NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Annual Report 2019-2020

NHS
Hambleton, Richmondshire and Whitby
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 Hambleton, Richmondshire and Whitby 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 Hambleton, Richmondshire and Whitby 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 Hambleton, Richmondshire and Whitby we have:

- Consulted on a new vision for the Friarage Hospital to safeguard services and ensure local people continue to have access to high quality and safe urgent and emergency care.
- 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[1], a website offering free online counselling and emotional wellbeing support. Adults now can access a website improving

[1] https://www.kooth.com/

access to psychological therapies (IAPT) service, which offers talking therapies treatments[2]. The website includes an option to self-refer online without having to go through a GP.

- 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 Hambleton, Richmondshire and Whitby. 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 Hambleton, Richmondshire and Whitby, 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

[2] 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, 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 starts at section 7 on page 85 you can find out about our members, our senior leadership team and how we make decisions. Finally, from page 150, 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.

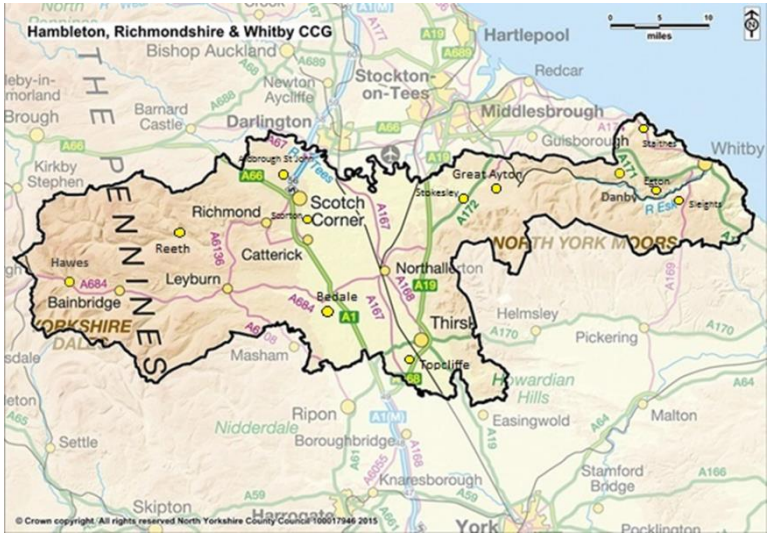
1.2 What we do

We are responsible for purchasing (or 'commissioning') healthcare services for around 144,000 people in the Hambleton, Richmondshire and Whitby 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:

"To commission (buy) first class healthcare which improves the health of everyone in Hambleton, Richmondshire and Whitby areas."

Our patients are at the heart of everything we do and we want to work closely with our local communities to help us achieve our goals.

1.4 Our values

We are a values-driven organisation. We try to ensure that we genuinely adhere to these values in every aspect of our work, whether we are engaging with the public, developing service improvement plans with providers or managing contracts and performance. The values that we work to are:

- Action
- Collaboration
- Courage
- Energy
- Focus
- Integrity
- Transparency

1.5 About us, Our Community and How We Work

We are a clinically led membership organisation of our 22 local GP practices. This means that health professionals with current patient experience are leading the decisions we make. Our Council of Members meets regularly 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[3]. You can also see papers and minutes from our Governing Body and Primary Care Commissioning Committee on our website[4].

1.6 Enabling Work to Create the North Yorkshire CCG

On 5 November 2019 we received approval from NHS England and NHS Improvement to merger 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[5]. As a single organisation we will be able to:

- Eliminate unnecessary duplication and bureaucratic boundaries to work more efficiently together and with our partners.
- Ensure consistency of decision making for the people of North Yorkshire.

[3] https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/documents/6631319/13704438/Constitution+V4.2+April+2018/e8409be7-4378-4ecb-a5ea-437f8675adb1
[4] https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/home
[5] https://www.england.nhs.uk/long-term-plan/

- 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 Hambleton, Richmondshire and Whitby 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 the Hambleton, Richmondshire and Whitby area.

1.7.1 Patient Participation Groups (PPGs)

Most of our practices now have a Patient Participation Group (PPG) A PPG is a group of patients interested in health and healthcare issues, who want to get involved with and support the running of their local GP practice. We have continued to develop robust relationships with the PPGs and include them within our communications and engagement activity as standard. Our Lead for Patient and Public Involvement and Health Engagement Network Representatives often attend PPG meetings and are able to feed back any queries, concerns or ideas to the CCG.

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.

Heartbeat Alliance

Heartbeat Alliance is a GP-based organisation established to provide high quality care for people delivered by local clinicians whom patients know and trust to care for them. 21 of the 22 GP practices in the CCG area have come together to create this alliance. The CCG has worked closely with Heartbeat during 2018/19 on various projects and services including extended access for GP services and cancer transformation.

1.7.3 NHS Providers

Four NHS trusts provide the majority of services to our patients. These are: County Durham and Darlington NHS Foundation Trust (CDDFT); Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV); Humber Teaching NHS Foundation Trust (HFT); and South Tees Hospitals NHS Foundation Trust (STHFT) which provides more specialist care when needed. Our ambulance services are provided by Yorkshire Ambulance Service NHS Trust who is also the provider of NHS 111 for our region.

1.7.4 Local Authorities

We work in partnership with public health colleagues and jointly with North Yorkshire County Council, Hambleton District Council, Richmondshire District Council and Scarborough Borough Council to commission a number of services, such as community step-up and step-down beds, medical equipment and weight management.

1.7.5 Local Elected Members

We meet regularly with our local MPs and elected members and proactively brief and include them within developments in the area along with receiving and responding to feedback from their constituents about local health services.

1.7.6 Integrated Care System

Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby Sustainability and Transformation Partnership (DDTHRW STP)

Made up of CCGs, local authorities, acute and mental health care providers and other health organisations the STP enables these organisations to work closely together to plan services and address the challenges facing health and care services across the region. DDTHRW STP is also part of the wider North East and North Cumbria Integrated Care System which oversees strategic commissioning from coast to coast across the most northern part of England.

Humber Coast and Vale Health and Care Partnership

The Humber, Coast and Vale Health and Care Partnership (previously Humber, Coast and Vale STP) is a collaboration of 28 health and social care organisations who are working together to improve health and care across our area and a population of 1.4 million.

1.7.7 Community and Voluntary Sector

We work closely with community and voluntary organisations in the Hambleton, Richmondshire and Whitby area who make significant contributions to local health care.

Health Engagement Network (HEN) and Representatives

We continue to build a membership of people with a particular interest in local health services. The HEN is a key tool in enabling us to reach our local communities and it is our 'go to' resource for feedback on services and our plans for the future. We currently have around 200 members and our aim is to continue to grow and engage the membership and develop the network.

1.7.8 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.

1.7.9 North Yorkshire Scrutiny of Health Committee

The CCG keeps the Committee up to date with engagement activities and service proposals through attendance at formal and informal meetings and via the stakeholder newsletter. We have continued to maintain a positive working relationship with the Committee during 2019/20.

1.7.10 Healthwatch North Yorkshire

The CCG works with Healthwatch to support their work and drive engagement with members of the public.

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 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 Hambleton, Richmondshire and Whitby and achieve the strategic priorities across North Yorkshire.

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. 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 Transforming Care Partnership

The three North Yorkshire CCGs and key partners 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 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 The CCG's Key Strategic Aims

We have four core strategic aims which will help us to deliver our mission:

- Involve people in their care and as part of that, we will encourage self-care.
- Buy quality services.
- Change services for the better and in doing so, we will provide care as close to home as is possible, that is easily accessible.
- Use the money we have in the best possible way.

2 Delivering Our Priorities

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. To help us achieve this we have a five year strategic plan which sets out our priorities and guides our work. Our priorities are:

- Transforming the community system – to create effective, integrated community services that enable patients to be cared for as close to home as possible.

- Mental health and dementia care – to meet the challenge of providing the best possible care for the rising numbers of patients with dementia.
- Clinically appropriate planned care – to ensure care pathways and referrals across all specialties are as clinically efficient and effective as possible.
- Children's health – to ensure that urgent care services are safe and sustainable and we build improved services in the community for vulnerable children and those with complex needs.
- Patients with long term conditions – to improve patient's ability to self-care and achieve their own goals, supported by earlier diagnosis and better identification of patients who are at risk.
- Prevention of ill-health – to work with the North Yorkshire Health and Wellbeing Board to take forward plans and projects to improve the health of the local population.
- Productivity in primary care.

2.1 Priority 1: Primary Care

2.1.1 Ensuring Continued Access to Really Good Local GPs

The CCG continues to work closely with its GP Federation, Heartbeat Alliance, ensuring that the service continues to deliver as planned.

The service is fully operational operation from a total of 10 "hubs" across the CCG footprint. There is a range of appointments available for booking ranging from GP, nursing, first contact physio and clinical pharmacist. This allow patients to have access to different expertise depending on their clinical need and also help ensure we maximise support for our busy GPs who are able to focus on those patients who most need their skills.

2.1.2 Continuation of GP Out of Hospital Services

The CCG still continue to deliver a wide range of services within local GP practices which enables us to achieve our local vision of maintaining services as close to home as possible. These include services to support patients without them needing to visit hospital, clinical pharmacist, complex wound care and a range of alternatives to outpatient appointments. Whilst there was a period over the past year where the Minor Injury service was ceased, this has now been reinstated to cover certain elements only, All of the services commissioned are closely monitored from both a quality and performance perspective, and regular feedback upon the delivery of these services is undertaken.

2.1.3 Encouraging General Practice Resilience

Cluster Managers continue to support practices across the CCG and help to address issues as they arise. Practices continue to offer Care Navigation which provides patients with a first point of contact ensuring they are directed to the most appropriate source of help, which quite often, is NOT a GP.

The CCG continues to encourage practices to use web and app-based portals to help provide self-help and self-management resources to patients. The CCG was successful in its application for funding to support the roll-out of a self-care app to help patients suffering from long term conditions such as diabetes, asthma and chronic obstructive airways disease (COPD). Health professionals across both primary and secondary care are identifying patients who would benefit from using this app.

2.1.4 Practice Manager Development

The CCG continues to support Practice Managers to identify any particular training necessary. This support includes understanding any funding streams available and where necessary helping with the development of bid applications.

2.1.5 Online Consultations

We now have twelve practices within the CCG offering a secure, future-proof online consultation platform that offers the potential for a two way confidential messaging service between clinicians and their patients. We are slowly starting to see a reduction in inappropriate appointments which is allowing for time in general practice to be spent more wisely.

2.1.6 Workforce Planning

Since December 2018 the CCG has been working closely with a NHSE accredited provider to roll out a primary care workforce planning tool across the locality. The tool provides software and support to analyse workload and workforce capacity of Primary Care, GP practices and Out of Hospital Services. It also provides insights on demand, activity and utilisation levels allowing the transformation of services through better design and costing of resources, capacity, clinical case mix and new care models. To date, there is a limited number of practices using this tool, but work is ongoing with these practices to look at benefits realisation that then can be shared more widely across other practice.

2.2 Priority 2: Community Care

2.2.1 Progressing the Whitby Memorial Hospital Redevelopment

At a meeting of the NHS Hambleton, Richmondshire and Whitby CCG Governing Body held in Whitby on 24 January 2019, the Governing Body approved the Whitby Hospital full business case. This was the CCG's final responsibility to ensure progression of the redevelopment of Whitby Hospital.

The redevelopment will result in a new and fit for purpose hospital in Whitby. The hospital will have inpatient beds, outpatient facilities, diagnostic services such as X-ray, physiotherapist and occupational therapy services and other services to support patients. The facility will also act as a base for community services staff.

The next step in the process will be planning for the decant of beds from the tower block into the old maternity ward. Other existing services will continue in the front part of the hospital. This will allow the tower block to be redeveloped.

2.2.2 Investing in the Catterick Area

During 2019/20 the CCG continued to work in partnership with colleagues from NHS England and the Ministry of Defence (MOD) to develop a sustainable, long term solution for health and care services on the Catterick Garrison site. The aspiration for the site has been named the 'Catterick Integrated Care Campus'. This project aims to promote modern health services across the whole of the Catterick area including the Garrison and in support of the wider Richmondshire area. This means creating an active partnership between primary, secondary, community and mental health provision though both the NHS and MOD so that the whole population, armed forces and civilian, experience equal access to high quality services in the most efficient way. On completion, this will be the first fully integrated joint NHS and MOD health and care facility in the country.

2.2.3 Delivering the 'Transforming our Communities' Programme

Our vision for this programme is to deliver models of care across Hambleton and Richmondshire that enable patients to receive the care they need close to home or at home if possible. This vision was developed and informed by the views of our local population and stakeholders when we developed new models of care including integrated locality teams of health and social care professionals, step-up/step-down beds in key locations across the localities, community based end of life care and the establishment of a pathway for the frail elderly. These models of care are now established and are delivering positive patient outcomes across the two localities.

Nine step-up/step-down bed facilities across Hambleton and Richmondshire being utilised by local patients preventing some admissions to hospital and providing support for patients and families prior to going home after discharge from hospital. They are also being used to provide care closer to home for patients at end of life.

These models place a greater emphasis on services being delivered in the community to support our local vision and are now being delivered. They have been supported by investment into primary and community care in the form of primary care nursing workforce, step-up/step-down beds, district nursing, intermediate care and fast response and establishment of digital technology into care homes known as 'Immedicare'.

2.2.4 Focussing on our Older People

We know that a majority of our population is over the age of 50 compared to the national average with even more people living longer. Whilst this is to be celebrated, we know from our engagement that there is real concern for a growing elderly population and whether we have the services to meet this as generally, this population uses more health services.

This year we have been working with colleagues to deliver robust assessment and care planning process, particularly for elderly and frail patients so that patients and their families are well supported and local GPs and community staff caring for them have a better understanding of their care preferences later in life. This includes ensuring local teams are working together to offer patients more complete and less fragmented care and support as multi-disciplinary teams. This concept is a natural extension to the Multi Agency Meetings (MAMs) which provide a local forum for collective decision making in relation to patients.

For our most elderly patients, we have developed a new way of sharing patient wishes and care plans with multi-agency partners such as the ambulance service. Patients identified by their own GP have completed a comprehensive assessment resulting in a patient-led care plan specific to their individual needs and wishes. In addition Emergency Health Care Plans (EHCP) are being completed, this allows the patient's wishes to be communicated to health care professionals in a health emergency. The care plans and EHCP are in 'red folders' in patients' own homes, any service which has access to homes of the local elderly will have instant access to important documentation about their care to reduce duplication and any unnecessary admission to services.

2.2.5 End of Life Pathway for Hambleton and Richmondshire

The integrated end of life care pathway is now well established in Hambleton and Richmondshire. This service allows patients to die at home knowing they are receiving the best possible care and support. Day time care is provided by Herriot Hospice Home Care, supported by the District Nurses, Community Nurses, Specialist Palliative Care and GPs. Marie Curie continue to provide the overnight care. Comments from the End of Life Survey (S/Tees):

- We were so impressed by the 'seamless' care provided. There was obviously good communication between all of the services. Cared for patient and family.
- Never having had need of help before we didn't know what to expect. Everything was put in place very quickly and efficiently. Equipment was loaned and the ladies cared for dad with kindness and professionalism. We are very grateful such services exist (ladies from Herriot Hospice Homecare and St Teresa's Hospice). Special thanks to our local District Nurse who gave her time, kindness and help to us all.
- Myself and my family felt that all the services we used were able to provide the best possible care for my Dad, they were all very professional, compassionate and caring, this helped us all immensely.
- It is impossible to exaggerate how much difference your wonderful people made to my wife and myself during her final weeks.
- My husband's wish was to die at home – this would not have been possible without all this caring help.
- The service we received from all staff was exemplary – a testament to effective team working across discipline boundaries. All should be congratulated. If I can ever be of assistance please do not hesitate to ask.
- Wished we had known sooner what help would be available when we needed it. Once the doctor involved district nurses etc everything fell into place, nurses always came at appointed time or telephoned. The only time we had a Marie curie nurse was the night of my husband's death. It was such a relief to know someone was coming – I hope this service can be extended.

2.2.6 Assessing Patients in the Right Place to Support Independence

At any one time there are a number of people in an acute hospital bed who have received the care needed right away, but are awaiting further assessment to decide any ongoing care they may need once they are discharged from hospital. These patients are reported as a 'Delayed Transfer of Care' and are often in hospital too long and often unnecessarily which results in poor patient outcomes and increasing cost to the CCG. We also see that some elderly patients in particular can physically and mentally deteriorate if they spend too long in hospital making it difficult to really know the long term support they need. We also know that the independent care sector is under pressure meaning there is limited availability of care packages and long term residential or nursing care placements.

Since 2016 the CCG has been working with partners in the acute hospitals and North Yorkshire County Council to implement a model known as 'Discharge to Assess' which has seen improved outcomes for patients and improved the flow of patients in and out of hospital by ensuring people are transferred out of hospital as soon as possible back home or to a another setting speedily, effectively and safely. The model includes trusted assessment processes, which reduces the number of assessments a patient

receives within the hospital environment and provides a coordinated assessment across services. This model allows people to be assessed in a more suitable setting where they can be assessed for their long term care needs and have the opportunity to maximize their ability to live independently (see section 6.5.4).

2.2.7 Helping the Very Elderly to Live Well

We commission a telemedicine service across Hambleton, Richmondshire and Whitby, the service has been in place from 2016 in 28 Nursing, Residential and Extra Care Facilities. The service provides access to clinical support 24 hours a day enabling the frail and elderly to remain in the usual place of residence and reducing ambulance conveyances and A&E attendance.

The CCG have supported healthy hydration initiative and provided resources to local care homes, providers and local public events.

2.2.8 Commitment to Integration

The new models of care we have delivered with our partners demonstrate that 'integration' is an important issue and that services working together will deliver better outcomes for patients. The CCG and North Yorkshire County Council have agreed to the development of a joint commissioning strategy to support the integration of services as a commitment to continue to work collectively in the best interests of the population.

2.3 Priority 3: Urgent and Emergency Care

2.3.1 Services at the Friarage Hospital

The longstanding challenges affecting the recruitment of doctors and emergency nurse practitioners to the Friarage Hospital have continued during 2019/20.

Moving to a more sustainable service model on the Friarage site remains the priority and we continue our work in partnership with Yorkshire Ambulance Service, Harrogate District Foundation Trust and South Tees NHS Hospitals Foundation Trust to deliver this.

Due to an further deterioration of the staffing situation South Tees Hospitals Trust had no option but to introduce, on a temporary basis, a new clinical model on the Friarage Hospital site from March 2019 and simultaneously change the 24/7 A&E department to a 24/7 Urgent Treatment Centre.

The new service models have continued to see over 90% of patients at the Friarage compared to before the changes took effect. The new clinical model has seen no issues or concerns raised in relation to patient safety and has provided a number of additional clinical and quality benefits through safely managing the arrival of the most appropriate patients to the site for their injury or illness and wherever possible avoiding a secondary onward transfer to another hospital.

The model has operated safely and successfully for the last year with the temporary changes in place and was subject to a public consultation into the proposed changes during 2019/20.

The outcome of the consultation is due to report back in April 2020, with a decision on the opening hours of the Urgent Treatment Centre (options were 24hrs or 16hrs) and confirmation that the new medical model for the site will continue unchanged.

Patients have continued to receive the highest quality of urgent and emergency care during the trial period, receiving the right care at the first time of asking and with the shortest possible wait.

Our priority remains the protection and sustainability of clinically safe services at the Friarage Hospital, as well as maintaining and where possible increasing the range of services delivered from the site.

2.3.2 Ambulance Service Clinicians Supporting Primary Care

The Northallerton based urgent care practitioner initiative has continued throughout 2019/20, integrating highly trained Yorkshire Ambulance Service (YAS) clinicians with the GP out of hours service based at the Friarage hospital and covering the Hambleton and Richmondshire localities.

In addition, their in hours work, integrated with both Mayford and Mowbray GP practices in Northallerton, continues to work extremely well.

The main objective of the scheme is to urgently see and treat patients within the community or in the local GP practice environment and avoid an unnecessary journey to hospital, continuing to support our vision of care closer to home.

Results from 2019/20 demonstrate that following attendance by an advanced paramedic the scheme has consistently delivered some of the highest percentage rates for patients being “seen and treated” locally of any CCG in Yorkshire and also some of the highest percentage rates of non-conveyance rates to hospital of any CCG in Yorkshire.

YAS advanced paramedics safely see, treat and discharge to the community without the need for ambulance conveyance to hospital over twice the number of patients that a traditional ambulance crew are able to achieve due to their extended clinical skills. The CCG is currently in discussions with YAS to further expand this initiative in 2020/21.

2.3.3 Helping Reduce Unnecessary Use of the 999 Emergency Service

This “urgent” patient transport initiative, operating in partnership with the private sector since 2014, continues to run across Hambleton, Richmondshire and Whitby and has provided a high quality and timely conveyance for many of our patients, whether this is from the community into hospital or transfers between hospital sites in North Yorkshire, County Durham and Teesside.

During 2019/20 this initiative resulted in 98% of patients using the service being conveyed by the attending private ambulance crew within the target time which has in turn avoided the unnecessary use of a 999 emergency ambulance crew who remain available to respond to the next potentially lifesaving emergency call in the local area.

The current contract has been extended for a further 12 months covering 2020/21.

2.3.4 NHS 111 online

An online version of NHS 111, replicating the existing telephony system, was rolled out across Hambleton, Richmondshire and Whitby, 24hours per day, during 2018/19 and has further embedded during 2019/20.

The introduction of an online service was part of a national roll out and will provide callers to the NHS 111 telephony service with the option to utilise the online service if that is a more convenient option for them. This service continues to be well utilised and works well across Hambleton, Richmondshire and Whitby.

2.3.5 Access to Community Defibrillators

There are over 90 defibrillators now installed across our local area thanks to the CCG, YAS and local communities; a number of which have been successfully deployed during the last 12 months.

A defibrillator is a device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest. These can be easily recognised and if needed, used by any member of the public after calling 999, without training, on a person whose heart has stopped.

Five years ago, there were very few defibrillators accessible by our very rural communities. This meant that the crucial early stage in saving a patient’s life was a little more difficult as ambulances have further to travel.

These defibrillators are part of the portfolio of measures the CCG has introduced to help improve the quality of outcomes for patients following emergency care.

2.3.6 Ambulance Response Times

We know how important ambulance response times are to our rural population.

In 2017/18 a new ambulance 999 call prioritisation and dispatch system (Ambulance Response Programme or ARP for short) was introduced as part of a national change to how ambulance services prioritise and respond to all 999 calls.

This new system further embedded during 2019/20 bringing additional improvements to patient care and the quality of response delivered by our ambulance service.

The new system focuses on the average response time to a 999 call (target average of seven minutes response for the most serious calls; Category 1) instead of an absolute target time of eight minutes as was the case under the previous system.

During 2019/20 (April19 to December19) YAS' cumulative performance against this 7 minute average response time target reported 7 minutes 7 seconds.

2.3.7 Promoting Self-Care and Prevention

The local health and social care system has again performed very well during the winter months, at times under extreme pressure and simultaneously making urgent preparations to contain any impact on the UK of Coronavirus.

The Friarage hospital achieved above the national urgent treatment centre standard of 95% completion and discharge form the department within four hours, achieving 98% during the most challenging months of December 2019 and January 2020.

Public messages around choosing the most appropriate service for healthcare needs and the presence of alternative services and pathways of care for our primary care and ambulance service colleagues have again supported our patients in receiving the care they needed and as close to their home as possible. In turn, this helped hospital services deal with those more seriously ill patients and be able to better manage under the additional winter pressures.

The CCG continues to share messages of wellbeing and self-care which can be found on our website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/campaigns.

2.4 Priority 4: Planned Care

2.4.1 Ensuring Patients Receive Clinically Beneficial Treatment

The CCG have continued to work with GP practices and our acute providers to reduce clinical variation for GP referrals, subsequent procedures in hospital and achieve a sustained reduction in outpatient activity. We continue to ensure that all services are as clinically effective as possible and patients only receive an operation where it will be clinically beneficial.

During late summer 2018, the CCG introduced a referral management service across all constituent practices. Following monitoring of the service on a monthly basis, this service was de-commissioned in Summer 2019. The pilot showed few referrals were being "rejected" back to primary care which indicated that all alternatives to referral had been considered prior to an actual referral being submitted. Work continues to closely monitor primary care referrals and should this increase, consideration will be given to the re-implementation of a referral management service.

2.4.2 Gastroenterology

In the summer of 2019, the CCG introduced across all its GP practices, a new diagnostic test called Faecal Immunochemical Testing (FIT), which is a screening test for colon cancer. Early indications are that the introduction of this test is seen as a positive step and further analysis will be undertaken to fully understand any impact.

2.4.3 Orthopaedics

We continue to work with our orthopaedic consultant colleagues reviewing pathways particularly for shoulder and hand surgery. We have adapted pathways for our local circumstances and then implemented them.

2.4.4 Diabetes Services

The diabetes prevention programme has been actively implemented with 5.7% of the population being identified as having Non Diabetic Hyperglycaemia and therefore at risk of diabetes. This is higher than the national average of 4.2% of the population. There were more patients referred into the Prevention Program 24.13%, which compares well to the national average of 21.48%. This means a total of 1,490 patients have been offered Diabetes Prevention.

A particular focus of the additional funding was to provide additional Structured Education for those newly diagnosed with Type 2 Diabetes. This has shown a dramatic improvement where 725 or 85.8% (National Average 79.7%) of those newly diagnosed were offered an education programme. Out of these 24.9% attended the course (National average 13.5%). This has been brought about through the collaboration of the HDFT Dietetics team, Heartbeat Alliance and the GP practices.

The GP practices were also introduced to Eclipse, an approved national tool to help practices identify patients whose care may be sub-optimal. This was taken up by all the practices. Patients highlighted through this software were either discussed at a virtual Outpatients clinic and a plan developed with a Consultant specialising in Diabetes, or they were invited to a joint clinic with a Diabetes Specialist Nurse supporting the practice nurse to provide optimal care.

2.4.5 Cancer Transformation

During 2019/20, 9 further practice visits were carried out by our Cancer Research UK (CRUK) Facilitator relating to the roll out of Faecal Immunochemical Testing (FIT), the No Fear cervical screening campaign and development of cancer champions. Dr Amann stepped down from her role as our Macmillan GP in September and we are working with colleagues in Macmillan to determine the future shape of Macmillan support for primary care. Alongside this, we have agreed some funding with the alliance to support Primary Care Networks (PCNs) to take up the enhanced role relating to cancer, as described in the new national specification and continue to work with them to firm up the proposal which will support earlier diagnosis of cancer as well as improving support post discharge and treatment.

This year, our CRUK representative has continued development work with our practice champions, providing additional group training sessions on cancer screening programmes and prevention and lifestyle information. This has also provided opportunities for champions to share learning and experience and develop peer support, something they have valued. This has also been supported by funding from the Northern Cancer Alliance.

We have successfully completed the roll out of the pathway for patients with serious non-specific symptoms (SNSS) across HRW. During 2019/20 this pathway received 98 referrals, the top three presenting symptoms were weight loss, fatigue and abdominal pain. Nearly half of patients had experienced their symptoms for three months or more and 12% of patients were referred in on a GP “gut feeling”. We found 8 cancers, giving a total conversion rate of 8.2%. Feedback from patients has been positive. This pathway is now becoming a formal Rapid Diagnostic Centre pathway in line with the national guidance.

We have continued to work with South Tees Hospitals NHS Foundation Trust (STHT) to develop the Living With and Beyond (LWB) programme, again supported by alliance funding. In particular we are aiming to develop a tool that can be used in primary care to deliver high quality cancer care reviews and to increase the amount of Health Needs Assessments (HNAs) and treatment summaries that are being completed and shared with primary care to support that process. HNAs are now offered across all tumour sites for manual completion and uptake is very good in this format. The e-HNA is offered in all tumour groups with the exception of Urology, Gynaecology, Upper GI, Head and Neck, and Haematology though uptake in this format remains lower.

Health and Wellbeing events have been have been held for all tumour groups except Lung, Gynaecology and Head and Neck.

2.5 Priority 5: Mental Health and Learning Disabilities Services

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 workforces 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 Terms of Reference and addressed Information Governance issues regarding 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. The CCG did work jointly with HDFT to develop and implement a new and sustainable model for children and young people across HaRD and HRW CCGs (see section 2.5.7).

2.5.1 'Transforming Mental Health Services'

Commissioning the right mental health services for our patients remains a priority for the CCG.

Following the closure of the inpatient beds at the Friarage Hospital, Northallerton all key metrics and outcomes agreed as part of the transformation project have been delivered, these included:

- Reduction in Length of Stay
- Reduction in Admissions
- Changes / Increases to Staffing Establishment

By investing in community services we aim to reduce the number of inpatient admissions as well as the length of time individuals need to spend in hospital (this is what people told us they wanted). When people need to spend time in hospital these services are provided in specialist facilities in Darlington and Middlesborough.

2.5.2 Living Well with Dementia

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.

2.5.3 New Models of Care for Crisis Support and Intensive Home Treatment

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) continue the pilot for new models of care for crisis support and intensive home treatment to support children and young people in a mental health crisis. This project has established a model based on planned and unplanned care, with the crisis team 'holding' urgent cases until and after assessment and decisions regarding care and treatment.

In the Hambleton, Richmondshire and Whitby locality a full Crisis and Intensive Home treatment service is in place, this is in operation seven days a week, 24 hours a day.

Tees, Esk and Wear Valleys NHS Foundation Trust are also working towards a 24/7 service across all of North Yorkshire.

Savings from the New Models of Care model have been used by TEWV to commission Kooth online counselling in North Yorkshire. Kooth[6] is an online counselling tool for young people.

2.5.4 North Yorkshire School Mental Health Project

In May 2019 North Yorkshire CCGs, Vale of York CCG and NYCC worked jointly with TEWV to submit a joint Green Paper Trailblazer bid to NHS England. The application for Mental Health Support Teams in schools was successful and will provide mental health support for young people aged 15-19 in Scarborough and Selby Localities. The teams will be launched in 2020 and Learning from the trailblazer sites will be shared across the NY locality.

[6] https://www.kooth.com/

2.5.5 Integrated Pathways for Children and Young People's Mental Health

Integrating pathways for Children and Young Peoples Mental Health services is a key priority across the North Yorkshire CCGs. Work continues between key partners to integrate pathways and key accomplishments include:

- Development of a signposting website for children and young people's mental health across North Yorkshire. The website called 'The Go To' has been developed in partnership with NYCC and designed in collaboration with children and young people. The website is scheduled for launch at the end of Q4 19/20.

The Go-To
For healthy minds in North Yorkshire

- Joint commissioning – the North Yorkshire CCGs and North Yorkshire County Council (NYCC) are working together to explore joint commissioning options for CYP early intervention mental health services in schools post 2020 (currently Compass BUZZ and Compass Reach).

2.5.6 Transforming Care for Children and Young People

The final NHS England TCP Children and Young People's benchmarking exercise took place in April 2019 which received great feedback and resulted in a green rag rating (an improvement from the previous benchmarking exercise in October 2018 that was rag rated amber). It was recognised that the positive outcomes included successful implementation and fully embedded TCP Children and Young People's Dynamic Support Register (DSR) and low in-patient numbers and compliance with Care Education and Treatment Reviews. The DSR identifies those children and young people who have been admitted to inpatient or residential settings, or who are at risk of escalating into such settings within the next six months. The DSR continues to be monitored at the monthly multi-agency TCP Children and Young People's Dynamic Support Register meetings.

NHS England lead for Children and Young People Learning Disability and Autism Programme attended the February 2020 the DSR meeting with positive feedback on the identification and managing needs of the Children and Young People on the DSR. There continues to be low in-patient admissions from North Yorkshire.

2.5.7 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

2.5.8 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 six weeks. There is a requirement that 90% of these requests should be returned within the six weeks. During 2019/20 the CCG Children's Commissioning Team worked with partners at North Yorkshire County Council to improve the internal administration processes for EHCP monitoring, and the process is now in place. This has resulted in a notable improvement in EHCP heath returns performance with 96% being achieved across North Yorkshire in Q3 2019/20 (Q4 2019/20 performance available end April 2020).

We have also developed an EHCP Exceptions Health Advice Form for teams to complete which will support the audit of valid and non-valid late returns. This will help us improve EHCP performance and quality.

The recent SEND Peer Review with North Yorkshire County Council recognised a significant improvement in health representation and relationship with Local Authority with evidence of CCG commitment to engage. There are some areas for improvement, particularly around a whole-system approach to SEND and joint commissioning which the team will be working on with our Local Authority partners in 2020/21.

Moving in to 2020/21 the key priorities will be to improve the quality and outcomes from Health Providers in the EHCP. This will improve outcomes for children and support measureable outcomes.

2.5.9 Children's Continuing Care

The Children's Continuing Care Team works across the North Yorkshire and NHS Vale of York CCGs providing continuing care packages to children and young people with complex needs whose health needs are not met through universal or targeted services alone.

The team has undergone a period of review with team remodelling including additional hours for a Continuing Care Nurse commencing April 2020.

The team have developed a training package which has been delivered to Providers and Local Authority with excellent feedback. The next stage will be to develop this into an online training package.

The team have developed a caseload tracker to identify caseload capacity, dates for review, and dates for EHCP. The team is aiming to align the Continuing Care review with EHCP to improve patient experience and work towards joint outcomes.

Integrated working is key to the delivery of Continuing Care and the team continues to develop positive working relationships with local partners, including Local Authorities and both local NHS and private Providers.

The team has recognised the need to develop engagement with children and young people and their families who are eligible for Continuing Care and this is a priority for 2020/21. Work has started on an Engagement Tool to support this.

3 Our Financial Position

The CCG is reporting an in year breakeven position, this is following receipt of £6.6m of Commissioner Support Funding (CSF) from NHS England. The CCG has a brought forward deficit from 2018/19 of £5.78m, with the 2019/20 in year breakeven position the CCGs cumulative deficit will therefore remain at £5.78m.

The CCG developed its 2019/20 financial plan in the same way as previous financial years. The CCG recognises the importance of delivering its statutory duties. After a number of iterations of the plan, NHS England agreed that the CCG should submit a deficit plan of £1.6m to ensure it was eligible for Commissioner Support Funding (CSF). This required the CCG to deliver a challenging savings target (QIPP) of £3.8m.

The CCG is reporting delivery against its QIPP of £3.5m which is a significant achievement against a challenging target.

Despite this achievement the CCG still experienced significant financial volatility in the Acute and Independent Sectors, Continuing Healthcare, Mental Health out of area and out of contract placements and prescribing budgets, which meant it would not meet its £1.6m deficit plan, NHS England and Improvement has supported this position and provided additional CSF support of £5.0m to enable the CCG to breakeven.

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 150 onwards.

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%	**77.6%**
Maximum 6 weeks diagnostic test waiting times	≤1%	**15.5%**
A&E waits – 4 hours to assessment, treatment and discharge	95%	**85.3%**
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	92.0%
Maximum one month (31-day) wait from decision to treat to treatment for all cancers.	96%	95.7%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	85%	83.6%

* 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

Performance has steadily reduced throughout 2019/20 and continues to be below the 92% national standard. This position is reflected nationally. Specialties failing the target are: Cardiothoracic Surgery, General Medicine, General Surgery, Neurology, Neurosurgery, Ophthalmology, Plastic Surgery, Trauma & Orthopaedics and Urology.

The waiting list position was planned to be no higher than 7,727 by March 2020. The waiting list position has been growing throughout the year and finished at a total of 8,519 which was an increase of 618 patients compared with March 2019.

6.1.3 Diagnostic Test Waiting Times

CCG level Performance against this metric in December failed to meet the 1% target set out in the NHS Constitution, coming in at 6.0%. There were 164 breaches of the 6 week target for this metric in December 2019.

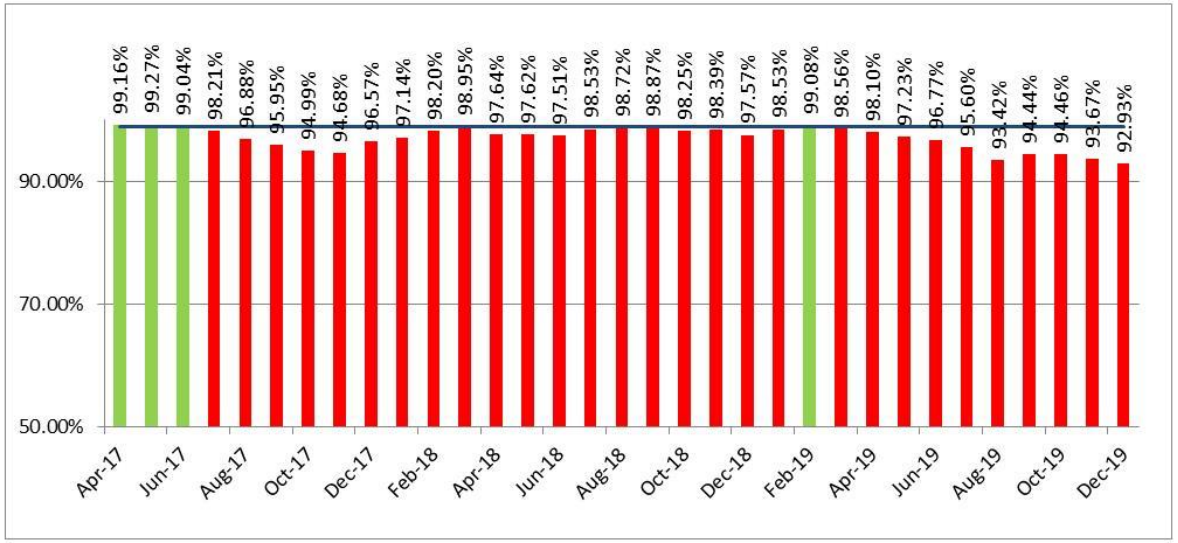
The main providers who contributed to this under performance were South Tees FT (131 Breaches in December) and York FT (27 Breaches in December) with the main tests underperforming being Colonoscopies at South Tees (42 Breaches), Neurophysiology - peripheral neurophysiology at South Tees FT (10 Breaches) and Audiology – Audiology Assessments at South Tees FT (38 Breaches).

South Tees FT have advised they plan on the following measures to resolve the issue and help prevent further issues:

- **Gastroenterology**: Commencing Saturday working from Jan 2020, the trust has approval to fund for six months.
- **Audiology**: Upgrade of 'Auditbase' database, this has been delayed to April 2020 due to worldwide shortage of i-7 chips.
- **Urodynamics**: Consultant recruitment cited for Summer 2020, impact on performance likely to be November 2020.
- **Flexi –Sigmoidoscopy**: Breaches all require consultant intervention, nurse led diagnostics are now down to 6 weeks. Capacity & Demand work is underway, with early discussions as to whether insourcing additional capacity will be suitable.

DIAGNOSTICS : % patients waiting 6 weeks or less for a diagnostic test [Target 99%]

Dec 19	Q3	Q2	Q1	YTD
92.93%	96.04%	98.13%	97.35%	95.11%



- **MRI**: Currently off track due to booking staff sickness and backfill not utilising slots appropriately. Recovery meeting has been undertaken and a plan developed going forward, the trust continues to monitor this weekly. Additional sessions have also been identified in Feb and March to support getting back on track.

6.1.4 A&E Waits

A&E performance has fallen across the year with the lowest figures seen in the winter months. This performance requirement continues to be a challenge at a national level.

6.1.5 Cancer Waiting Times

In 2019/20 we have achieved four of the eight cancer waiting standards. The delivery against the Cancer two week waiting time target of 93% compliance was not met. This could be explained by the rise in the number of patients being referred which has increased by 10% since 2018/19. The two week wait for breast symptoms has achieved the 93% target. The one month wait from decision to treat to treatment target was met in five months of the financial year but just fell short of the 96% target. The one month wait for subsequent treatment target of 94% was met where the subsequent treatment was surgery or radiotherapy. The percentage of patients receiving first definitive treatment for cancer within two month of referral from a GP was slightly below the 96% target; however, the percentage being referred from an NHS Cancer Screening Service did achieve the target with a performance of 98.1%.

6.2 The Quality Premium

In previous years, as part of the Quality premium, each of the CCG organisation has have 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 a 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 55.0%	53.9%

Indicator	Data	Target	Position
Max 62 day wait for first definitive treatment for cancer following an urgent GP referral for suspected cancer	2019/20 (Apr-Mar)	85%	83.6%
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%	73.5%
National Cancer Patient Experience Survey	2018	Nat Av 8.80	8.81

During 19-20, 9 further practice visits were carried out by our CRUK Facilitator relating to the roll out of FIT, the No Fear cervical screening campaign and development of cancer champions. Dr Amann stepped down from her role as our Macmillan GP in September and we are working with colleagues in Macmillan to determine the future shape of Macmillan support for primary care.

We have worked with colleagues from across the North East to engage in their Screening Saves Lives programme. This programme aims to increase the uptake of cervical screening by providing information in a friendly format in a magazine and incentivising uptake through a rewards system (Screen Stars), supported by local businesses. 21 out of 22 practices have become No Fear practices and received their promotion materials and those who are below 76% coverage have been offered additional support with in-house training for staff, deliver by the CRUK Facilitator.

14 of our practices have signed up to provide information to the National Cancer Diagnosis Audit and this should mean that we receive a CCG level report on the findings. This will provide useful information about routes to diagnosis, prompt further analysis of data and can open conversations with practices to identify actions that will lead to earlier diagnosis in the future.

We have worked with colleagues across South Tees and with CRUK to roll out the use of FIT testing for symptomatic patients and this has been supported by training packages which were delivered in primary care by a series of expert guest speakers. Cancer Champions also received training in processing FIT tests in practices as part of the sessions on screening. To date 427 tests have been completed. The roll out of FIT in the screening programme has also occurred alongside this.

Post surgery, all tumour groups except urology (excluding prostate), brain and CNS, Cancer of Unknown Primary and Head and Neck are completing treatment summaries. Treatment summaries are also being completed post chemotherapy and radiotherapy.

In addition to the focus on earlier diagnosis which we hope will lead to better outcomes and increased survival for our patients, we have been working with STHT and using cancer transformation funding to transform support post diagnosis in primary and secondary care and to embed the pathway for SNSS patients. In general we perform well on the National Cancer Patient Experience Survey but hope the work we are doing will bring further improvements in areas including support during treatment and involvement in decision making throughout the pathway. Further detail about the work can be found in the cancer transformation section 2.4.5.

6.3.2 Dementia

Indicator	Data	Target	Position
Dementia: Estimated diagnosis rate for people with dementia	Mar 2020	66.7%	**55.6%**
Dementia: Care planning and post- diagnostic support	2018/19	Nat Av 83.6%	83.7%

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 for more information on the work being undertaken see section 2.5.2.

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%	41.7%
People with diabetes diagnosed less than a year who attend a structured education course	Jan – Sep 2019	Nat Av 13.2%	24.9%

HRW CCG completed the third year of its transformation programme to improve care for patients with diabetes, with support from transformational funding from NHSE. The successes and learning from the programme will now be reviewed in order to confirm how services will be made recurrent and sustainable going forward.

Structured education for patients with Type 2 diabetes continues to be delivered within primary and community settings. The overall programme is co-ordinated by Heartbeat Alliance working closely with the Dietetics Department at STHFT (South Tees Hospitals NHS trust) and with Humber Foundation Trust for Whitby area. The programme has increased overall access to education, through practice nurse educators working across practices.

Practices have also been actively improving compliance with treatment processes. This has been accomplished with support from an expert practice nurse, who works across practices to provide education and training and proactive support. Practices also receive support from a consultant diabetologist out-reaching into primary care for virtual case-review of complex or non-compliant patients with GPs and practice nurses. This work has been supported by active use of Diabetes Eclipse software (funded through NHS Digital) which allows practices to determine performance against key treatment targets.

Foot care particularly is also being actively improved through greater emphasis on rapid access and triage in primary care through podiatry and a multi-disciplinary foot team working at acute level. This includes a full MDT weekly clinic at the Friarage Hospital, Northallerton. Again, practices receive training and support to improve the quality of initial work in primary care, including clearer pathways for rapid escalation where there are active problems.

Where patients require acute care, particularly Type 1 patients, or those type 2 patients which are not well-controlled, then increased support has been provided through an additional diabetes specialist nurse. This is is helping to improve quality and reduce acute lengths of stay.

6.3.4 Mental Health

Indicator	Data	Target	Position
Improving Access to Psychological Therapies: Access	2019/20 to Feb	15%	11.4%
People with first episode of psychosis starting treatment with a NICE recommended package of care within 2 weeks of referral.	2019/20	50%	63.2%
Improving Access to Psychological Therapies: Recovery Rate	2019/20 to Feb	50%	55.8%
The proportion of people that waited 6 weeks or less from referral to their first IAPT treatment	2019/20 to Feb	No target	83.7%
Children and Young People's mental health service transformation	Jan 2020	34%	**23.1%**

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 Harrogate and Rural District CCG website[7].

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

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

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.

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 Maternity

Following on from NHS England's National Maternity Review, Better Births, in February 2016 the Durham Darlington Tees & Hambleton Richmondshire and Whitby Local Maternity System developed a delivery plan for 2017–2020 to which the CCG contribute. Over 2019/20 the Local Maternity System has concentrated on:

- Choice, Personalisation and Continuity of Carer
- Safety
- Perinatal Mental Health
- Enablers including digital transformation
- Maternity Voices Partnership (MVP)

The key achievements within HRW during 2019/20 have been:

- South Tees Hospital NHS FT securing funding to support the introduction of the Continuity of Carer model at the midwifery led unit at the Friarage Hospital, Northallerton
- The development of the maternity voices partnership outreach into Catterick
- Support for routine outcome measures for peri-natal mental health services
- Progress has been demonstrated across the Durham Darlington Tees and Hambleton Richmondshire and Whitby Local Maternity System readdressing still births
- The Local Maternity System has funded and appointed 2 x Breastfeeding Co-ordinators to support UNICEF Accreditation. This will support the ambition of 100% of units gaining level 2 UNICEF UK baby friendly accreditation in 2020
- The Local Maternity System has developed an Nicotine Replacement Therapy (NRT) best practice guide and NRT decision aid for use in local practice to improve consistency of provision

- Development across both the Durham Darlington Tees & Hambleton Richmondshire and Whitby and the Northumberland, Tyne and Wear and Durham Local Maternity System of the alcohol in pregnancy tool which is now ready for use.

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	64.8%	**51.5%**
Completeness of the GP learning disability register	2018/19	Nat Av 50.0%	58.3%

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.

There are a number of carbon hotspots in the NHS and we are helping to reduce carbon emissions by:

	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. • 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.

	What are we doing?
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 the Hambleton, Richmondshire and Whitby are and 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 the Hambleton, Richmondshire and Whitby 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

Commissioning health services which are environmentally, socially and economically sustainable is paramount to meeting the health needs of our local population. Prevention is embedded in the development of all our models of care, to address the wider determinants of health and causes of illness. The organisation is aware of its legal obligations in commissioning and procurement of care under the Public Services (Social Value) Act 2012 and The Governing Body understands sustainable care models and

Sustainable use of resources is embedded as a decision criterion in the development and commissioning of care models via the use of Sustainability Impact Assessments (SIAs). Quality Impact Assessments and SIAs also link sustainability as a dimension of quality with other dimensions of quality such as fairness/inequalities/social justice when we design, deliver and commission care models.

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 Harrogate and Rural District CCG (HaRD 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 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 CCG continues to work closely with its GP Federation, Heartbeat Alliance, ensuring that the service continues to deliver as planned.

The service is fully operational operation from a total of 10 “hubs” across the CCG footprint. There is a range of appointments available for booking ranging from GP, nursing, first contact physio and clinical pharmacist. This allow patients to have access to different expertise depending on their clinical need and also help ensure we maximise support for our busy GPs who are able to focus on those patients who most need their skills.

6.5.2 Care Quality Commission (CQC) Inspection of GP Practices

From January 2016 to December 2019, 21 out of 22 practices within Hambleton, Richmondshire and Whitby CCG footprint were inspected by the Care Quality Commission (CQC). The remaining practice is due an inspection imminently. 18 practices were rated “Good” with 3 practices rated as “Outstanding”.

Patient satisfaction scores in respect to ‘overall experience’ of their GP service as being ‘Good’ are an overall 93% for the 2019 survey.

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 Improving Hospital Discharge Processes and Reducing Delayed Transfers of Care (DTOCs)

We have been working closely with North Yorkshire County Council (NYCC) and South Tees Hospital foundation Trust to develop our discharge pathways under discharge to assess.

The discharge to assess pathway 1 home had been developed and introduced enabling less complex elderly patients to be discharged earlier. NYCC have trained nursing staff to become Trusted Assessors allowing the patient is discharged home, supported by the Hospital from Home Service. Social Care will visit the patient at home to complete a full assessment reducing the length of stay a patient is in hospital.

Discharge to assess pathway 3 continues to embed, allowing patients to be transfer from an acute hospital to a community setting or home to allow time for recovery and recuperation before a Continuing Health Care Assessment is made.

We have been working with Tees Esk and Wear Valley (TEWV) review patients suffering from a delirium as part of the discharge to assess pathway. TEWV have being piloting supporting the patient from the acute hospital through to the community settings and assessing the patient with social care colleagues. The initial feedback from this pilot received is good.

6.5.5 Continuing Healthcare

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.

6.5.6 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.

6.5.7 Diabetes Transformation

The diabetes prevention programme has been actively implemented with 5.7% of the population being identified as having Non Diabetic Hyperglycaemia and therefore at risk of diabetes. This is higher than the national average of 4.2% of the population. There were more patients referred into the Prevention Program 24.13%, which compares well to the national average of 21.48%. This means a total of 1,490 patients have been offered Diabetes Prevention.

A particular focus of the additional funding was to provide additional Structured Education for those newly diagnosed with Type 2 Diabetes. This has shown a dramatic improvement where 725 or 85.8% (National Average 79.7%) of those newly diagnosed were offered an education programme. Out of these 24.9% attended the course (National average 13.5%). This has been brought about through the collaboration of the HDFT Dietetics team, Heartbeat Alliance and the GP practices.

The GP practices were also introduced to Eclipse, an approved national tool to help practices identify patients whose care may be sub-optimal. This was taken up by all the practices. Patients highlighted through this software were either discussed at a virtual

Outpatients clinic and a plan developed with a Consultant specialising in Diabetes, or they were invited to a joint clinic with a Diabetes Specialist Nurse supporting the practice nurse to provide optimal care.

6.5.8 Early Cancer Diagnosis

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.

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.

In the CCG we have continued to work closely with the Living Well team who have supported two practices within the Northallerton locality. Appointments are available on a weekly basis and patients can be referred either by their GP or self-refer. Primary Care Networks are in the process of employing Social Prescribing Link Workers who will be able to assist patients from other practices.

6.5.10 Care Homes

We have continued to work collaboratively with the Quality Improvement team from North Yorkshire County Council to lead on the implementation and monitoring of the National Enhanced Health in Care Homes Framework initiatives and present at local provider engagement events. This has included the launch of the "REACT to" series, which are online resources relating to differing topics, aiming to build a culture of safety improvement and learning whilst improving the quality of life for the care home residents.

Immedicare has been introduced into locations across Hambleton Richmond and Whitby CCG. This is a digital nursing hub which gives patients and staff immediate, face to face access to a team of senior nurses who have the support of a wider team of hospital senior doctors and specialist nurses if required. In real time, residents can be monitored via a secure two way video link, with the specific aim to enable the frail elderly residents to be assessed within their place of residence, advice and guidance given or onward referral to the GP or emergency services. There are currently 29 facilities including nursing and residential care homes and extra care utilising this service, calls are now averaging 150 per month. Our General Practitioners are supporting this initiative and in December 2019 the use of Immedicare allowed 92% of our patients to remain in their place of residence.

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 Hambleton and Richmondshire locality there are a total of 97 schools and of these schools:

- 94 schools received or booked Level 1 training;
- 82 schools received or booked Level 2 training;
- 65 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 Hambleton, Richmondshire and Whitby (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’.

Overall the CCG has assessed itself as demonstrating ‘significant compliance’ against the EPRR core standards in 2019. The CCG assessed itself against as being fully compliant in all but four of the individual standards; being "partially compliant" in these four areas. An action plan has been developed to address the four standards showing partial compliance in the 2019 assessment.

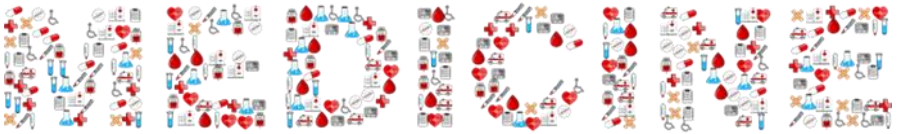
In terms of Business Continuity it was found that the Covid-19 pandemic created an unprecedented situation, with Major Incident Plans being of limited value due to having been created around very different scenarios involving major trauma. Pandemic Flu Plans were also of limited value to the highly contagious 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 focus 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 in HaRD showed a reduction in waste of 57% following implementation of on-line ordering and we would expect similar results in HRW care homes.

- 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 has demonstrating an overall reduction of 9% in the number of patients prescribed an opioid analgesic in HaRD and this work is to be extended across all of North Yorkshire during 2020.
- Antimicrobial prescribing: results continue to demonstrate controlled use in HRW, remaining below national rates of total antibiotic prescribing. During this financial year, the Medicines Management team have supported HRW GPs in making significant reductions in the prescribing of broad spectrum antibiotics and the CCG now meets the target for this set by NHSE. Broad spectrum antibiotics are more likely to select for and to spread antibiotic resistance, so reduction in their use is a key part of the national strategy to control rates of antimicrobial resistance.
- Our local hospital Trust has achieved a successful switch of patients from the branded Humira to the biosimilar version adalimumab; releasing savings to the local health economy. From the most recent data available (August 2019), the Trust has achieved a 92% switch rate as compared to a national rate of 74%.
- A focus on increasing pharmacist led medication reviews, particularly for frail patients and those on multiple medicines. At the time of writing, 19 of our 22 practices have access to a CCG funded clinical pharmacist. Data demonstrates savings but most importantly interventions have improved patient outcomes, reduced impact on secondary care services and reduced potential for error or adverse event. Reviews undertaken by this team and the subsequent interventions have been assessed as preventing a total of 165 admissions to hospital so far this year (as graded by the RiO scoring scale).
- A separate work stream is focusing on pharmacist led medication reviews for residents in care home settings. To date the care home pharmacy team has carried out 160 medication reviews which have resulted in 280 clinical interventions and there were a total of 113 medicines stopped following discussion with the patients' GPs.

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 of England Commissioning Support Unit. The

CCG receives all serious incident reports for review and closure and they attend the Serious Incident panel where all SIs are discussed and lessons learned are shared.

6.5.19 HCA Infections

Clostridium Difficile (CDiff): Healthcare associated infections remain a major cause of potential avoidable harm. The CCG participates in both national and local initiatives, sharing resources and learning. This year we are close to our trajectory of 31 cases, all toxin positive cases are reviewed to identify any lapses in care and any lessons learned. We are working closely with our acute trusts, primary care, medicines management and the community infection prevention control team to reduce the incidence of these cases.

	Hambleton, Richmondshire and Whitby CCG
CDiff	34

Gram Negative Blood Stream Infections: E-Coli blood stream infections remain a concern for the CCG as we are over trajectory for the nationally agreed target reduction. A key focus this year has been related to raising awareness of the importance of hydration for our population. Working with colleagues from the North East Infection Prevention and Control Collaborative hydration information leaflet has been produced and has been distributed to GP practices, care homes and providers across the Hambleton, Richmondshire and Whitby area. We will continue to work collaboratively and engage in local and national initiatives to support a reduction in cases.

	Hambleton, Richmondshire and Whitby CCG
E-Coli	149

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 two 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

6.6.1 Our Statutory Duties Explained

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in the commissioning of services for NHS patients ('the public involvement duty').

For CCGs this duty is outlined in Section 14Z2 of the Act and for NHS England the duty is outlined in Section 13Q. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

- the planning of services,
- the development and consideration of proposals for changes which, if implemented, would have an impact on services, and
- decisions which, when implemented, would have an impact on services.

Fig 1: NHS England, 'Patient and public participation guidance'

6.6.2 Communications and Engagement Strategy 2017/19

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

The 2017/19 Communications and Engagement Strategy will therefore be refreshed to reflect the single organisation considering the population of the wider North Yorkshire area and build on the good examples from each CCG. However, a local focus will remain where appropriate to ensure we remain targeted and accessible to all communities.

Up until 1 April, the CCG continued to align work to the 2017/19 strategy. It sets out a clear and consistent approach to communication and engagement and how it will strengthen individual and public participation over and above its statutory requirement: to better understand the needs of the communities we serve and through effective communication and engagement to empower local people to make better choices about their own health, wellbeing and future. Our success depends on having full, two-way, open and honest discussions with patients, carers, the general public, clinicians, local authorities, voluntary groups and other key stakeholders.

We also work to a number of communications and engagement principles:

- Accessible and inclusive, to all people in our community.
- Clear and professional, demonstrating pride and credibility.
- Targeted, to ensure people are getting the information they need.
- Open, honest and transparent.
- Accurate, fair and balanced.
- Timely and relevant.
- Sustainable, to ensure on-going mutually beneficial relationships.
- Two-way, we won't just talk, we'll listen.
- Cost effective, always demonstrating value for money.

Our Governing Body currently includes a Lead for Patient and Public Involvement as well as representatives for each locality known as Health Engagement Network Representatives (HEN Reps). They are responsible for ensuring the public and patient voice is heard at Governing Body level.

6.6.3 How participation works throughout the organisation

The Lead for Patient and Public Involvement has a seat on Governing Body and has a role in overseeing many elements of the CCG with an emphasis on ensuring that, in all aspects of business, the public voice of the local population is heard and opportunities are created and protected for patient and public empowerment.

Health Engagement Network Representatives (HEN Reps) are non-voting members of the CCG's Governing Body and the crucial link between the CCG and patients and their respective localities (Hambleton, Richmondshire and Whitby).

They are the CCG's 'critical friends' who support in the sharing of important messages to groups such as Patient Participation Groups (PPGs) in general practice and the Health Engagement Network membership as well as gathering service feedback and 'soft intelligence'. HEN Reps provide a regular update of their involvement at Governing Body meetings as non-voting members.

We aim to make a particular effort to identify hard to reach and vulnerable groups and ensure we are inclusive of all our population and services are developed in response to their special needs.

6.6.4 Our stakeholders

The CCG continues to build supportive and trusting relationships with its key stakeholders and the wider public via newsletters and face to face presentations as well as press and social media. For example:

- We circulated 11 monthly newsletters for patient and public across Hambleton, Richmondshire, Whitby and the surrounding area.
- Provided content for the Friarage Hospital newsletter which was developed in partnership between the CCG, South Tees NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.
- Provided briefings to local Councillors and met with local MPs to update them on the current and future health landscape, as well as the North Yorkshire Scrutiny of Health Committee, Healthwatch North Yorkshire and voluntary sector organisations.
- Involved key stakeholders in the Catterick Integrated Care Campus programme via the Strategic Engagement Advisory Group and Communications and Engagement Working Group. The CCG and partners, to include the Ministry of Defence, Healthwatch North Yorkshire, Richmondshire District Council and North Yorkshire County Council have worked together to develop a tailored communications and engagement strategy.
- Continued to work with the County Council, providers and other CCGs regarding the ongoing contract for medical equipment. Further information around recycling and collection of unwanted equipment has been shared right across North Yorkshire as a result.

- In partnership with other North Yorkshire CCGs, the CCG published an insert to be included with Whitby council tax correspondence and have been working to be included again for 2020 issued to all households across the wider county.
- Continued to share information via the CCG's Health Engagement Network which is a membership of people who have a particular interest in local health services. Collectively they are the key to enabling the CCG to reach out to the local communities in ensuring patients and public are involved. The network added 11 new members between April 2019 and March 2020 with an overall total of 169 members.

In line with our statutory duties, to ensure the public are involved and consulted in the commissioning process, listed below are a number of consultation and engagement activities the CCG held or supported during 2019/20:

- A full public consultation took place around the future of the Friarage Hospital Accident and Emergency in Northallerton. This was to look at building a sustainable future for the hospital with particular emphasis on urgent and emergency care and the

public were presented with two options for consideration. The consultation was extensively publicised in print, on radio and television, via social media, on websites and through a programme of leaflet and poster distribution across the hospital catchment area. 13 public events took place attended by 326 and in addition there were four public and eight self-facilitated voluntary sector focus groups. Over 1,600 people completed the survey including 601 on the street in locations across the area, 701 online and 309 on paper. Finally a number of groups were met with directly including Save the Friarage, Healthwatch North Yorkshire, Parkinson's UK, Age UK, the Thirsk and Malton Area constituency meeting and the community in Snape. All feedback is being collated and a final report will be available in spring 2020.

- Work has continued with the Catterick Integrated Care Campus and we have been actively engaged with partners including Healthwatch North Yorkshire and the Friends of the Friary, in particular. A Patient Representative Group will re-meet in spring 2020 to discuss proposals and will pave the way for ongoing engagement in the Richmondshire area.
- The CCG's Annual General Meeting was held on 25 July in Northallerton which was open to the public. Talking points included the challenges faced by the NHS over the last 12 months, local health spending and developments in the area as well as the priorities of the CCG over coming year.
- The CCG attended a Right Care, Right Place conversation event which was held in Northallerton hosted by Tees, Esk and Wear Valleys NHS Foundation Trust where partners and voluntary sector representatives attended to discuss the current and future model of North Yorkshire mental health services.
- The CCG was invited by 38 residents of Fairfield Court in Whitby to talk through and answer questions on 'keeping healthy' subjects such as hydration, falls, medicine management and keeping warm.
- On behalf of the CCG, the Lead for Patient and Public Involvement and HEN Reps attended a number of Dying Matters engagement events supporting the community team in areas such as Bedale and Whitby.
- On behalf of the CCG, the Lead for Patient and Public Involvement and HEN Reps attended a number of PPG meetings to share information on key CCG projects and feedback any queries or concerns.

All three North Yorkshire CCGs have been working with lay members and HEN reps to develop a new engagement model to take forward from 1 April 2020. The overall intention is to strengthen engagement across the whole of North Yorkshire and to adopt the best of each CCG's approaches where appropriate. Localised engagement during key programmes of work will continue including Whitby Hospital and the Catterick Integrated Care Campus.

6.6.5 How we communicate and gather feedback

We use a number of channels to communicate and gather feedback from our stakeholders including:

- Briefings
- Face to face at meetings and events
- Engagement/ consultation
- Website
- Email
- Telephone
- Stakeholders (via HEN Reps, PPGs, practices and provider organisations)
- Letters
- Social media
- Newspaper ‘letters’
- Posters
- Leaflets/ booklets/ Easy Read versions
- Via the media (releases and statements)
- Text messages (via GP practice systems)

The CCG also reviews data sets including GP surveys, the Friends and Family Test along with the ‘soft intelligence’ from HEN Reps and PPGs.

During 2019/20 the CCG has proactively issued press releases on subjects including:

- Merger of North Yorkshire CCGs
- Consultation into services at the Friarage Hospital
- Dying Matters campaign
- GP advice on staying well in winter
- Proposed launch of ‘The Go-To’ website for young people
- New online mental health support for young people
- Norovirus, Coronavirus and flu warning
- Antibiotics Awareness Week

- New recycling point for community equipment
- Year of the Nurse campaign
- Wake Up North Yorkshire alcohol campaign.

6.6.6 Social Media

In the twelve months up until the end of March 2020, we posted 1,751 tweets on Twitter with a total of 661,800 impressions. Our posts were re-tweeted 874 times, liked 841 times with 418 mentions, 36 comments and 161 new followers.

On Facebook we posted over 1,700 posts reaching a total of 99,224 people with 75,000 post engagements and 7,500 page views. At the end of March, we gained 129 page followers and 112 new page likes.

6.6.7 Being inclusive

We aim to make particular efforts to identify hard to reach and vulnerable groups and individuals representative of our population to ensure that we develop services in response to their specific needs. For every project, we develop communication and engagement strategies which include stakeholder maps.

We have continued to develop our HEN to try and ensure we do not exclude or underrepresent certain people - these may include people from the nine protected characteristics. In early 2020 and in line with GDPR, we began the process of writing to each HEN member to invite them to join The Loop which is to be the new network across the North Yorkshire CCG from 1 April.

During consultations and engagement we continue to have ‘easy read’ versions of key documentation including information leaflets and a summary consultation document. We will continue to offer this in future projects. Similarly, we have placed bigger emphasis on hosting engagement and consultation events in accessible locations accessible to our population and at different times of the day. More information can be found in individual consultation strategies our website: www.hambletonrichmondshireandwhitbyccg.nhs.uk/consultations-and-engagement

6.6.8 Patient relations

The total number of contacts received by the Patient Relations Team for the period 1 April 2019 to 31 March 2020 was 140. The table below shows the number and category of contacts received by the Patient Relations Team (excluding contacts relating to specific GP issues, dentists, opticians and pharmacists).

Complaints	Concerns	Queries / Other	Compliments	Total
20	37	83	0	140

The majority of contact to the Patient Relations Team related to the Autism assessment pathway (53) and the withdrawal of Minor Injuries Service (7). Due to the remaining numbers being so low no other themes were identified. An increased waiting time for autism assessments resulted in a service review. A new model was implemented and the number of enquiries has reduced.

The CCG welcomes feedback, positive or negative, about experiences of local NHS services as this helps us to improve services for patients. If you are unhappy with the treatment or service you have received from NHS services, you have the right to make a complaint, have it looked into and receive a response. You can also raise your concerns immediately by speaking with the staff involved. If you're pleased with one of the services commissioned by the CCG or wish to raise a concern or make a complaint, then please let us know by contacting us by phone, letter or email:

Email: HRWCCG.PatientRelations@nhs.net

Phone: 01609 767607

Address: Patient Relations, NHS Hambleton, Richmondshire and Whitby CCG, Civic Centre, Stone Cross, Northallerton DL6 2UU.

6.6.9 Parliamentary affairs

The total number of MP letters received by the CCG for the period 1 April 2019 to 31 March 2020 was 17. The table below shows the number received from each MP.

Robert Goodwill MP	Kevin Hollinrake MP	Rishi Sunak MP	Other	Total
5	1	11	0	17

6.6.10 What we have learnt – You Said, We Did

Improve communications around local projects

Due to significant changes within the CCG, some communications resources have been focussed on ensuring staff and stakeholders are aware and engaged in the merger towards a single organisation.

"We used to hear more news about positive CCG and Trust service developments"

However, significant work has continued to progress with local projects including Whitby Hospital and the Catterick Integrated Care Campus. They have both reached key milestones and the CCG is working with partners to ensure we communicate and engage with our communities.

The CCG has been reviewing the stakeholder newsletter which has previously included updates from local hospitals and other services. This will continue in future issues under a brand new North Yorkshire CCG newsletter.

Reducing unnecessary length of stay in hospital

We have been working closely with North Yorkshire County Council and South Tees Hospitals Foundation Trust to develop our discharge pathways under discharge to assess.

A new discharge to assess pathway to home has been developed and introduced enabling less complex elderly patients to be discharged earlier.

Another discharge to assess pathway continues to embed, allowing patients to be transfer from an acute hospital to a community setting or home to allow time for recovery and recuperation before a Continuing Health Care Assessment is made.

"I'm scared of going into hospital and not coming out for months."

Reinstatement of the Minor Injuries Scheme

Since the withdrawal of the primary care Minor Injury Scheme in April 2019, a number of conversations took place with stakeholders, partners and patients which helped give a wider appreciation of the benefit of this service. This was of particular concern in our more rural areas. Taking into account the outcome of these conversations, it was agreed that certain elements of the service would be reinstated with effect from 1 December 2019. These interventions include lacerations requiring sutures, burns including broken skin and eyelid injuries. Whilst the Friarage Hospital continues to treat these patients, reintroduction of the service at GP practices means that patients attending can also be treated in a clinically appropriate way.

"The withdrawal of the funding would hit the most rural practices hardest."

Continuation of the end of life care service

The integrated end of life care pathway is now well established in Hambleton and Richmondshire. This service allows patients to die at home knowing they are receiving the best possible care and support. Day time care is provided by Herriot Hospice Home Care, supported by the District Nurses, Community Nurses, Specialist Palliative Care and GPs. Marie Curie continues to provide the overnight care.

"It was such a relief to know someone was coming – I hope this service can be extended"

6.6.11 What worked well this year

The most significant engagement carried out this year involved the Friarage Hospital consultation. Evaluation forms were handed out at the public consultation events and in total, 78 were completed and returned. Some good feedback was received regarding the events which included:

- All attendees who completed a form agreed that the venue for the event was easy to get to.
- A further 96% of attendees who completed a form agreed the venue was accessible.
- Of those that completed a form, 86% agreed that they found the event informative.

Some feedback suggested that improvements could be made to the variety of times during the day the events were available, which the CCG will revisit for future consultations.

Over 1,000 online and hard copy survey responses were received during the consultation plus over 600 ‘on the street’ surveys. We will aim to replicate similar responses in future consultations.

The HEN Reps continue to act as our critical friends and offer vital ‘soft intelligence’ from their communities helping us to make small but important changes to the way we communicate and engage. Along with the Lead for Patient and Public Involvement, they have been instrumental in building stronger links with PPGs and have lay the groundwork for the future of Primary Care Networks.

We will continue these approaches throughout next year where appropriate along with opportunities for proactive North Yorkshire-wide and localised engagement.

6.6.12 How to get involved

Our Health Engagement Network (HEN) is for local people who care about the NHS and health services. By joining the membership, it is an opportunity to learn more about and be involved in the development of local health services.

There are currently three categories of membership with levels of involvement:

- Advocate – actively participating in projects, surveys and volunteering time at engagement events.
- Associate – participating in surveys and questionnaires, receiving newsletters and general updates.
- Information only – receiving newsletters and general updates.

Visit our website to join and select ‘get involved’ to complete the online form: www.hambletonrichmondshireandwhitbyccg.nhs.uk

There are a number of other ways to get involved with the work of the CCG whether it is taking part in engagement and consultations or working groups on specific projects. We do our very best to promote opportunities and support those who wish to get involved, including those more vulnerable groups.

From 1 April 2020, it is proposed that all HEN members will be transferred to ‘The Loop’ for the North Yorkshire CCG (subject to permission and GDPR).

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

We serve a deeply rural population, much older than the national average, where good outcomes for many people, for example early cancer diagnosis or atrial fibrillation, mask poorer outcomes for patients with diabetes, those with health inequalities like our armed forces population, and frail patients in the last year of their life.

The main health challenges facing the communities across Hambleton, Richmondshire and Whitby are linked to an increasingly ageing population that has significant and complex long-term conditions. The population also faces significant geographical and social isolation in many of our rural communities, which contribute to the significant health inequalities across the CCG and a complex health profile. At least 50% of our population has at least one long term condition.

We take our responsibilities for reducing health inequalities very seriously; it is a core feature of every programme of work we undertake. We consider what our local communities require and how those needs can best be met by the services we commission. We are determined to reduce health inequalities through continually working to understand the health needs of local communities and making the services we commission inclusive and accessible, as outlined in our four year Equality and Diversity plan published in 2015.

Our 5 year plan on a page, our 20:20 vision based on what patients tell us and our part in delivering the North Yorkshire Health and Wellbeing Board priorities are key to the functioning of our CCG programmes and we work hard with partner agencies and as an active member of the Health and Wellbeing Board to deliver these programmes. Both our current and previous Accountable Officers are/were standing members of the NY HWB.

Recent projects in which health inequalities have been identified include step-up/step down beds, ‘Transforming Mental Health Services’ and the development of the vision for a new Catterick Integrated Care Campus.

In addition, North Yorkshire County Council produces an annual Joint Strategic Needs Assessment (JSNA). The core aim of the JSNA is to improve the public’s health and reduce inequalities across the whole County. This is done by bringing together local

authorities, community voluntary sector service users, NHS partners and others to research and agree a comprehensive local picture of health and wellbeing needs. The JSNA encourages a joined up approach to the development of services and is used to identify priorities for commissioning.

Summary reports are produced for each CCG and provide a snapshot of the current health and wellbeing indicators and allows us to understand local health inequalities, such as differences in life expectancy across the locality and the difference in outcomes between different groups of people.

The information provided below is from the NHS Hambleton, Richmondshire and Whitby CCG JSNA and demonstrates what work has been done to improve health inequalities.

6.7.1 Health profile

There are 22 general practices in NHS Hambleton, Richmondshire and Whitby CCG with 143,900 registered patients (December 2018). There is a high proportion of people aged over 65 (25.1%) in the CCG compared with England (17.3%). The proportion of people aged 5-14 (10.2%) is slightly lower than England (11.6%).

In 2015, there were 10.8% of children aged 0-15 years living in low income families, compared with 19.9% in England. The 2015 Index of Multiple Deprivation (IMD) identifies 3 Lower Super Output Areas (LSOAs) out of a total of 95 across the CCG which are amongst the 20% most deprived in England. One of them is amongst the 10% most deprived in England and it is in the Whitby West Cliff ward of Scarborough Borough.

Deprivation scores, using IMD-2015, have been estimated for general practices. They show two practices in the CCG have populations experiencing higher levels of deprivation than England.

Many people have longstanding health problems. The census in 2011 showed 26,200 people living with long-term health problem or disability (17.3% compared to 17.6% in England).

Improved access and outcomes for patients, particularly for long term conditions, including reducing health inequalities for the armed forces and their families and dependents is also a key concern for us.

6.7.2 Lifestyle and Behaviours

Whilst the health of the population is generally good there are still variations in health outcomes. A lot of risk factors can be avoided by a good diet, active lives, not smoking and reduced alcohol consumption. Therefore, prevention is key to our work and features throughout our strategic programmes.

The higher proportion of older people in the CCG area emphasises the need to promote healthy, active ageing approaches as well as the need to manage demand for services. The burden of ill health is often experienced more by particularly vulnerable groups such as the very elderly, those with mental illness and those living in deprived communities.

Smoking

NHS Hambleton, Richmondshire and Whitby CCG has the lowest rate of smoking prevalence in the Cumbria and North East ICS and lower rate of smoking prevalence compared to the England average (11.2% vs 14.4%).

Areas: All in Cumbria and North East | All in England Display: Table | Table and chart

Smoking Prevalence in adults (18+) - current smokers (APS) 2018

Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,360,957	14.4	14.2	14.7
Cumbria and North East	–	-	-	-	-
NHS Sunderland CCG	–	-	20.2	17.7	22.7
NHS South Tyneside CCG	–	-	18.8	16.2	21.4
NHS Durham Dales, Easington And Sedgefie…	–	-	17.4	14.1	20.7
NHS Hartlepool And Stockton-On-Tees CCG	–	-	17.2	15.2	19.1
NHS Newcastle And Gateshead CCG	–	-	16.7	14.7	18.8
NHS South Tees CCG	–	-	15.5	13.8	17.1
NHS North Tyneside CCG	–	-	14.9	12.2	17.6
NHS Darlington CCG	–	-	13.8	11.7	16.0
NHS North Cumbria CCG	–	-	13.7	11.1	16.4
NHS North Durham CCG	–	-	12.4	9.3	15.6
NHS Northumberland CCG	–	-	12.1	9.9	14.3
NHS Hambleton, Richmondshire And Whitby …	–	-	11.2	6.6	15.9

Source: Annual Population Survey (APS)

Disease Prevalence

There is a significant gap between life expectancy across the STP footprint and that of England and within communities across our localities. In the CCG, hypertension, obesity and depression are the most common health problems, followed by diabetes and asthma. The prevalence for most diseases and risk factors is higher in the CCG than for England.

Improving the health and wellbeing of our population remains a priority for the CCG. Working alongside North Yorkshire County Council (NYCC) Public Health Team the CCG supports a number of initiatives. Included within this is the NHS Health Check Programme commissioned by NYCC and delivered within Primary Care.

This programme screens patients between the ages of 40 and 75 for Cardio-vascular Disease, and diabetes. From these results clinicians can offer lifestyle advice or pharmaceutical intervention to reduce this risk when required.

NYCC has published the annual report for 2019/20 which demonstrates that the CCG practices managed to invite 18.3% (n=7274) of the eligible population for the NHS Health Check programme this is marginally lower than North Yorkshire average (22.5% n= 33094). Of those offered an NHS Health Check 47.8% (n=3476) of patients received the Health Check, this is lower than North

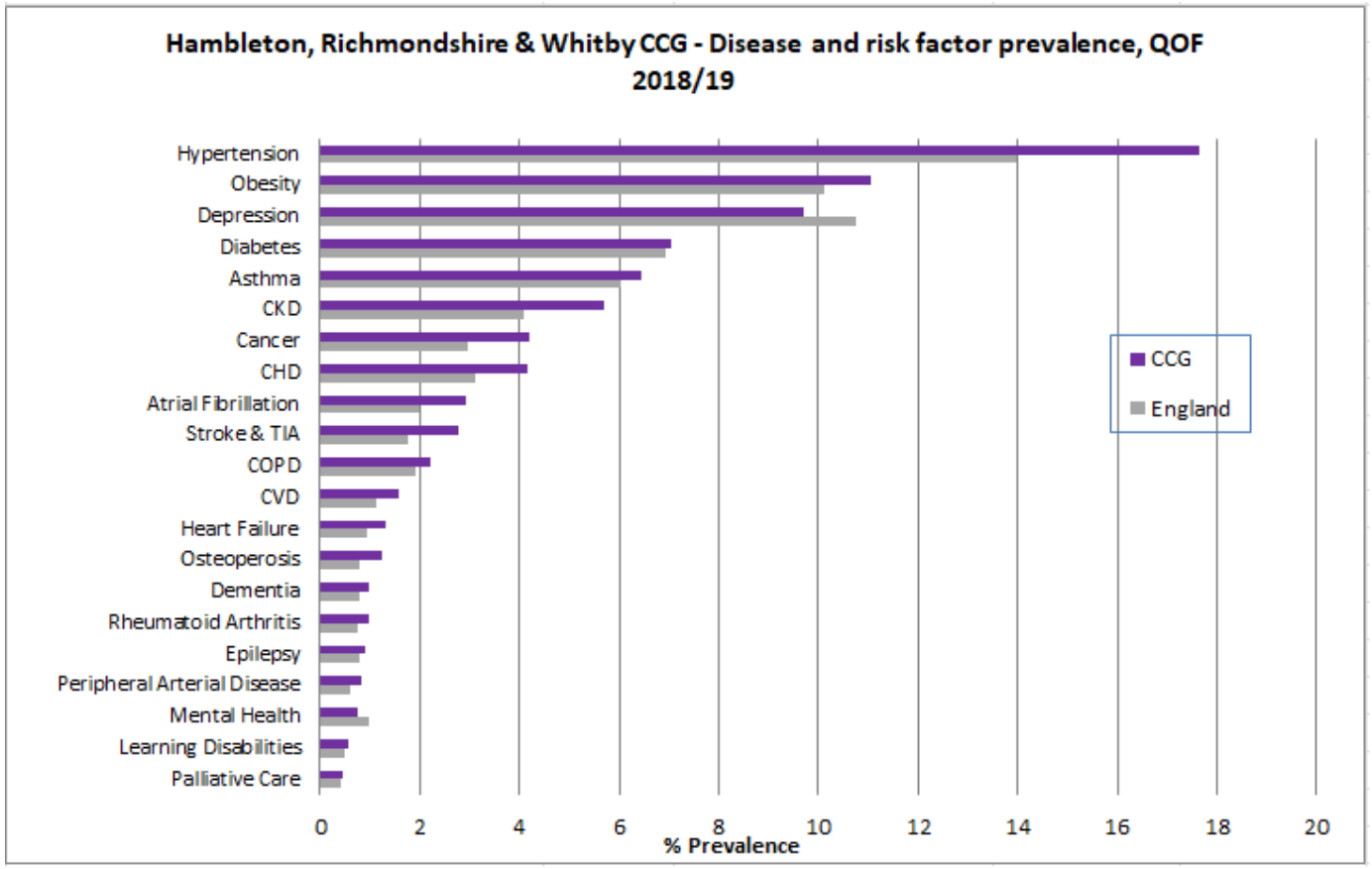
Yorkshire (50.4% n=16691) and the North Yorkshire 50% set target. This is also well below the nationally aspirational target of 75%.

26.1% (n=908) of those who received an NHS Health Check across the CCG area 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.

Key themes have also been identified through analysis of Right Care data that has identified key areas such as respiratory, CVD, Musculoskeletal and cancer.

Prevalence rates for CHD, hypertension, atrial fibrillation, diabetes and Chronic Kidney Disease are above the national average.



Our reported prevalence and treatment for atrial fibrillation is excellent based on previous work, but others are more variable, e.g. chronic kidney disease. In particular, reported prevalence and some outcomes for diabetes, particularly amputation rates, are lower than expected for our population.

The demographics of our populations leads to an increase in social isolation and the prevalence of dementia and trauma and injuries as a result of falls contributes to non-elective admissions particularly in >65s.

Programmes are in place to improve outcomes focus on preventative interventions specifically screening and early diagnosis, lifestyle changes and vaccinations.

Other specific programmes in place are:

Hypertension

In the CCG, there are nearly 25,500 people with known hypertension and prevalence is higher than England. Most GP practices (20 out of 22) have rates significantly higher than England; just one has significantly lower rates than England.

Hypertension: QOF prevalence (all ages) 2018/19 — Proportion - %

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↑	8,290,457	14.0*	13.9	14.0
NHS Hambleton, Richmondshire And Whitby CCG	↑	25,498	17.6	17.3	18.0
B82078 - Leyburn Medical Practice	↑	1,376	22.8	21.2	24.5
B82622 - Reeth Medical Centre	→	346	21.7	18.7	25.1
B82034 - Quakers Lane Surgery	↑	1,361	21.5	20.0	23.2
B82101 - Sleights and Sandsend Medical Pra...	↑	1,092	21.1	19.4	22.9
B82075 - Mayford House Surgery	↑	1,684	19.5	18.2	20.7
B82066 - Glebe House Surgery	→	1,805	18.6	17.4	19.9
B82046 - Staithes Surgery	→	529	18.5	16.3	20.8
B82035 - Scorton Medical Centre	→	673	18.4	16.5	20.5
B82029 - Aldbrough St John Surgery	↑	591	18.2	16.2	20.4
B82017 - Whitby Group Practice	↑	2,544	18.1	17.1	19.1
B82050 - Mowbray House Surgery	↑	3,588	18.0	17.2	18.9
B82062 - Egton Surgery	→	426	18.0	15.7	20.6
B82045 - Central Dales Practice	→	748	17.8	16.0	19.7
B82042 - Lambert Medical Centre	→	1,435	17.1	15.9	18.4
B82086 - The Danby Practice	→	408	17.1	14.8	19.6
B82044 - Stokesley Surgery	→	1,552	16.9	15.8	18.2
B82072 - The Friary Surgery	→	949	16.9	15.4	18.5
B82022 - Great Ayton Surgery	→	912	16.7	15.2	18.3
B82049 - Thirsk Doctors Surgery	→	1,168	16.4	15.1	17.8
B82023 - Catterick Village Surgery	→	1,052	15.9	14.5	17.3
B82019 - Topcliffe Surgery	→	462	14.3	12.5	16.4
B82104 - Harewood Medical Practice	→	595	7.7	6.8	8.7

Source: Quality and Outcomes Framework (QOF), NHS Digital

The CCG is supporting hypertension screening with the NHS Health a Check programme and the CCG has also taken extra steps to add reminders onto clinical systems.

Depression

There are more than 11,500 people with a record of depression in the CCG, with a slightly lower rate than seen in England. Six practices have rates which are significantly higher than England, while eleven practices have significantly lower rates. There is a near 3-fold difference between the practices with the lowest (5.2%) and the highest (13.4%) rates.

Areas: All in NHS Hambleton, Richmondshire And Whitby CCG | Display: Table | Table and chart

Depression: Recorded prevalence (aged 18+) 2018/19 — Proportion - %

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↑	5,077,090	10.7*	10.7	10.8
NHS Hambleton, Richmondshire And Whitby CCG	↑	11,536	9.7	9.4	10.0
B82075 - Mayford House Surgery	↑	1,066	13.4	12.2	14.6
B82101 - Sleights and Sandsend Medical Pra...	↑	563	12.7	11.3	14.3
B82023 - Catterick Village Surgery	↑	659	12.7	11.4	14.2
B82019 - Topcliffe Surgery	→	307	12.7	10.7	14.9
B82042 - Lambert Medical Centre	↑	821	11.9	10.7	13.1
B82034 - Quakers Lane Surgery	↑	591	11.0	9.7	12.3
B82035 - Scorton Medical Centre	↑	332	10.9	9.3	12.8
B82049 - Thirsk Doctors Surgery	↑	643	10.9	9.7	12.2
B82086 - The Danby Practice	↑	214	10.5	8.6	12.8
B82066 - Glebe House Surgery	↑	840	10.4	9.4	11.5
B82104 - Harewood Medical Practice	→	508	10.2	8.9	11.6
B82050 - Mowbray House Surgery	↑	1,626	9.9	9.2	10.6
B82046 - Staithes Surgery	↑	234	9.8	8.1	11.8
B82017 - Whitby Group Practice	↑	964	8.2	7.4	9.0
B82022 - Great Ayton Surgery	↑	376	8.2	7.0	9.5
B82029 - Aldbrough St John Surgery	↑	222	8.1	6.6	9.8
B82078 - Leyburn Medical Practice	↑	389	7.4	6.4	8.6
B82044 - Stokesley Surgery	↑	520	6.7	5.9	7.7
B82622 - Reeth Medical Centre	→	88	6.3	4.5	8.6
B82062 - Egton Surgery	→	119	6.0	4.5	7.8
B82072 - The Friary Surgery	↑	263	5.7	4.7	6.8
B82045 - Central Dales Practice	→	191	5.2	4.2	6.4

Source: Quality and Outcomes Framework (QOF), NHS Digital

Asthma

In the CCG, asthma prevalence is higher than England. There are over 9,000 people on asthma registers in the area. Seven practices have asthma prevalence rates which are lower than England. There are ten practices with significantly higher recorded prevalence than England.

Areas: All in NHS Hambleton, Richmondshire And Whitby CCG | Display: Table | Table and chart

Asthma: QOF prevalence (all ages) 2018/19 — Proportion - %

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	→	3,591,392	6.0*	6.0	6.1
NHS Hambleton, Richmondshire And Whitby CCG	↑	9,286	6.4	6.2	6.6
B82042 - Lambert Medical Centre	→	629	7.5	6.7	8.4
B82017 - Whitby Group Practice	→	1,051	7.5	6.8	8.2
B82101 - Sleights and Sandsend Medical Pra...	→	379	7.3	6.3	8.5
B82022 - Great Ayton Surgery	→	398	7.3	6.3	8.4
B82072 - The Friary Surgery	→	401	7.1	6.1	8.3
B82062 - Egton Surgery	→	168	7.1	5.6	8.9
B82045 - Central Dales Practice	→	289	6.9	5.8	8.2
B82050 - Mowbray House Surgery	→	1,349	6.8	6.3	7.4
B82078 - Leyburn Medical Practice	→	400	6.6	5.7	7.7
B82019 - Topcliffe Surgery	→	211	6.6	5.3	8.0
B82066 - Glebe House Surgery	→	629	6.5	5.8	7.3
B82075 - Mayford House Surgery	→	605	6.2	5.5	7.1
B82622 - Reeth Medical Centre	→	97	6.1	4.5	8.2
B82086 - The Danby Practice	→	145	6.1	4.7	7.8
B82034 - Quakers Lane Surgery	→	382	6.0	5.2	7.0
B82104 - Harewood Medical Practice	→	439	5.7	4.9	6.6
B82029 - Aldbrough St John Surgery	→	179	5.5	4.4	6.9
B82044 - Stokesley Surgery	→	503	5.5	4.8	6.3
B82023 - Catterick Village Surgery	→	354	5.3	4.5	6.3
B82035 - Scorton Medical Centre	↑	192	5.3	4.2	6.5
B82049 - Thirsk Doctors Surgery	→	358	5.0	4.3	5.9
B82046 - Staithes Surgery	→	128	4.5	3.4	5.8

Source: Quality and Outcomes Framework (QOF), NHS Digital

Coronary Heart Disease

Coronary heart disease (CHD) prevalence is higher in the CCG compared with England and there are over 6,000 people with diagnosed CHD. Most general practices (16 of the 22) have prevalence rates significantly higher than England and just one general practice has a rate significantly lower than England.

Areas: All in NHS Hambleton, Richmondshire And Whitby CCG | Display: Table | Table and chart

CHD: QOF prevalence (all ages) 2018/19 — Proportion - %

Export table as image | Export table as CSV file

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	↓	1,839,211	3.1*	3.1	3.1
NHS Hambleton, Richmondshire And Whitby CCG	→	6,041	4.2	4.0	4.3
B82101 - Sleights and Sandsend Medical Pra...	→	294	5.7	4.8	6.8
B82017 - Whitby Group Practice	→	685	4.9	4.3	5.5
B82044 - Stokesley Surgery	→	441	4.8	4.2	5.5
B82046 - Staithes Surgery	→	135	4.7	3.6	6.1
B82072 - The Friary Surgery	→	264	4.7	3.9	5.6
B82022 - Great Ayton Surgery	→	255	4.7	3.9	5.6
B82035 - Scorton Medical Centre	→	164	4.5	3.5	5.7
B82050 - Mowbray House Surgery	→	874	4.4	4.0	4.9
B82034 - Quakers Lane Surgery	→	275	4.3	3.6	5.2
B82049 - Thirsk Doctors Surgery	→	300	4.2	3.5	5.0
B82045 - Central Dales Practice	→	177	4.2	3.3	5.3
B82042 - Lambert Medical Centre	→	349	4.2	3.5	4.9
B82078 - Leyburn Medical Practice	→	249	4.1	3.4	5.0
B82062 - Egton Surgery	→	97	4.1	3.0	5.5
B82075 - Mayford House Surgery	→	390	4.0	3.5	4.7
B82066 - Glebe House Surgery	→	386	4.0	3.4	4.6
B82023 - Catterick Village Surgery	→	242	3.6	3.0	4.4
B82086 - The Danby Practice	→	86	3.6	2.6	5.0
B82029 - Aldbrough St John Surgery	→	115	3.5	2.7	4.7
B82622 - Reeth Medical Centre	→	56	3.5	2.3	5.2
B82019 - Topcliffe Surgery	→	88	2.7	2.0	3.8
B82104 - Harewood Medical Practice	→	119	1.5	1.2	2.0

Source: Quality and Outcomes Framework (QOF), NHS Digital

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 Hambleton, Richmondshire and Whitby 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 CCG 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 2.5.3) 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 2.5.5), 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 our hospital providers, 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.

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Accountability Report - Corporate Governance

7 Members Report

7.1 The Governing Body

Governing Body Members	
	**Dr Charles Parker** **Chair of NHS Hambleton, Richmondshire and Whitby CCG – December 2015 to March 2020** **GP Governing Body Member – April 2012 to November 2015** Charles has lived and worked in Hambleton for 30 years. Having trained in London, he moved up to work in Northallerton for a year or two and stayed. He trained to be a GP in Northallerton working at the Friarage Hospital, where his two sons were born. Charles joined Topcliffe Surgery as a partner in 1992. The priority for the practice has been accessible, evidence based care. For 16 years he also worked as a civilian medical practitioner for the local barracks at Topcliffe. He joined NHS Hambleton, Richmondshire and Whitby CCG as a Lead GP and when it was fully established, was appointed as a GP member of the Governing Body. He was appointed as Clinical Chair in December 2015, a role he now has with NHS North Yorkshire CCG.
	**Amanda Bloor** **Accountable Officer, North Yorkshire CCGs (Voting) - December 2018 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 she enjoys yoga, running and spending time walking in the Yorkshire countryside with her family and two dogs.
	**Dr George Campbell** **GP Governing Body Member (Voting) – April 2012 to March 2020** George lives in Whitby. After 24 years he retired as a partner from Whitby Group Practice in 2017. He still does GP locum sessions in Whitby. He has an interest in dermatology and worked in community and hospital clinics. George has been involved in clinical management for some years. He has in the past been a non-executive director of the old North Yorkshire Health Authority, a fundholding clinical lead and chair of a practice based commissioning consortium. More recently he has been deputy chair of the clinical executive of NHS North Yorkshire & York.

Dr Mark Hodgson
GP Governing Body Member (Voting) – April 2012 to March 2020

Mark qualified at Manchester University in 1982 and he has worked as a GP in Aldbrough St John since 1988. It is a small, rural practice serving 3,250 patients over a wide area.

During his time as a Governing Body with NHS Harrogate and Rural District CCG, Mark's portfolio of responsibility included being Clinical Lead for Transformation of Community Services, end of life care and innovation and technology. He is also the Caldicott Guardian for the CCG.

Dr Jonathan James
Secondary Care Doctor (Voting) – September 2013 to March 2020 – September 2013 to March 2020

Jon is a retired Consultant Paediatrician who has worked in the district for 24 years. He also has some experience of NHS clinical management and has built up a knowledge of how local hospital care functions. Jon lives in Northallerton and is married with four grown-up children, one of whom is a local GP and another is a junior doctors working in West Yorkshire. Jon's role with the CCG was to help forge a good understanding and well-coordinated relationship with local hospitals and help to maintain a high standard of care.

Governing Body Lay Members

Linda Lloyd
Lay Member (Voting) Patient and Public Involvement/Vice Chair – April 2017 to March 2020

Linda has lived in the Est Valley for over 25 years and is engaged with the community both socially and as a volunteer. She has served on committees at local, regional and national levels representing the public and patients.

Kenneth Readshaw
Lay Member with responsibility for Governance (Voting) – September 2013 to March 2020

Ken is a chartered accountant who trained with KPMG. He then moved into industry and has considerable experience of the chemical and power generation sectors, both in the UK and abroad. He has been Chair of the Governing Body of The Wensleydale School and Sixth Form for seven years and is passionate about helping to provide communities with the best possible public services.

Ken is married with three children, all born and bred in North Yorkshire, and works with the CCG and the local community to improve health services.

Philip Hewitson
Lay Member (Voting) – October 2016 to March 2020

Philip is a graduate in Economics and trained as a Chartered Accountant before joining the NHS. He held a succession of finance posts and then various health chief executive posts in Yorkshire. More recently as a consultant, he worked with health and local authority teams and the pharmaceutical industry on organisational and community strategies and change management.

Governing Body Executive Members

Wendy Balmain
Director of Strategy and Integration, North Yorkshire CCGs – June 2019 to March 2020

Wendy was appointed Director of Strategy and Integration for the three North Yorkshire clinical commissioning groups in June 2019 and continues with that role in the new organisation.

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.

Jim Hayburn
Interim Chief Finance Officer (Voting) - July 2018 to June 2019

Jim is a Director of his own company that provides services to the NHS and was in Hambleton, Richmondshire and Whitby CCG on an interim basis.

Iain Dobinson
Interim Chief Finance Officer (Voting) – 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 Hambleton, Richmondshire and Whitby 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.

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, North Yorkshire CCGs – 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.

Health Engagement Network (HEN) Representative)

Jim Forrest
Health Engagement Network Representative, Hambleton (Non-Voting) – September 2018 to March 2020

Jane Ritchie MBE
Health Engagement Network Representative, Richmondshire (Non-Voting) – April 2013 to March 2020

Jane was awarded an MBE in January 2002 for her services to Education Business Partnership and now chairs the Elm House Trust and the Vocational Learning Trust charities as well as being Chairman of the Burton-cum-Walden Parish Council and Honorary Secretary of the Middleham Moor Gaitowners Association and the Upper Dales Health Watch.

Doff Pollard
Health Engagement Network Representative, Whitby (Non-Voting) – April 2017 to March 2020

Doff has been a resident in Whitby for over 10 years and was Chief Officer at the Tees Valley Rural Community Council until September 2015 where the services she brought to the rural areas included a Community Agents project targeting support to enable people to stay in their own homes and leave hospital earlier.

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 22 GP Practices. 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	
Hambleton Practices	Dr A Trzeciak and Partners Great Ayton Health Centre Mowbray House Surgery Stokesley Health Centre	Glebe House Surgery Lambert Medical Centre Mayford House Surgery Topcliffe Surgery
Richmond Practices	Catterick and Colburn Medical Group Doctors Lane Surgery The Friary Surgery Reeth Medical Centre Leyburn Medical Practice	Central Dales Practice Harewood Medical Practice Quakers Lane Surgery Scorton Medical Centre
Whitby Practices	Egton Surgery Sleights and Sandsend Surgery Staithes Surgery The Danby Surgery Whitby Group Practice	

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: https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/documents

8.2 Personal Data Related Incidents

I can confirm that NHS Hambleton, Richmondshire and Whitby 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 Hambleton and Richmondshire 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.[8]

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 Hambleton, Richmondshire and Whitby CCG.

[8] https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/documents/6631319/17051654/Slavery+and+Human+Trafficking+HRW+CCG.pdf/5c888337-bea1-4284-809a-b8d63a755d00

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 NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW)

9.1 Introduction and context

NHS Hambleton, Richmondshire and Whitby 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 22 member practices across Hambleton, Richmondshire and Whitby CCG (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

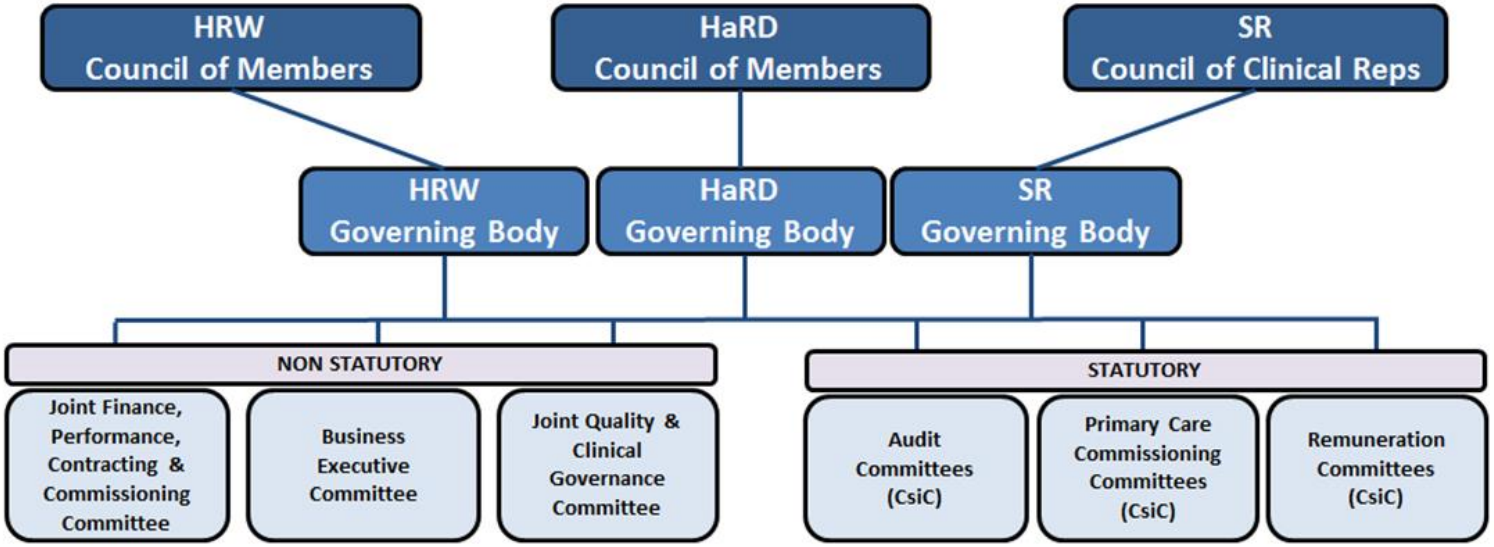
The Governing Body is responsible for the functions conferred on it through the constitution. In summary these are:

- 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.

Committee / Meeting	Role
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.
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.

Committee / Meeting	Role
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 HRW 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.
Joint Committee: STP for Cumbria and the North East	NHS England has asked NHS organisations to work together on improvement plans for their area, called Sustainability and Transformation Plans (STPs) to tackle three challenges: Improving the health and wellbeing of the population, Improving the quality of care that is provided, Improving the efficiency of NHS services.

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

Governing Body Workshop	Governing Body Workshop Topic
September 2019	• North Yorkshire CCGs – Joint Governance Arrangements
October 2019	• North Yorkshire CCG – Joint Governance Arrangements • Finance Update – Spending Approach
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.

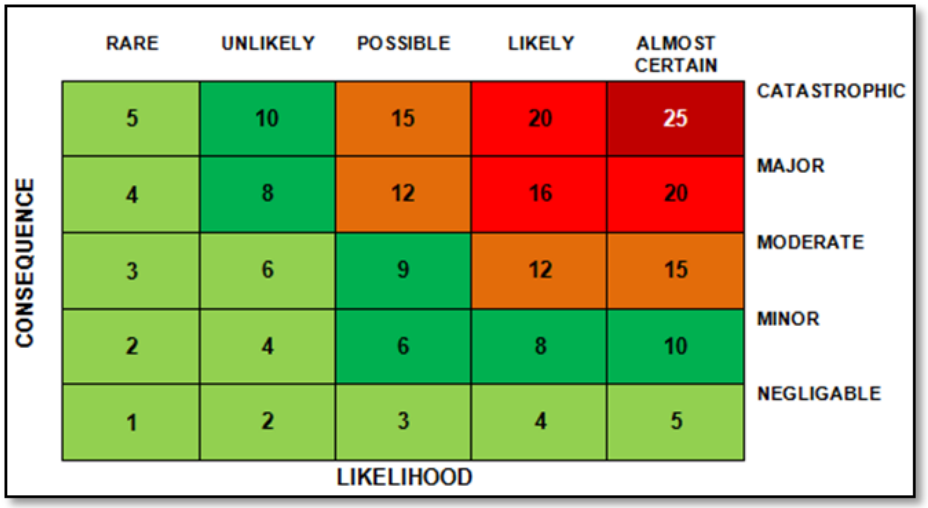
All committee and Governing Body papers carry a specific section within the executive summary page to identify high level risks arising from the area under discussion.

The Governing Body has formally 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;
- Equality Impact Assessments;
- Policies and procedures;

- Standing Financial Instructions and Standing Orders;
- Joint risk registers with external partners;
- Counter Fraud Policy and awareness campaigns; and
- Individual performance management process.
- 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 Hambleton, Richmondshire and Whitby 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:

- The CCG is unable to manage activity within resources. Including meeting QIPP targets and unplanned care demands.
- Procurement lacks transparency, and exposes conflict of interest. Non- compliance with NHS Procurement and Competition Regime.
- The CCG cannot afford to buy the services it needs. Quality is compromised.
- Quality Monitoring - Providers do not deliver the services to the required quality, including implementing changes to how services are delivered / behaviours do not change.
- The CCG does not manage its on-going responsibility for risks associated with services commissioned or provided by third parties.
- Service changes are not for the better.
- The CCG has insufficient capacity to deliver its objectives.
- There is insufficient information to measure the impact / success of services on objectives.
- The constituent GP member practices do not adequately engage with the CCG in its work plans and programmes to change services for the better.
- Failure to secure on-going engagement of local people, patients and politicians
- There is insufficient capacity/reliability of information/clarity of responsibility between commissioners to encourage Patient self-care.

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 or 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

The CCG was required to submit a governance return to NHS England and Improvement (NHSE/I) as at the 31 December 2019, highlighting any control issues that it might have. At that time the CCG advised NHSE/I of a Failure to Discharge its Statutory Duties, on the basis that despite working with NHSE/I, our ICS and Provider partners, it was unlikely that the CCG could manage the current level of risk and it was therefore forecasting a year end deficit. This position was been reported to our regulator, our Council of Members, our Governing Body, our external auditors and various internal committees. Since that time the CCGs allocation has been increased by NHSE/I which has changed the year end forecast to breakeven.

As previously described, the CCG continues to demonstrate strong leadership and is has received an internal audit opinion of high assurance on its Budgetary Control and Key Financial Systems Audit.

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 high 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 HAMBLETON, RICHMONDSHIRE AND WHITBY 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. However, some weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.**

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

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

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

HRW CCG has good processes in place to support risk management during this transition period in 2019/20, whereby Harrogate and Rural District CCG's Risk Management Strategy has been used to inform the Risk Management processes across the three North Yorkshire CCGs before the creation of the new North Yorkshire CCG from 1st April 2020. 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 HRW 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 HRW 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
Combined Governance Assurance	On hold – Covid 19
Joint Commissioning/AIC	Significant
Equality & Diversity	Limited
Quality Strategy & Assurance Processes	Deferred to 2020/21 – due to change in priorities with the merger of NY CCG.
Primary Care Commissioning	Substantial

Audit Area	Assurance Level
Contract Management	Significant
Handling Complaints	High
Hosted Services	Limited
Children's Continuing Care	On hold – Covid 19
Budgetary Control and Key Financial Systems	High
Budgetary Management Processes	On hold – Covid 19
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

Whilst a significant overall opinion has been provided, attention is drawn to the fact that 2 final reports have been issued in 2019/20 with a "limited assurance" opinion.

1. Equality & Diversity

Testing identified that whilst the CCG's Constitution and the Equality and Diversity Policy correctly explained the public sector equality duties in line with the Equality Act 2010, one policy selected within our sample had not been subjected to an Equality Impact Assessment and none of the policies reviewed had been created with consultation from relevant groups with protected characteristics. Furthermore there was a lack of monitoring of equality and diversity within the CCG with no action plan, responsible governing group or officer recognised as leading in this area.

From 1st April 2020 the 3 CCG's noted in this annual report merged to become the North Yorkshire CCG. Within this merger one of those CCG's had received significant assurance in this area during 2019/20 and it is therefore expected that the good practices demonstrated there will be used as a starting point on which to strengthen Equality & Diversity arrangements across the new CCG as a whole.

As this has been awarded limited assurance, this will be followed up as part of the 2020/21 Audit Plan.

2. Hosted Services

Testing identified that, at the time of the review no Memorandum of Understanding was in place for the Children's Commissioning team service. Without this MOU in place we were unable to fully assess the process of monitoring performance, quality and costs against an agreed set of standards. Our understanding is that a MOU is currently being drafted with the ambition that this will be agreed in Summer 2020 (Covid 19 allowing).

As this has been awarded limited assurance, this will be followed up as part of the 2020/21 Audit Plan.

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

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Remuneration and Staff Report

10 Remuneration 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 2019/20

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 Remuneration of Very Senior Managers (subject to audit)

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)

Name and Title	2019/20					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mrs A Bloor Accountable Officer	45-50	0	0	0	42.5-45	90-95
Mrs W Balmain Director of Strategy and Integration	35-40	0	0	0	7.5 – 10	45-50
Dr G Campbell GP Member	60-65	0	0	0	0	60-65
Mr S Cox Director of Acute Commissioning	40-45	0	0	0	12.5-15	50-55
M I Dobinson Interim Chief Finance Officer	10-15	0	0	0	0	10-15
Mrs J Hawkard Chief Finance Officer	15-20	0	0	0	25-27.5	40-45
Mr J Hayburn Interim Chief Finance Officer	30-35	0	0	0	0	30-35
Mr P Hewitson Lay Member	5-10	0	0	0	0	5-10
Dr MD Hodgson GP member	55-60	0	0	0	0	55-60
Dr J James Lay Member	5-10	0	0	0	0	5-10
Mrs L Lloyd Lay Member	10-15	0	0	0	0	10-15
Dr C Parker Chair	70-75	0	0	0	17.5-20	90-95

Name and Title	2019/20					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mrs S Peckitt Chief Nurse	20-25	0	0	0	45-47.5	65-70
Mr K Readshaw Lay Member	15-20	0	0	0	0	15-20
Mrs J Warren Director of Corporate Services	20-25	0	0	0	0	20-25

Note 1:

On 29 October 2018, the Government confirmed that the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate will reduce from 2.8% to 2.4%. The Government Actuary's Department (GAD) use this rate when setting the factors that are used to work out cash equivalent transfer values (CETVs). This will affect the calculation of the real increase in CETV in this report.

Note 2:

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 Hambleton, Richmondshire and Whitby's proportionate share of the total cost

a) Mrs A Bloor is Accountable 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 Interim 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 from 1st June 2019.
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								
Name and Title	**Start Date (if applicable)**	**End Date (if applicable)**	**(a) Salary (bands of £5,000)**	**(b) Expense payments (taxable) to nearest £100**	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)**	**(f) TOTAL (a - e) (bands of £5,000)**
			£000	**£**	**£000**	**£000**	**£000**	**£000**
Dr George Campbelll, GP Governing Body Member			50-55	0	0	0	0	50-55
Mrs Gill Collinson, Chief Nurse			100-105	0	0	0	40-42.5	140-145
Dr Mark D Hodgson, GP Governing Body Member			50-55	0	0	0	0	50-55
Dr Jonathan James, Secondary Care Doctors Governing Body			5-10	0	0	0	0	5-10
Dr Charles Parker, Clinical Chair			70-75	0	0	0	0-2.5	75-80
Amanda Bloor, Accountable Officer	**01/12/2018**		15-20	0	0	0	12.5-15	30-35
Mrs Janet Probert, Chief Officer		**30/11/18**	130-135	100	0	0	5-7.5	135-140

2018/19								
Name and Title	Start Date (if applicable)	End Date (if applicable)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a - e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Mr Kenneth Readshaw, Lay member with responsibility for Governance			15-20	0	0	0	0	15-20
Mr Philip Hewitson, Lay Member			5-10	0	0	0	0	5-10
Mrs Linda Lloyd, Lay Member			10-15	0	0	0	0	10-15
Mr Bernard Chalk, Interim Chief Finance Officer		30/06/18	25-30	0	0	0	0	25-30
Mr Jim Hayburn, Interim Chief Finance Officer	01/07/18		85-90	0	0	0	0	85-90

Note 1:

On 29 October 2018, the Government confirmed that the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate will reduce from 2.8% to 2.4%. The Government Actuary's Department (GAD) use this rate when setting the factors that are used to work out cash equivalent transfer values (CETVs). This will affect the calculation of the real increase in CETV in this report.

Note 2:

From the 1st December 2018 NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Accountable Officer. "The figures disclosed in the table above for this period represent NHS Hambleton, Richmondshire and Whitby CCG's proportional share of the total cost. For this period, Mrs Bloor's total salary falls within the bands of £45,000 to £50,000 and her pension related benefits fall within the bands of £42,500 to £50,000.

Note 3:

Mrs J Probert From the 1st December 2018 NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG had a single Accountable Officer. As a result the existing Chief Officer for NHS Hambleton, Richmondshire and Whitby CCG ceased in her role from the 30th November 2018, the CCGs share of the termination costs are also included.

10.6 2019/20 Pension Benefits (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2020	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2020	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mrs A Bloor Accountable Officer	5.0-7.5	10-12.5	55-60	130-135	933	121	1099	0
Mrs W Balmain Director of Strategy and Integration	0-2.5	0-2.5	15-20	35-40	346	22	392	0
Mr S Cox Director of Acute Commissioning	2.5-5	0-2.5	45-50	60-65	669	38	740	0
Mrs J Hawkard Chief Finance Officer	0-2.5	0-2.5	40-45	95-100	748	26	848	0
Dr C Parker Chair	0-2.5	(0-2.5)	15-20	50-55	417	12	440	0
Mrs S Peckitt Chief Nurse	2.5-5	0-2.5	35-40	110-115	653	106	823	0
Mrs J Warren	(0-2.5)	(7.5-10)	35-40	80-85	713	(35)	697	0

Note 1

On 29 October 2018, the Government confirmed that the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate will reduce from 2.8% to 2.4%. The Government Actuary's Department (GAD) use this rate when setting the factors that are used to work out cash equivalent transfer values (CETVs). This will affect the calculation of the real increase in CETV in this report.

Note 2

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 Secondary Care Doctor, GP Governing Members and Lay Members.

b) 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.

c) 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 scheme or arrangement).

10.8 Compensation on early retirement of 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 £180-£185 (2018-19 was £180-£185) thousand. This was 4.22 times (2018-19 4.29 times) the median remuneration of the workforce, which was £43,772 (£43,041 in 2018-19). The median remuneration is calculated 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 by 1.7%, this 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.

In 2019-20 zero (2018-19 zero) employees received remuneration in excess of the highest-paid director/member of the governing body. Remuneration ranged from £15-£20 thousand to £180-£185 thousand (2018-19, £15-£20 thousand to £180-£185 thousand).

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.

11 CCG Staff Information

11.1 Number of Senior Managers

At the end of the financial year, the number of senior managers by pay band can be broken down as follows:

Pay Band (annual salary range)		Number
Governing Body		13
VSM	(£95,000 - £150,000)	0
Band 9	(£89,537 - £103,860)	0
Band 8d	(£73,936 - £86,687)	2
Band 8c	(£61,777 - £72,597)	0
Band 8b	(£52,306 - £60,983)	3
Band 8a	(£44,606 - £50,819)	4
Any other Spot Salary		3

Please note that the annual salary information declared in the 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.

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

One 8b has been on secondment to another organisation throughout 2019/20 and their costs have been fully recovered by the CCG.

11.2 Staff Numbers and Costs (subject to audit)

On the 31 March 2020 the CCG employed 39 directly employed staff. This includes 1 independent secondary care consultant, 1 independent audit committee chair and 2 Governing Body lay members. This equates to 31.23 full-time equivalents of directly employed staff.

The CCG is the host organisation for the children's CHC and commissioning teams 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.

For 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	Permanently Employed	Other	Total
Total Number	33	6	39

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 2.74%. This equates to approximately 320.83 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, which can be accessed via: https://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 Hambleton, Richmondshire and Whitby 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

The CCG 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 £18,936 (£15,850 in 2018-19) on consultancy, £18,000 was through 1 company. This consultancy work related to financial advice and guidance for the development of the Catterick Integrated Care Business Case.

11.9 Off-payroll Engagements

	Number
Number of existing engagements as of 31 March 2020	0
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
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	1
Of Which:	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	1
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.	1
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	1
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)

Since the 1st April 2019 NHS Hambleton, Richmondshire and Whitby CCG (HRWCCG), NHS Harrogate and Rural District CCG (HARDCCG) and NHS Scarborough and Ryedale CCG (SRCCG) have made joint decisions in the development of a single management structure and therefore shared equally any costs incurred. Note 4.4 in the CCG’s statutory accounts discloses this CCGs share of the exit payment (£68,356) for staff terminations in both HARDCCG and SRCCG.

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000		0		0				
£10,000 - £25,000	1	15,556		0				
£25,001 - £50,000		0		0				
£50,001 - £100,000	1	52,800		0				
£100,001 - £150,000		0		0				
£150,001 –£200,000		0		0				
>£200,000		0		0				
TOTALS	2	68,356		0				

12 Parliamentary Accountability and Audit Report (subject to audit)

NHS Hambleton, Richmondshire and Whitby CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities (note 12), losses and special payments (note 20), gifts, and fees and charges (note 2) are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report in section 13.

13 Independent Auditor's Report to the Governing Body of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Hambleton, Richmondshire and Whitby 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 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 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 Hambleton, Richmondshire and Whitby 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 Hambleton, Richmondshire and Whitby CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Kirkham
For and on behalf of Mazars LLP
5th Floor, 3 Wellington Place
Leeds, LS1 4AP
24 June 2020

ANNUAL ACCOUNTS

Amanda Bloor

Accountable Officer

23 June 2020

Entity name:	NHS Hambleton, Richmondshire & Whitby CCG
This year	2019-20
Last year	2018-19
This year ended	31-March-2020
Last year ended	31-March-2019
This year commencing:	01-April-2019
Last year commencing:	01-April-2018

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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	(594)	(495)
Other operating income	2	(467)	(829)
Total operating income		**(1,061)**	(1,324)
Staff costs	4	2,924	2,754
Purchase of goods and services	5	231,817	217,614
Depreciation and impairment charges	5	31	0
Provision expense	5	0	0
Other Operating Expenditure	5	194	187
Total operating expenditure		**234,966**	220,555
Net Operating Expenditure		**233,905**	219,231

The notes on pages 5 to 28 form part of this statement

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Current assets:			
Trade and other receivables	9	881	1,641
Cash and cash equivalents	10	40	180
Total current assets		**921**	1,821
Total assets		**921**	1,821
Current liabilities			
Trade and other payables	11	(13,454)	(14,247)
Total current liabilities		**(13,454)**	(14,247)
Assets less Liabilities		**(12,533)**	(12,426)
Financed by Taxpayers' Equity			
General fund		(12,533)	(12,426)
Total taxpayers' equity:		**(12,533)**	(12,426)

The notes on pages 5 to 28 form part of this statement

The financial statements on pages 1 to 4 were approved by Audit Committee on the 23rd June 2020 and signed on its behalf by:

Amanda Bloor
Accountable Officer

J Hawkard

Jane Hawkard
Chief Finance Officer

31 March 2020

	General fund £'000
Changes in taxpayers' equity for 2019-20	
Balance at 01 April 2019	(12,426)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(12,426)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20	
Net operating expenditure for the financial year	(233,905)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(233,905)**
Net funding	233,798
Balance at 31 March 2020	**(12,533)**

	General fund £'000
Changes in taxpayers' equity for 2018-19	
Balance at 01 April 2018	(9,557)
Transfer of assets and liabilities from closed NHS bodies	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	(9,557)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19	
Net operating costs for the financial year	(219,231)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(219,231)
Net funding	216,362
Balance at 31 March 2019	(12,426)

The notes on pages 5 to 28 form part of this statement

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		(233,905)	(219,231)
Depreciation and amortisation	5	31	0
(Increase)/decrease in trade & other receivables	9	761	(55)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	(794)	2,935
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	0	0
Increase/(decrease) in provisions	12	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(233,906)**	(216,351)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(31)	0
Net Cash Inflow (Outflow) from Investing Activities		**(31)**	0
Net Cash Inflow (Outflow) before Financing		**(233,937)**	(216,351)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		233,798	216,362
Net Cash Inflow (Outflow) from Financing Activities		**233,798**	216,362
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(140)**	11
Cash & Cash Equivalents at the Beginning of the Financial Year		**180**	169
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**40**	181

The notes on pages 5 to 28 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. 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 have been prepared on a going concern basis**.**
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.
NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group, Harrogate and Rural District Clinical Commissioning Group and Scarborough and Ryedale Clinical Commissioning Group (the CCG's) merged on the 1st April 2020 to establish NHS North Yorkshire Clinical Commissioning Group .
The CCG does not believe this affects the CCG's ability to continue as a going concern as services will continue to be provided.

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

1.4 **Joint arrangements**

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

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

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.
The clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 with North Yorkshire County Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement (Note 1.5).

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The CCG has no joint ventures.

1.5 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with North Yorkshire County Council and the following CCGs, in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the Better Care Fund and note 16.1 to the accounts provides details of the income and expenditure.
The pool is hosted by North Yorkshire County Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Airedale, Wharfedale & Craven CCG
Hambleton, Richmondshire & Whitby CCG
Harrogate & Rural District CCG
Scarborough & Ryedale CCG
Vale of York CCG
Consideration has been given as to whether IFRS 10 - Consolidated Financial Statements applies to this pooled budget arrangement, but has been deemed irrelevant as no individual organisation has sole control over the fund.

Consideration has been given as to whether 'IFRS 11 - Joint Arrangements' applies to this pooled budget arrangement, and as a consequence it has been deemed a 'jointly controlled operation'. These accounts have therefore been produced in accordance with this as set out above.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group (Note 15).

1.7 **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 the performance obligations part of a contract that has an original expected duration of one year or less,

Notes to the financial statements

• 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.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

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

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including 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.

1.8.2 **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.

1.9 **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.

1.10 **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.

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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.

1.11 **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 **Continuing Healthcare Risk Pooling**
In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31st March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims. This annual contribution ceased on 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 from 2018/19 and has paid over tax due to HMRC in respect of previously unassessed periods of care that have been settled during 2018/19.

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.

Notes to the financial statements

1.17 **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 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.

1.18 **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.

1.19 **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.

1.19.1 **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.

1.19.2 **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.

1.19.3 **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.

1.19.4 **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 Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.20 **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.

1.20.1 **Financial Guarantee Contract Liabilities**

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

Notes to the financial statements

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

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

1.21 **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.

1.22 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.23 **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).

1.24 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. 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.

1.24.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

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

• Prescribing - The actual data received on which to base the out-turn prescribing expenditure is two month in arrears. The forecast is based on robust information from the Business Services Authority who provide monthly prescribing profiles based on previous years trends from which the estimate of twelve months prescribing expenditure is based. These profiles take into account the national financial impact of prescribing days and Category M drugs but are also adjusted for local factors with regard to local actions to reduce prescribing expenditure. The CCG has estimated expenditure for February and March 2020 to be £4.18m.

• Secondary Care Activity - The actual data received on which to base the out-turn for acute hospital activity is two months in arrears. The forecast is based on robust information from data submitted by providers through the secondary uses service (SUS) and processed and validated by the Data Services for Commissioners Regional Office (DSCRO). This has been augmented where appropriate using local data flows including mandated non Payment by Results (PBR) data sets, provider monitoring reports and other locally agreed data flows.

• 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. The CCG has also included a negotiated settlement for CHC invoices relating to the financial year 2017/18 (£0.3m), this has been discounted to reflect the uncertainty regarding the CCGS liability; the balance remains within the accounts of NHS Scarborough and Ryedale CCG as host.

1.25 **Net Accounting Arrangements for Hosted Services**
NHS Scarborough & Ryedale Clinical Commissioning Group (SR CCG) host the following services:
• Continuing Healthcare services
• Strategic Clinical Networks
• Safeguarding services
These services are hosted on behalf of Hambleton, Richmondshire and Whitby CCG, Scarborough & Ryedale CCG (SR CCG) and Harrogate and Rural District CCG (HaRD CCG).

NHS Hambleton, Richmondshire and Whitby CCG (HRW CCG) host children's commissioning functions.

NHS Harrogate and Rural District CCG (HaRD CCG) host:
• Transforming Care Partnerships.
• Mental Health & Learning Disability (Adults) Commissioning
These services are hosted on behalf of Hambleton, Richmondshire and Whitby CCG, Scarborough & Ryedale CCG (SR CCG), Harrogate and Rural District CCG (HaRD CCG) and Vale of York CCG (VoY CCG).

Notes to the financial statements

The host organisation is responsible for the recharge arrangements for these services. All payments relating to Mental Health out of contract services continued to be transacted through the SRCCG ledger until 31st November 2018, they then transferred to HARD CCG.
The following hosted services are recharged to NHS Hambleton Richmondshire & Whitby CCG on an actual cost basis:
• Continuing Healthcare/Funded Nursing Care
• Mental Health Out of Contract Placements
• Specialist Neurological Rehabilitation
The CCG has entered into a risk share arrangement for Transforming Care Partnerships, with Scarborough & Ryedale CCG (SR CCG), Harrogate and Rural District CCG (HaRD CCG) and Vale of York CCG (VoY CCG). Income and expenditure are apportioned between CCGs on a weighted capitation basis.

The following hosted services are apportioned between CCGs:

NHS Scarborough & Ryedale CCG Hosted Teams
The costs of these staff are apportioned between the CCG's on a weighted capitation basis, dependant on the service, there are different % for services shared across 3 NY CCG's, services across all 4 CCGs and service across 4 CCG's for Legal team.
• Continuing Healthcare/Funded Nursing Care Assessment Team
• Children's Safeguarding Team
• Primary Care Safeguarding
• Strategic Clinical Networks

Referral Support Services
NHS Vale of York Clinical Commissioning Group host a referral support service (incorporating choose & book) on behalf of Harrogate & Rural District CCG, Hambleton, Richmondshire & Whitby CCG, Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through Vale of York CCG's ledger and expenditure is recharged on an actuals basis.

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

Primary Care Co-Commissioning - Finance
NHS Harrogate & Rural District Clinical Commissioning Group host the Primary Care Co Commissioning Finance team on behalf of Harrogate & Rural District CCG, Hambleton, Richmondshire & Whitby CCG and Scarborough & Ryedale CCG. All payments relating to these services are transacted through Harrogate & Rural District CCG's ledger and expenditure is recharged on a risk share basis.

Children's Commissioning Functions
NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group host the following services on behalf of Harrogate & Rural District CCG, Hambleton, Richmondshire & Whitby CCG, Scarborough & Ryedale CCG and Vale of York CCG. All payments relating to these services are transacted through Hambleton, Richmondshire & Whitby CCG's ledger and expenditure is recharged on a risk share basis as follows:

• Children's CHC Team
• Children & Young Peoples Commissioning

1.26 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Department of Health and Social Care 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 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
• IFRS 16 Leases – is being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1 April 2021.
• IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, 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.
It has agreed by the Financial Reporting Advisory Board (FRAB) and HM Treasury, that the implementation of IFRS 16 for entities following the FReM will not go ahead in the 2020-21 financial year, but is deferred until the 2021-22 financial year. This represents a further 1 year delay for those entities who haven't adopted the Standard, but were due to on 1st April 2020.

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 all other Standards as revised would not have a material impact on the accounts for 2018-19, were they applied in that year.

2. Other Operating Revenue

	2019-20 Total	2018-19 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	21	25
Other Contract income	510	463
Recoveries in respect of employee benefits	63	7
Total Income from sale of goods and services	**594**	495
Other operating income		
Other non contract revenue	467	829
Total Other operating income	**467**	829
Total Operating Income	**1,061**	1,324

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	0	0	0	0	0	0	304	0
Non NHS	0	21	0	0	0	0	206	63
Total	**0**	**21**	**0**	**0**	**0**	**0**	**510**	**63**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	0	21	0	0	0	0	510	63
Over time	0	0	0	0	0	0	0	0
Total	**0**	**21**	**0**	**0**	**0**	**0**	**510**	**63**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not

	2018-19 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	0	0	0	0
Later than 1 year, not later than 5 years	0	0	0	0
Later than 5 Years	0	0	0	0
Total	**0**	**0**	**0**	**0**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**2019-20**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	2,014	304	2,318
Social security costs	221	0	221
Employer Contributions to NHS Pension scheme	317	0	317
Termination benefits	68	0	68
Gross employee benefits expenditure	**2,620**	**304**	**2,924**
Less recoveries in respect of employee benefits (note 4.1.2)	(63)	0	(63)
Total - Net admin employee benefits including capitalised costs	**2,557**	**304**	**2,861**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,557**	**304**	**2,861**

4.1.1 Employee benefits	Total		2018-19
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,996	249	2,245
Social security costs	220	0	220
Employer Contributions to NHS Pension scheme	236	0	236
Termination benefits	53	0	53
Gross employee benefits expenditure	2,505	249	2,754
Less recoveries in respect of employee benefits (note 4.1.2)	(7)	0	(7)
Total - Net admin employee benefits including capitalised costs	2,498	249	2,747
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	2,498	249	2,747

From the 1st December 2018 NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG agreed to share a single management structure and from this time had a single Accountable Officer. The information included in this note reflects the Clinical Commissioning Group's share of the costs of moving to this structure and this post.

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	(50)	0	(50)	(5)
Social security costs	(6)	0	(6)	(1)
Employer contributions to the NHS Pension Scheme	(7)	0	(7)	(1)
Total recoveries in respect of employee benefits	**(63)**	**0**	**(63)**	(7)

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	**43.31**	**5.78**	**49.09**	44.86	4.92	49.78
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	0	0

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	0	0	0	0	0	0
£10,001 to £25,000	1	15,556	0	0	1	15,556
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	1	52,800	0	0	1	52,800
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**68,356**	**0**	**0**	**2**	**68,356**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	1	53,333	0	0	1	53,333
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	1	53,333	0	0	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	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	0	0

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	0	0

2019-20: Since the 1st April 2019 NHS Hambleton, Richmondshire and Whitby CCG (HRWCCG), NHS Harrogate and Rural District CCG (HARDCCG) and NHS Scarborough and Ryedale CCG (SRCCG) have made joint decisions in the development of a single management structure and therefore shared equally any costs incurred. Note 4.4 in the CCG's statutory accounts discloses this CCGs share of the exit payment (£68,356) for staff terminations in both HARDCCG and SRCCG.

2018-19: From the 1st December 2018 NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG had a single Accountable Officer. As a result the existing Chief Officer for NHS Hambleton, Richmondshire and Whitby CCG was made redundant and the Clinical Commissioning Group's share of the termination costs 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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.

For 2019-20, employers' contributions of £241,746 were payable to the NHS Pensions Scheme (2018-19: £233,720 were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. NHS England paid an additional 6.3% , £74,198, on behalf of the Clinical Commissioning Group, which is accounted for within the Clinical Commissioning Group accounts. These costs are included in the NHS Pension line of note 4.1.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of Healthcare from NHS Bodies:		
Services from other CCGs and NHS England	369	411
Services from foundation trusts	133,169	125,978
Services from other NHS trusts	11,407	9,325
Purchase of other goods and services:		
Purchase of healthcare from non-NHS bodies	28,322	24,796
Prescribing costs	25,135	23,820
General Ophthalmic services	71	73
GPMS/APMS and PCTMS	24,608	23,642
Supplies and services – clinical	641	624
Supplies and services – general	6,620	7,010
Consultancy services	19	37
Establishment	344	557
Transport	340	261
Premises	587	736
Audit fees	44	53
Other professional fees	110	249
Legal fees	26	4
Education, training and conferences	5	38
Total Purchase of goods and services	**231,817**	217,614
Depreciation and impairment charges		
Depreciation	31	0
Total Depreciation and impairment charges	**31**	0
Other Operating Expenditure		
Chair and Non Executive Members	146	144
Expected credit loss on receivables	0	9
Other expenditure	48	35
Total Other Operating Expenditure	**194**	187
Total operating expenditure	**232,042**	217,801

Non-audit services 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 an extra £1,500 in 2019/20 when the 2018/19 work was completed.

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	3,058	43,429	2,887	38,626
Total Non-NHS Trade Invoices paid within target	3,049	43,377	2,876	38,612
Percentage of Non-NHS Trade invoices paid within target	**99.71%**	**99.88%**	99.62%	99.96%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,201	171,813	2,063	159,476
Total NHS Trade Invoices Paid within target	2,192	171,681	2,061	159,475
Percentage of NHS Trade Invoices paid within target	**99.59%**	**99.92%**	99.90%	100.00%

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	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Operating Leases

7.1 As lessee

The clinical commissioning group occupies property managed by NHS Property Services Ltd.

The lease is for the CCG headquarters. The lease commenced on the 11th March 2017 and was for 1 year with the option to extend for a further 2 years or until termination. The CCG has renewed the lease for 12 months with effect from 1st April 2020.

7.1.1 Payments recognised as an Expense

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	0	529	0	**529**	0	679	0	679
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**529**	**0**	**529**	0	679	0	679

Included within the payments recognised as an expense are the CCG headquarters, hosted services headquarters and NHS Property Services Ltd recharges for void and sessional space. The movement between financial years reflects NHS Property Services Ltd 'True Up Exercise'. Costs are invoiced based on the annual charging schedules, costs are then re-calculated again based on the actual amount of facilities or services used, the CCG is then either invoiced for the difference or refunded. This is known as year-end reconciliation or ‘true-up’.

7.1.2 Future minimum lease payments

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	0	62	0	**62**	0	59	0	59
Between one and five years	0	0	0	**0**	0	0	0	0
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**62**	**0**	**62**	0	59	0	59

This note includes the future minimum lease payments for the occupancy of the CCG headquarters only, as per the licence agreement. The future years rental charge for void spaces has not been agreed with NHS Property Services Ltd, so is excluded from this note.

8 Property, plant and equipment

2019-20	Information technology £'000	Total £'000
Cost or valuation at 01 April 2019	7	7
Additions purchased	31	31
Cost/Valuation at 31 March 2020	**38**	**38**
Depreciation 01 April 2019	7	7
Charged during the year	31	31
Depreciation at 31 March 2020	**38**	**38**
Net Book Value at 31 March 2020	**0**	**0**
Purchased	0	0
Donated	0	0
Government Granted	0	0
Total at 31 March 2020	**0**	**0**
Asset financing:		
Owned	0	0
Held on finance lease	0	0
On-SOFP Lift contracts	0	0
PFI residual: interests	0	0
Total at 31 March 2020	**0**	**0**

9. 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	121	0	86	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	332	0	333	0
NHS accrued income	0	0	141	0
NHS Contract Receivable not yet invoiced/non-invoice	0	0	139	0
NHS Non Contract trade receivable (i.e pass through funding)	140	0	803	0
NHS Contract Assets	0	0	0	0
Non-NHS and Other WGA receivables: Revenue	162	0	12	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	2	0	0	0
Non-NHS and Other WGA accrued income	0	0	0	0
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	95	0	84	0
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	0	0	52	0
Non-NHS Contract Assets	0	0	0	0
Expected credit loss allowance-receivables	0	0	(9)	0
VAT	29	0	0	0
Total Trade & other receivables	**881**	**0**	1,641	**0**
Total current and non current	**881**		1,641	
Included above:				
Prepaid pensions contributions	0		0	

9.1 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	159	69	744	68
By three to six months	55	0	0	0
By more than six months	140	0	140	0
Total	**354**	**69**	884	68

10 Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	180	169
Net change in year	(140)	10
Balance at 31 March 2020	**40**	180
Made up of:		
Cash with the Government Banking Service	40	179
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**40**	180
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	0
Balance at 31 March 2020	**40**	180
Patients' money held by the clinical commissioning group, not included above	0	0

11. Trade and other payables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	0	0	0	0
NHS payables: Revenue	791	0	2,328	0
NHS payables: Capital	0	0	0	0
NHS accruals	1,658	0	2,125	0
NHS deferred income	0	0	0	0
NHS Contract Liabilities	0	0	0	0
Non-NHS and Other WGA payables: Revenue	1,810	0	1,179	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	8,946	0	8,222	0
Non-NHS and Other WGA deferred income	0	0	0	0
Non-NHS Contract Liabilities	0	0	0	0
Social security costs	21	0	26	0
VAT	0	0	0	0
Tax	18	0	80	0
Payments received on account	0	0	0	0
Other payables and accruals	210	0	287	0
Total Trade & Other Payables	**13,454**	**0**	14,247	0
Total current and non-current	**13,454**		14,247	

There are no liabilities due in future years, under the arrangements to buy out the liability for early retirement over 5 years.

Other payables include £210,105 outstanding pension contributions at 31 March 2020 (including Primary Care Comissioning).

12. Provisions

The CCG has no provisions as at 31st March 2020.

13. Contingencies

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 2019/20. Of these 7 cases 5 were found to be eligible and the impact of this is included in these accounts. The reamining 2 were not found to be eligible although they do have the right to appeal and all cases are currently going through the appeals process. A number of uncertainties impact upon the CCG's ability to assess a reasonable provision:

- following assessment; patients may be deemed to be not eligible for care, fully eligible or eligible for only part of the assessed period
- eligibility is only for costs actually incurred by the individual
- 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.

14. Financial instruments

14.1 Financial risk management

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

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.

14.1.1 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.

14.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

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.

14.1.4 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.

14. Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	**Equity Instruments designated at FVOCI 2019-20 £'000**	**Total 2019-20 £'000**
Equity investment in group bodies		0	0
Equity investment in external bodies		0	0
Loans receivable with group bodies	0		0
Loans receivable with external bodies	0		0
Trade and other receivables with NHSE bodies	84		84
Trade and other receivables with other DHSC group bodies	270		270
Trade and other receivables with external bodies	163		163
Other financial assets	0		0
Cash and cash equivalents	40		40
Total at 31 March 2020	**557**	**0**	**557**

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Equity investment in group bodies		0	0
Equity investment in external bodies		0	0
Loans receivable with group bodies	0		0
Loans receivable with external bodies	0		0
Trade and other receivables with NHSE bodies	217		217
Trade and other receivables with other DHSC group bodies	892		892
Trade and other receivables with external bodies	208		208
Other financial assets	0		0
Cash and cash equivalents	180		180
Total at 31 March 2019	1,497	0	1,497

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	**Other 2019-20 £'000**	**Total 2019-20 £'000**
Loans with group bodies	0		**0**
Loans with external bodies	0		**0**
Trade and other payables with NHSE bodies	1,382		**1,382**
Trade and other payables with other DHSC group bodies	6,456		**6,456**
Trade and other payables with external bodies	5,368		**5,368**
Other financial liabilities	0		**0**
Private Finance Initiative and finance lease obligations	0		**0**
Total at 31 March 2020	**13,206**	**0**	**13,206**

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	0		0
Loans with external bodies	0		0
Trade and other payables with NHSE bodies	3,122		3,122
Trade and other payables with other DHSC group bodies	6,360		6,360
Trade and other payables with external bodies	4,373		4,373
Other financial liabilities	0		0
Private Finance Initiative and finance lease obligations	0		0
Total at 31 March 2019	13,855	0	13,855

15. Operating segments

The clinical commissioning group consider they have only one segment: commissioning of healthcare services.

16. Joint arrangements - interests in joint operations

The NHS clinical commissioning group's share of the income and expenditure handled by the pooled budget in the financial year were:

16.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2018-19				Amounts recognised in Entities books ONLY 2018-19			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	Assets	Liabilities	Income	Expenditure
From the 1st April 2019 the CCG entered into a pooled budget with North Yorkshire County Council and the following CCGs for the Better Care Fund (note 1.5):										
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, Wharfedale & Craven CCG, North Yorkshire County Council	Formal pooled budget arrangement for the delivery of Better Care Fund requirements	0	0	0	(9,726)	0	0	0	(9,461)
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	0	0	0	(16,383)	0	0	0	(15,628)

Details of related party transactions with individuals are as follows:

POSITION	CCG OFFICE	RELATED PARTY	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Partv
			£000	£000	£000	£000
CCG SENIOR MANAGER						
Dr George Campbell	Vice Chair of Governing Body	Whitby Group Practice	2,421	0	148	(16)
Dr Mark Hodgson	GP Governing Body Member	Doctors Lane Surgery	1,023	0	55	(29)
Dr Charles Parker	GP Governing Body Member/Clinical Chair	Topcliffe Surgery	630	0	40	(2)
Dr Jonathan James	Secondary Care Doctor Governing Body	Son - GP at Scorton Medical Centre	1,079	0	56	(31)
Dr Mark Duggleby	Prescribing Adviser	Stokesley Health Centre	1,200	0	92	(10)
Dale Owens, Assistant Director Care and Support	Local Authority Representative	NYCC	3,216	(304)	1,265	(58)
Lincoln Sargent, Consultant in Public Health	Local Authority Representative	NYCC	3,216	(304)	1,265	(58)
Katie Needham, Consultant in Public Health	Local Authority Representative	NYCC	3,216	(304)	1,265	(58)
Victoria Ononeze, Consultant in Public Health	Local Authority Representative	NYCC	3,216	(304)	1,265	(58)
COUNCIL OF MEMBERS						
Catterick Village Medical Centre	Member	Catterick Village Medical Centre	808	0	66	0
Central Dales Practice	Member	Central Dales Practice	1,153	0	59	(4)
Doctors Lane Surgery	Member	Doctors Lane Surgery	1,023	0	55	(29)
Egton Surgery	Member	Egton Surgery	668	0	27	(3)
Glebe House Surgery	Member	Glebe House Surgery	1,249	0	101	0
Great Ayton Health Centre	Member	Great Ayton Health Centre	665	0	43	0
Harewood Medical Practice	Member	Harewood Medical Practice	1,277	0	160	(36)
Lambert Medical Centre	Member	Lambert Medical Centre	1,466	0	93	(5)
Leyburn Medical Practice	Member	Leyburn Medical Practice	1,523	0	69	(41)
Mayford House Surgery	Member	Mayford House Surgery	1,722	(11)	106	(39)
Mowbray House Surgery	Member	Mowbray House Surgery	3,896	(14)	180	(10)
Quakers Lane Surgery	Member	Quakers Lane Surgery	1,042	0	50	(2)
Reeth Medical Centre	Member	Reeth Medical Centre	538	0	44	(2)
Scorton Medical Centre	Member	Scorton Medical Centre	1,079	0	56	(31)
Sleights and Sandsend Surgery	Member	Sleights and Sandsend Surgery	1,437	0	57	(4)
Staithes Surgery	Member	Staithes Surgery	943	0	39	(2)
Stokesley Health Centre	Member	Stokesley Health Centre	1,200	0	92	(10)
The Danby Surgery	Member	The Danby Surgery	821	0	35	(29)
The Friary Surgery	Member	The Friary Surgery	1,018	0	91	(29)
Thirsk Health Centre	Member	Thirsk Health Centre	1,269	0	58	(4)
Topcliffe Surgery	Member	Topcliffe Surgery	630	0	40	(2)
Whitby Group Practice	Member	Whitby Group Practice	2,421	0	148	(16)
ORGANISATION						
Heartbeat Alliance LTD			812	0	78	0
Hambleton North Primary Care Network			11	0	0	0
Hambleton South Primary Care Network			9	0	0	0
Richmondshire Primary Care Network	Included within Harewood Medical Practice		0	0	0	0
Whitby Coast and Moors Primary Care Network			20	0	0	0
GOVERNING BODY						
Dorothy Pollard	Whitby Health Engagement Network (Non-Voting Attendee)	Humber Teaching NHS Foundation Trust	7,125	(347)	7	0

Note
£1.5m has been accrued within the financial statements on an estimated basis in respect of Prescribing and Dispensing drugs reimbursement for GP Practices as a whole with amounts being paid in the new year once actual figures are confirmed.

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

Foundation Trusts	NHS Trusts	Clinical Commissioning Groups, NHS England and Commissioning Support Units	Other
County Durham & Darlington NHS Foundation Trust	Yorkshire Ambulance Services NHS Trust	NHS North East Commissioning Support Unit	NHS Shared Business Services
Harrogate & District NHS Foundation Trust	The Leeds Teaching Hospitals NHS Trust	NHS Harrogate & Rural District CCG	NHS Property Services Ltd
Humber Teaching NHS Foundation Trust		NHS Scarborough & Ryedale CCG	NHS Litigation Authority
The Newcastle upon Tyne Hospitals NHS Foundation Trust		NHS Vale of York CCG	Academic Health Science Network
North Tees & Hartlepool NHS Foundation Trust			
South Tees Hospitals NHS Foundation Trust			
Tees Esk & Wear Valleys NHS Foundation Trust			
York Teaching Hospital NHS Foundation Trust			

18. Events after the end of the reporting period

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group, NHS Harrogate and Rural District 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.

19. Third party assets

The clinical commissioning group held no third party assets as at 31 March 2020.

20. 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**	**Duty Achieved**	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	235,017	234,966	**Yes**	220,614	220,555
Capital resource use does not exceed the amount specified in Directions	0	0		0	0
Revenue resource use does not exceed the amount specified in Directions	233,955	233,905	**Yes**	219,290	219,231
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	31	31	**Yes**	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0		0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,155	2,844	**Yes**	3,396	3,175

21. Losses and special payments

21.1 Losses

The CCG identified an expected credit loss allowance-receivables in 2018/19 for £8,634. This was written off during 2019/20 (Note 9.2).

21.2 Special payments

The clinical commissioning group had no special paymenstas at 31 March 2020.