46% (£59,736)
Total - £130,632

1.23.4 **Strategic Clinical Networks**
NHS Scarborough & Ryedale Clinical Commissioning Group host the regional strategic clinical networks team on behalf of NHS Scarborough & Ryedale CCG, NHS East Riding of Yorkshire CCG, NHS Harrogate and Rural District CCG, NHS Hambleton Richmondshire & Whitby CCG, NHS North Lincolnshire CCG and NHS Vale of York CCG. All payments relating to these services are transacted through NHS Scarborough & Ryedale CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 13% (£22,382)
NHS Hambleton, Richmondshire & Whitby CCG - 11% (£19,733)
NHS Scarborough & Ryedale CCG - 10% (£16,506)
NHS Vale of York CCG - 28% (£49,398)
NHS East Riding of Yorkshire CCG - 24% (£41,810)
NHS North Lincolnshire CCG - 14% (£24,629)
Total - £174,458

1.23.5 **Referral Support Service**
NHS Vale of York Clinical Commission Group host a referral support service (incorporating choose & book) on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through NHS Vale of York CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate and Rural District CCG 7% £40,248
NHS Hambleton, Richmondshire and Whitby CCG 7% £40,248
NHS Vale of York CCG 56% £333,261
NHS Scarborough and Ryedale CCG 30% £180,796
Total Cost - £594,553

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

NHS Airedale, Wharfedale & Craven CCG - 28% (£251,181)
NHS Harrogate & Rural District CCG - 22% (£196,907)
NHS Hambleton, Richmondshire & Whitby CCG - 16% (£146,805)
NHS Scarborough & Ryedale CCG - 28% (£257,607)
NHS Vale of York CCG - 6% (£53,113)
Total Cost - £905,613

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

NHS Harrogate & Rural District CCG - 36% (£98,299)
NHS Hambleton, Richmondshire & Whitby CCG - 31% (£84,787)
NHS Scarborough & Ryedale CCG - 29% (£81,364)
NHS Vale of York CCG - 4% (£10,069)
Total Cost - £239,342

1.23.8 **Children & Young Adults Commissioning**
NHS Hambleton, Richmondshire & Whitby CCG Clinical Commissioning Group host the regional children & young adults commissioning team on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through NHS Hambleton, Richmondshire & Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 30% (£24,992)
NHS Hambleton, Richmondshire & Whitby CCG - 26% (£22,035)
NHS Scarborough & Ryedale CCG - 22% (£18,430)
NHS Vale of York CCG - 22% (£18,037)
Total Cost - £83,494

1.23.9 **Childrens CHC Team**
NHS Hambleton, Richmondshire & Whitby CCG Clinical Commissioning Group host the regional childrens CHC team on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through NHS Hambleton, Richmondshire & Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 21% (£25,952)
NHS Hambleton, Richmondshire & Whitby CCG - 18% (£22,883)
NHS Scarborough & Ryedale CCG - 15% (£19,138)
NHS Vale of York CCG - 46% (£57,278)
Total Cost - £125,251

1.23.10 **Specialist Neurological Rehab Commissioning Team**
NHS Vale of York CCG Clinical Commissioning Group host the regional specialist neurological rehab commissioning team on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through NHS Vale of York CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate and Rural District CCG 21% (£6,303)
NHS Hambleton, Richmondshire and Whitby CCG 18% (£5,557)
NHS Scarborough and Ryedale CCG 15% (£4,648)
NHS Vale of York CCG 46% (£13,911)
Total Cost - £30,419

1.23.11 **Serious Incidents Investigation Team**

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

NHS Harrogate and Rural District CCG 33% (£30,305)
NHS Vale of York CCG 33% (£30,305)
NHS Scarborough and Ryedale CCG 33% (£30,305)
Total Cost - £90,915

1.23.12 **Primary Care Co-Commissioning - Financial Management**
NHS Harrogate & Rural District Clinical Commissioning Group host the North Yorkshire Primary Care Co-Commissioning Financial Management team on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG & NHS Scarborough & Ryedale CCG. This hosting arrangement started on the 1st January 2019. All payments relating to this service are transacted through NHS Harrogate & Rural District CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 38% (£9,917)
NHS Hambleton, Richmondshire & Whitby CCG - 34% (£8,873)
NHS Scarborough & Ryedale CCG - 28% (£7,307)
Total Cost - £26,097

1.23.13 **Human Resources Team**
NHS Harrogate & Rural District Clinical Commissioning Group host the North Yorkshire & York Human Resources team on behalf of NHS Harrogate & Rural District CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Scarborough & Ryedale CCG, and NHS Vale of York CCG. This hosting arrangement started on the 1st April 2019. All payments relating to this service are transacted through NHS Harrogate & Rural District CCG's ledger and expenditure is recharged on a risk share basis as follows.

NHS Harrogate & Rural District CCG - 19% (£39,824)
NHS Hambleton, Richmondshire & Whitby CCG - 14% (£27,311)
NHS Scarborough & Ryedale CCG - 26% (£52,319)
NHS Vale of York CCG 41% (£84,890)
Total Cost - £204,345

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

1.24 **NHS Continuing Healthcare - Legacy**

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2021 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The impact of IFRS 16 may be material but the impact is not yet estimable because the leased property has not been separately valued and the detailed guidance relating to the application of the standard has not yet been published.

The application of the Standards as revised would not have a material impact on the accounts for 2019-20, were they applied in that year.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**1,096**	828
Other Contract income	**115**	84
Total Income from sale of goods and services	**1,211**	**912**
Other operating income		
Other non contract revenue	**-**	-
Total Other operating income	**-**	**-**
Total Operating Income	**1,211**	**912**

2019-20 operating income has increased by £299k in comparison to 2018-19. This has mainly arisen from the receipt of funding through the Mental Health Commissioning in North Yorkshire partnership.

3 Revenue

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue		
NHS	922	-
Non NHS	174	115
Total	**1,096**	**115**

	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue		
Point in time	1,096	115
Over time	-	-
Total	**1,096**	**115**

3.2 Transaction price to remaining contract performance obligations

NHS Harrogate & Rural District Clinical Commissioning Group does not have any remaining contract performance obligations

4. Employee benefits and staff numbers

4.1.1 Employee benefits for 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,392	595	**1,987**
Social security costs	314	-	**314**
Employer Contributions to NHS Pension scheme	541	-	**541**
Termination benefits	69	-	**69**
Gross employee benefits expenditure	2,315	595	**2,911**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	2,315	595	**2,911**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	2,315	595	**2,911**

4.1.1 Employee benefits for 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,687	448	2,134
Social security costs	298	-	298
Employer Contributions to NHS Pension scheme	354	-	354
Termination benefits	53	-	53
Gross employee benefits expenditure	2,392	448	2,840
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	2,392	448	2,840
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	2,392	448	2,840

4.1.2 Recoveries in respect of employee benefits

	2019-20			2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	**-**
Social security costs	**-**	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

4. Employee benefits and staff numbers

4.1.3 Employee benefits for 2019-20

	Admin			Programme			Total		
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	913	370	**1,283**	479	225	**704**	1,392	595	**1,987**
Social security costs	286	-	**286**	28	-	**28**	314	-	**314**
Employer contributions to the NHS Pension Scheme	504	-	**504**	37	-	**37**	541	-	**541**
Termination benefits	69	-	**69**	-	-	**-**	69	-	**69**
Gross employee benefits expenditure	**1,772**	**370**	**2,142**	**544**	**225**	**769**	**2,315**	**595**	**2,911**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**1,772**	**370**	**2,142**	**544**	**225**	**769**	**2,315**	**595**	**2,911**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**1,772**	**370**	**2,142**	**544**	**225**	**769**	**2,315**	**595**	**2,911**

4.1.3 Employee benefits for 2018-19

	Admin			Programme			Total		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	1,067	296	1,363	620	152	772	1,687	448	2,135
Social security costs	243	-	243	55	-	55	298	-	298
Employer contributions to the NHS Pension Scheme	294	-	294	60	-	60	354	-	354
Termination benefits	53	-	53	-	-	-	53	-	53
Gross employee benefits expenditure	1,657	296	1,953	735	152	887	2,392	448	2,840
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	1,657	296	1,953	735	152	887	2,392	448	2,840
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	1,657	296	1,953	735	152	887	2,392	448	2,840

The tables above highlight minimal overall increase in employee costs from 2018/19 to 2019/20.

- Administration employee benefits costs increased by £189k between 2018-19 and 2019-20. Whilst the average number of employees fell in the year, resulting in the employee benefits costs to fall, the increase in employer contributions to the NHS pension scheme more than offset cost reductions. The rise in employer contributions to the NHS pension scheme arises as the employers contribution increased from 14.3% to 20.6%
- Programme employee benefits costs decreased by £118k between 2018-19 and 2019-20. This is mainly due to reduction in staffing costs for the Continuing Healthcare Team.

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**45**	**8**	**54**	49	9	58
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		**2019-20 Other agreed departures**		**2019-20 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	15,556	-	-	1	15,556
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	53,333	-	-	1	53,333
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**68,889**	**-**	**-**	**2**	**68,889**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	53,333	-	-	1	53,333
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**53,333**	**-**	**-**	**1**	**53,333**

	2019-20 Departures where special payments have been made		2018-19 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

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

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

Where entities have agreed early retirements, the additional costs are met by that NHS entity and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

From the 1st December 2018 NHS Harrogate & Rural District Clinical Commissioning Group, NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group and NHS Scarborough & Ryedale Clinical Commissioning Group have been moving towards a single management team, in preparation of the merger of all 3 organisations on the 1st April 2020.

In 2019/20 the Chief Nurse for NHS Harrogate and Rural District Clinical Commissioning Group was made redundant, and NHS Harrogate & Rural District Clinical Commissioning Group's share (33%) of this cost is included in these accounts at £53,333. In the same year the Chief Nurse for NHS Scarborough and Ryedale Clinical Commissioning Group was made redundant, and NHS Harrogate & Rural District Clinical Commissioning Group's share (33%) of this cost is included in these accounts at £15,556.

In 2018/19 the Accountable Officer for NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group was made redundant, and NHS Harrogate & Rural District Clinical Commissioning Group's share (33%) of this cost is included in these accounts.

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.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

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 2020, is based on valuation data as 31 March 2019 updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	434	285
Services from foundation trusts	146,144	134,378
Services from other NHS trusts	16,118	15,933
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	33,323	31,199
Prescribing costs	27,072	25,828
General Ophthalmic services	186	137
GPMS/APMS and PCTMS	23,450	23,084
Supplies and services – clinical	203	199
Supplies and services – general	2,607	3,656
Consultancy services	115	25
Establishment	220	339
Transport	0	0
Premises	357	393
Audit fees	43	43
Other non statutory audit expenditure		
· Other services	-	10
Other professional fees	122	75
Internal audit fees	30	32
Legal fees	11	5
Education, training and conferences	30	17
Total Purchase of goods and services	**250,467**	**235,638**
Depreciation and impairment charges		
Depreciation	32	-
Amortisation	-	-
Impairments	-	-
Total Depreciation and impairment charges	**32**	**-**
Provision expense		
Provisions	-	-
Total Provision expense	**-**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	112	94
Grants to Other bodies	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**112**	**94**
Total operating expenditure	**250,611**	**235,732**

Non-statutory audit fees are in respect of Mental Health Investment Standard assurance that NHSE requires CCGs to obtain from an independent reporting accountant to demonstrate their investment in mental health expenditure rises at a faster rate than their overall published programme funding. £10,000 was accrued in 2018/19 with the work concluded successfully in 2019/20.

6.1 Better Payment Practice Code

Measure of compliance	2019-20 Number	2019-20 £'000	2018-19 Number	2018-19 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4131	51661	3063	41235
Total Non-NHS Trade Invoices paid within target	4070	51040	3019	41218
Percentage of Non-NHS Trade invoices paid within target	**98.52%**	**98.80%**	**98.56%**	**99.96%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2434	188469	2566	176690
Total NHS Trade Invoices Paid within target	2415	187120	2547	170096
Percentage of NHS Trade Invoices paid within target	**99.22%**	**99.28%**	**99.26%**	**96.27%**

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

	2019-20 £'000	2018-19 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Income Generation Activities

NHS Harrogate & Rural District Clinical Commissioning Group does not undertake any activities which result in income generation. All income is allocated to the CCG to enable it to commission additional health care for the Harrogate & Rural District's population.

8 Operating Leases

8.1 As lessee

NHS Harrogate & Rural District Clinical Commissioning Group's significant leasing arrangement is for office accommodation in Knaresborough, North Yorkshire. Unit 1 offices are leased from NHS Property Services Limited with the lease running from 28th March 2013 until 27th April 2023, with a break clause of the 2nd May 2018. Rent is charged on a commercial rates basis. Standard restrictions apply to the lease arrangement, namely that the building can only be used for office accommodation.

The CCG has also taken additional office accommodation in part of Unit 2. This is also leased from NHS Property Services Limited with the lease running from 1st October 2018 to the 30th April 2023. Rent is charges on a commercial rates basis. Standard restrictions apply to this lease arrangement, namely that the building can only be used for office accommodation. The contract was signed in 2019/20, but in the 2018/19 comparrison figutes the lease was not signed, hence the future minimum lease payments periods did not reflect this commitment.

8.1.1 Payments recognised as an Expense

			2019-20			2018-19
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	156	3	**159**	167	3	170
Contingent rents	-	-	**-**	-	-	-
Sub-lease payments	-	-	**-**	-	-	-
Total	**156**	**3**	**159**	167	3	170

8.1.2 Future minimum lease payments

			2019-20			2018-19
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	152	2	**154**	133	3	136
Between one and five years	316	-	**316**	411	2	413
After five years	-	-	**-**	-	-	-
Total	**468**	**2**	**470**	544	5	549

9 Property, Plant and Equipment

	Information Technology £'000	Total £'000
Cost or valuation at 01 April 2019	76	76
Additions purchased	32	32
Cost/Valuation at 31 March 2020	**108**	**108**
Depreciation 01 April 2019	76	76
Charged during the year	32	32
Depreciation at 31 March 2020	**108**	**108**
Net Book Value at 31 March 2020	**-**	**-**

9.1 Revaluation Reserve Balance for Property, Plant & Equipment

	Information Technology £'000	Total £'000
Balance at 01 April 2019	-	-
Balance at 31 March 2020	**-**	**-**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	0

10 Trade and other receivables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	1,547	-	938	-
NHS prepayments	367	-	367	-
NHS accrued income	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	86	-	21	-
Non-NHS and Other WGA accrued income	-	-	198	-
VAT	25	-	32	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**2,025**	**-**	**1,556**	**-**
Total current and non current	**2,025**		**1,556**	
Included above:				
Prepaid pensions contributions	-		-	

Outstanding debt is due from local organisations that the CCG works in partnership with, such as Harrogate & District NHS Foundation Trust, North Yorkshire County Council, NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group and NHS Scarborough & Ryedale Clinical Commissioning Group.

Prepayments arise resulting from the maternity pathway national tariff, which is paid to providers at the start of maternity to cover the care provided throughout the duration of maternity. This payment is adjusted where necessary, based on information from providers, to account for the element of care not yet provided at the 31st March 2020.

10.1 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000
By up to three months	802	5	1	11
By three to six months	-	23	-	-
By more than six months	134	-	135	6
Total	**936**	**28**	**136**	**17**

As at 19th June 2020 £805,557 of the amount above has subsequently been recovered post the statement of financial position date.

No collateral is held by NHS Harrogate & Rural District Clinical Commissioning Group for any outstanding debt.

11 Other Current Assets

NHS Harrogate & Rural District Clinical Commissioning Group does not have any other current assets in 2019-20.

12 Cash and Cash Equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	5	101
Net change in year	71	(96)
Balance at 31 March 2020	**76**	**5**
Made up of:		
Cash with the Government Banking Service	76	5
Cash and cash equivalents as in statement of financial position	**76**	**5**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**76**	**5**

13 Trade and other payables

	Current 2019-20 £'000	Current 2018-19 £'000
NHS payables: Revenue	4,035	5,257
NHS accruals	893	1,415
Non-NHS and Other WGA payables: Revenue	860	1,191
Non-NHS and Other WGA accruals	11,290	7,768
Social security costs	42	35
VAT	-	-
Tax	38	31
Other payables and accruals	285	287
Total Trade & Other Payables	**17,443**	**15,984**
Total current and non-current	**17,443**	**15,984**

NHS Harrogate & Rural District Clinical Commissioning Group does not have any future years liabilities under arrangements to buy out the liability for early retirement.

In total, payables/accruals has increased from £16m in 2018/19 to £17.4m in 2019/20. This is largely attributable to the increased prescribing accrual and that NHS Harrogate & Rural District Clinical Commissioning Group is the host across North Yorkshire for processing invoices for S117 patient care and learning disabilities care packages.

14. Other liabilities

NHS Harrogate & Rural District Clinical Commissioning Group does not have any other liabilities in 2019-20.

15 Financial instruments

15.1 Financial risk management

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

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

15.1.1 Currency risk

The NHS 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 NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS 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.

15.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

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

15.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	1,167	1,167
Trade and other receivables with other DHSC group bodies	381	381
Trade and other receivables with external bodies	86	86
Other financial assets	-	-
Cash and cash equivalents	76	76
Total at 31 March 2020	**1,710**	**1,710**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other payables with NHSE bodies	282	**282**
Trade and other payables with other DHSC group bodies	4,722	**4,722**
Trade and other payables with external bodies	12,359	**12,359**
Other financial liabilities	-	**-**
Total at 31 March 2020	**17,363**	**17,363**

16 Contingencies

16.1 Contingent liabilities

In March 2012, the Department of Health announced deadlines for individuals who wished to request an assessment for NHS Continuing Healthcare for the period 1 April 2004 and 31 March 2012.

The deadline for submitting all such requests for previously unassessed periods of care (PuPOCs) was 31 March 2013, and as a result the CCG inherited a large number of retrospective claims from the former North Yorkshire & York Primary Care Trust.

The majority of PuPOC claims were processed during 2016 and any financial liability relating to these claims is recharged to NHS England who hold a provision for this. However, it became evident during this process that a number of applicants had also requested a current assessment (for the period going forward), which has been termed the post PuPOC period.

The CCG has considered recording a provision for cases where a post PuPOC assessment has been requested, but assessment has not been carried out. There are now 3 cases requiring assessment across the three North Yorkshire CCGs with 7 having been assessed during 2018/920. Of these 7 cases 5 were found to be eligible. The impact of this is included in these accounts for the cases relating to NHS Harrogate & Rural District CCG patients. The remaining 2 were not found to be eligible although they do have the right to appeal and all these cases are currently going trough the appeals process. A number of uncertainties impact upon the CCG's ability to assess a reasonable provision are:

- following assessment; patients may be deemed to be not eligible for care, fully eligible or eligible for only part of the assessed period
- eligibility is only for costs actually incurred by the individual
- CCG's are only eligible for costs from April 2013.
- A number of patients may have subsequently been accepted for continuing care, and therefore have already had care funded
- claim periods can vary significantly, from a few days to several years.
- reimbursements can vary significantly from a few pounds to several thousand pounds per week depending on the level of care that the patient has sourced privately. No information has been received on assessed cases to determine the likely liability
- eligible individuals may choose not to pursue a claim

Consequently the CCG is identifying a contingent liability relating to these cases, but is not able to reasonably assess the value of the liability.

In addition to the above, NHS Harrogate & Rural District Clinical Commissioning Group has been made aware that HMRC is considering challenging the VAT recovery treatment in respect of out-sourced support services provided by entities sitting outside of the NHS family. NHS England, the regulatory body for Clinical Commissioning Groups, is fully supportive of the current VAT recovery treatment position, which is applied nationally. At the time of completing the accounts, this had not been resolved.

17 Operating segments

	Gross Expenditure	Income	Net Expenditure	Total Assets	Total Liabilities	Net Assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioned National Health Services	253,522	(1,211)	**252,311**	2,101	(17,443)	**(15,342)**
Total	**253,522**	**(1,211)**	**252,311**	**2,101**	**(17,443)**	**(15,342)**

18 Joint arrangements

18.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2019-20			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Mental Health Commissioning in North Yorkshire	NHS Harrogate & Rural District CCG, NHS Scarborough & Ryedale CCG, NHS Hambleton, Richmondshire & Whitby CCG, Tees Esk Wear Valleys NHS Foundation Trust	Formal joint arrangement for the commissioning of Mental Health Services in North Yorkshire	-	-	- 250	18,513
North Yorkshire Better Care Fund (BCF)	NHS Harrogate & Rural District CCG, NHS Scarborough & Ryedale CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Vale of York CCG, NHS Airedale, Wharfdale & Craven CCG, North Yorkshire County Council	Formal pooled budget arrangement for the delivery of Better Care Fund requirements	-	-	-	10,181
Integrated Community Care	NHS Harrogate & Rural District CCG, North Yorkshire County Council, Tees Esk Wear Valleys NHS Foundation Trust, Harrogate & District NHS Foundation Trust	Formal joint commissioning and service delivery of integrated health and social care community teams	-	-	-	5,104

			Amounts recognised in Entities books ONLY 2018-19			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Mental Health Commissioning in North Yorkshire	NHS Harrogate & Rural District CCG, NHS Scarborough & Ryedale CCG, NHS Hambleton, Richmondshire & Whitby CCG, Tees Esk Wear Valleys NHS Foundation Trust	Formal joint arrangement for the commissioning of Mental Health Services in North Yorkshire	-	-	-	16,461
North Yorkshire Better Care Fund (BCF)	NHS Harrogate & Rural District CCG, NHS Scarborough & Ryedale CCG, NHS Hambleton, Richmondshire & Whitby CCG, NHS Vale of York CCG, NHS Airedale, Wharfdale & Craven CCG, North Yorkshire County Council	Formal pooled budget arrangement for the delivery of Better Care Fund requirements	-	-	-	9,766
Integrated Community Care	NHS Harrogate & Rural District CCG, North Yorkshire County Council, Tees Esk Wear Valleys NHS Foundation Trust, Harrogate & District NHS Foundation Trust	Formal joint commissioning and service delivery of integrated health and social care community teams	-	-	-	5,123

18.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

NHS Harrogate & Rural District Clinical Commissioning Group does not have any interests in entities not accounted for under IFRS 10 or IFRS 11

19 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Beech House Surgery	1,279	-	58	-
Church Avenue Medical Group	1,553	-	68	-
Church Lane Surgery	2,393	-	101	-
Dr Ingram & Partners	1,097	-	50	-
Dr Akester & Partners	1,255	-	74	-
Dr Moss & Partners	2,189	-	95	-
East Parade Surgery	1,002	-	15	-
Eastgate Medical Group	1,431	-	71	-
Kingswood Surgery	943	-	35	-47
Leeds Road Practice	1,607	-	115	-
Nidderdale Group Practice	2,780	-14	114	-
North House Surgery	1,175	-	73	-
Park Parade Surgery	955	-	21	-
Ripon Spa Surgery	1,120	-	72	-
Springbank Surgery	1,647	-	54	-
Spa Surgery	2,022	-	85	-
Stockwell Road Surgery	851	-	46	-
BMI Healthcare Ltd	1,541	-	-	-
City of York Council	125	-	-	-
Cumbria, Northumberland, Tyne & Wear NHS FT	-1	-	-	-
Harrogate & District NHS FT	116,285	-	1,166	-
Haxby Group Practice	2	-	-	-
Humber Teaching NHS FT	4	-	-	-
Leeds CCG	21	-66	-	-
Leeds Teaching Hospitals NHS Trust	7,044	0	115	-
NHS Hambleton, Richmondshire & Whitby	171	-5422	34	-
NHS Scarborough & Ryedale CCG	23,615	-3295	-	-
NHS Vale of York CCG	1,915	-1102	21	-
North Yorkshire County Council	7,869	-198	755	-38
South Tees Hospitals NHS FT	2,443	-	-	-
St Michael's Hospice	1,020	-	64	-
Tees Esk & Wear Valleys NHS FT	17,432	-250	-	-
YOR Local Medical Commmittee Ltd	180	-16	-	-
Yorkshire Ambulance Services NHS Trust	8,081	-	269	-
Yorkshire Health Network Ltd	1,936	-	25	-
York Teaching Hospital NHS FT	6,496	-	6	-233

The 17 primary care practices listed above are listed as related parties as each practice is represented at NHS Harrogate & Rural District Clinical Commissioning Group's Council of Members.

BMI Healthcare is listed as a related party because a GP Partner of one of the members of the CCG's governing body is also an employee of that organisation.

Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust is listed as a related party because the spouse of a member of the CCG's governing body holds a position of responsibility within that organisation.

City of York Council is listed as a related party because one of the members of the CCG's governing body is also an employee of that organisation.

Harrogate & District NHS Foundation Trust is listed as a related party because several members of the CCG's Council of Members representatives / CCG's Governing body are either directly or indirectly employed by them.

Haxby Group Practice is listed as a related party because the spouse of one of the members of the CCG's Council of Members representatives holds a position of responsibility within that organisation.

Humber Teaching Hospital NHS Foundation Trust is listed as a related party because the spouse of a member of the CCG's governing body holds a position of responsibility within that organisation.

Both NHS Hambleton, Richmondshire & Whitby CCG and Scarborough & Ryedale CCG are listed as a related party because of the appointment of a joint leadership team across all 3 entities.

Leeds CCG is listed as a related party because a family member of a member of the CCG's governing body holds a position of responsibility within that organisation.

St Michaels Hospice is listed as a related party because one of the members of the CCG's governing body is a Trustee.

Tees Esk & Wear Valleys NHS Foundation Trust is listed as a related party because one of the members of the CCG's Council of Members representatives is also employed by them.

The Yorkshire Health Network is an alliance organisation whose membership consists entirely of the primary care practices noted above.

YOR Local Medical Committee Ltd is listed as a related party because two members of the CCG's Council of Members representatives are directly employed by them and hold positions of responsibility.

The organisations listed below are listed as related party transactions because either members of the CCG's Council of Members representatives, or members of the CCG's Governing Body, or employees of the CCG either employees of one of these organisations or have partners/GP partners who are employees.

- Leeds Teaching Hospital NHS Trust
- South Tees NHS Foundation Trust
- Vale of York Clinical Commissioning Group
- Yorkshire Ambulance Service NHS Trust
- York Teaching Hospitals NHS Foundation Trust

In addition, NHS Harrogate & Rural District Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with North Yorkshire County Council in respect of joint enterprises.

The Department of Health & Social Care (DHSC) is also the parent company of the NHS Harrogate & Rural District Clinical Commissioning Group.

20 Events after the end of the reporting period

NHS Harrogate and Rural District Clinical Commissioning Group, NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group and NHS Scarborough and Ryedale Clinical Commissioning Group were disestablished and replaced by a single organisation on the 1st April 2020 called NHS North Yorkshire Clinical Commissioning Group.

21 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2019-20 Target	**2019-20 Performance**	**Target Achieved?**	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	253,522	253,522	Yes	238,572	238,572
Capital resource use does not exceed the amount specified in Directions	32	32	Yes	-	-
Revenue resource use does not exceed the amount specified in Directions	252,311	252,311	Yes	237,660	237,660
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	3,525	3,525	Yes	3,395	3,268

22 Losses and special payments

22.1 Losses

NHS Harrogate & Rural District Clinical Commissioning Group did not incur any losses in 2019/20 (nor in 2018/19)

22.2 Special payments

NHS Harrogate & Rural District Clinical Commissioning Group did not made any special payments in 2019/20 (nor in 2018/19)