NHS Scarborough and Ryedale Clinical Commissioning Group

Annual Report 2019-2020

Scarborough and Ryedale
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 Scarborough and Ryedale 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 Scarborough and Ryedale 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 Scarborough and Ryedale we have:

- 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 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.

[1] https://www.kooth.com
[2] https://northyorkshireiapt.co.uk/

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 Scarborough and Ryedale. 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 Scarborough and Ryedale, 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

In Memoriam

Dr Phil Garnett

Sadly this year we said goodbye to Dr Phil Garnett, our Clinical Chair.

Dr Garnett led the CCG from its formal inception in April 2013 and was still working just a few days before his death.

Phil was driven by a burning desire to make the NHS the best it could be and throughout his time at the helm of our organisation – and indeed throughout his distinguished career as a GP – he was determined to secure the best possible services for patients.

He very much led from the front and was an exceptionally gifted speaker, possessing a wonderful sense of dry humour and wit to match his intellect. Phil was erudite, captivating and charming; and people always listened to what he had to say.

A keen thespian, Dr Garnett qualified as a doctor in Leeds in 1973 and joined Filey Surgery in 1978. He held senior positions with the local Primary Care Trust, Primary Care Group and Saint Catherine's Hospice and was heavily involved in the North Yorkshire Local Medical Committee.

Dr Garnett also worked for five years in secondary care with a focus on paediatrics where he gained a Diploma in Child Health from the Royal College of Obstetricians and Gynaecologists and became a Member of the Royal College of Physicians.

The CCG would like to express its enduring gratitude to Dr Garnett for all that he did to make us a better, compassionate, outcome-driven organisation. The health and wellbeing of our local community was always at the front of his mind. He will be sorely missed.

Table of Contents

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 at 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 at section 7 which starts on page 87 you can find out about our members, our senior leadership team and how we make decisions. Finally, from page 155, 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 121,000 people in the Scarborough and Ryedale 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 region. 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 improve the health and wellbeing of our local communities'

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

1.4 Our values

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

- To commission high quality services
- To engage patients, carers and other organisations in our planning and decision process
- To ensure value for money
- To be open and honest in our transactions, and accountable to our communities
- To respect our staff and promote a learning environment
- To improve health outcomes

1.5 About us, Our Community and How We Work

We are a clinically led membership organisation of our 12 local GP practices. This means that health professionals with current patient experience are leading the decisions we make. Our Council of Clinical Representatives, comprised of a representative from each practice, 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. You can also see papers and minutes from our Governing Body and Primary Care Co-Commissioning Committee on our website.

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. 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.
- 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 Scarborough and Ryedale. 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 Scarborough and Ryedale.

1.7.1 Patient Participation Groups (PPGs)

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

1.7.2 Primary Care Organisations

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

1.7.3 NHS Providers

Four NHS trusts provide the majority of services to our patients. These are: York Teaching Hospital NHS Foundation Trust (YTHT); Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV); Humber Teaching NHS Foundation Trust (HFT) and Hull University Teaching Hospitals NHS Trust (HUT). 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, Scarborough Borough Council and Ryedale District Council to commission a number of services, such as mental health crisis service, support for people affected by dementia, website to help young people access mental health services and community equipment.

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: 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 sector organisations across Scarborough and Ryedale who make significant contributions to local health care.

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 the Scarborough and Ryedale area 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 Our CCG's Key Strategic Aims

We have three strategic aims. These aims help us prioritise our work, and drive our decision making. Our strategic aims are:

- Commission sustainable, high-quality services within the available resources (people, money, buildings)
- Create a stronger community system and integrate care across the whole health care economy
- Secure improvement in priority areas of health need and reduce health inequalities.

2 Delivering Our Strategic Aims

2.1 Urgent and Emergency Care

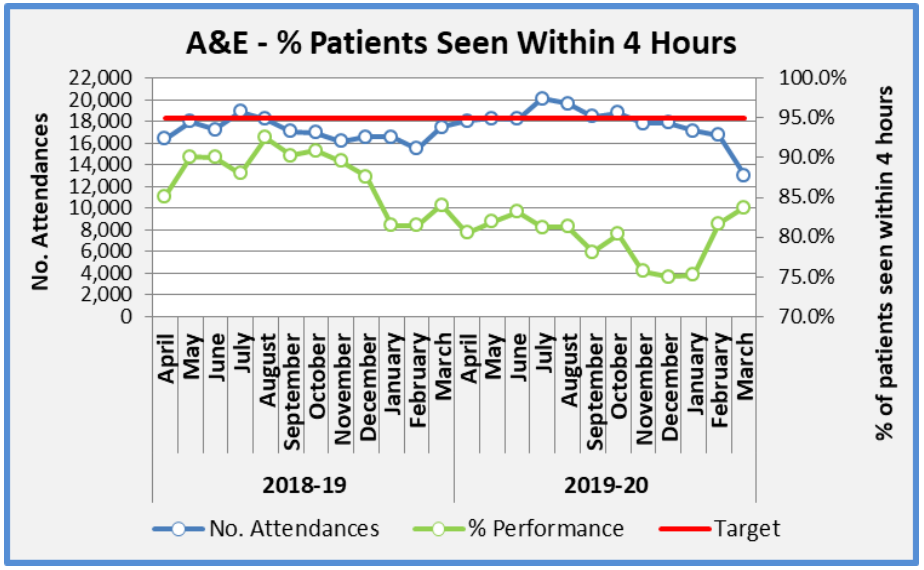
The national target for this indicator is that 95% of patients who attend A&E units are seen and discharged or admitted within four hours of the arrival. The CCG measures its performance against this target across all unit types. This will include patient activity at A&E departments and Urgent Care Centres.

A&E Waiting Times				
Indicator	Target	January 2020	February 2020	March 2020
Number of CCG patients waiting over 4 hours to be seen and discharged	95%	4,483	4,478	3,724
Number of CCG patients seen and discharged within A&E		5,810	5,453	4,429
% of CCG patients seen and discharged within 4 hours		77.2%	82.1%	84.1%

There have been some improvements in A&E flow, however significant challenges have continued to impact on the overall 4 hour performance. The local picture has been reflected nationally and regionally and includes; increased admissions, higher acuity of patients, high bed occupancy, bed closures due to respiratory viruses and Norovirus, workforce challenges and provider resilience across the health and social care system. Within quarter four there have been 32 12hour Trolley breaches declared from our main acute services provider. All of these breaches have been reviewed by the CCG and assurance regarding patient safety has been received. This figure is the lowest of any quarter throughout the year, but will have been impacted by the lower numbers seen in A&E due to the outbreak of COVID-19.

The Health and Resilience Board have reviewed and revised the programme of work and revised the programme of work; this still includes the previous initiatives: front door streaming, improving patient flow and frailty, but has more emphasis on performance recovery and system wide working.

Robust System wide operational processes are now established. Multi-agency discharge events continue and daily progress chasing of all patients over seven days. This has resulted in a partnership approach to the day to day challenges across the system and has led to earlier escalation and resolution of issues.



2.2 Ambulance Response Times

Yorkshire Ambulance Service (YAS) was one of the first English ambulance trusts to participate in the Ambulance Response Programme (ARP) pilot, led by NHS England, when it began in October 2016, which has now been successfully implemented. ARP allows extra time for emergency call handlers to make a more detailed analysis of some 999 calls and to decide upon the most appropriate response for patients' needs.

At present, performance is not available at CCG level and is therefore monitored at ambulance trust level. The CCG monitors, on a monthly basis, the Category 1 to 4 performance standards.

Indicator	Mean		90th Percentile	
	Standard	Actual	Standard	Actual
Category 1	00:07:00	00:07:12	00:15:00	00:12:26
Category 2	00:18:00	00:20:33	00:40:00	00:42:41
Category 3				02:00:00 / 01:54:36
Category 4				03:00:00 / 03:01:10

Proposed standards

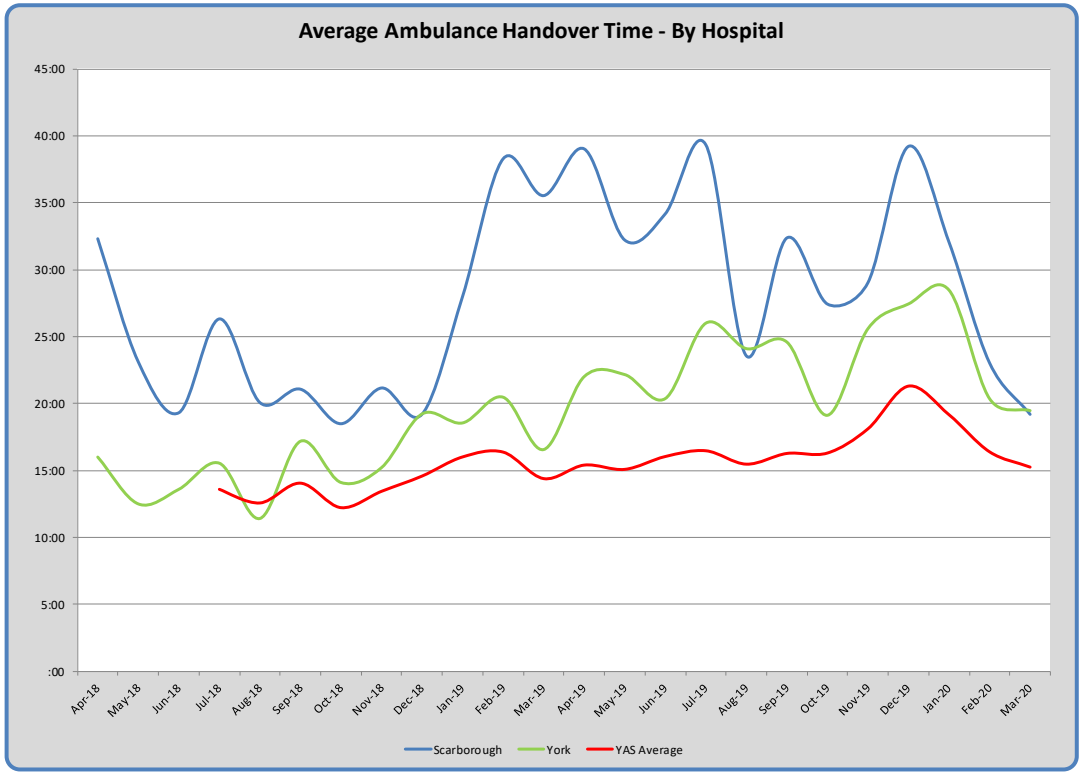
Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

2.3 Ambulance Handover Times

Patient handover is where the professional responsibility and accountability for the care of the patient is transferred from the ambulance crew to the medical/nursing staff at the hospital. Timely handover of patient care can help reduce response delays and improve the service offered to patients. Turnaround time is the overall time taken for the ambulance crew to handover the patient, and then clean, restock and make the vehicle available to respond to another call. This is important as it affects the number of patients that YAS can respond to in a timely manner.

Ambulance handover remains variable, see chart, and is dependent on a number of factors including: pressure/surges of activity; flow throughout the department/hospital; and workforce.

The CCG has been involved in a whole system programme of work to improve ambulance handover. This has included implementation of initiatives to avoid conveyance to hospital and in addition further initiatives on arrival to the hospital for example, the introduction of “fit to sit” pathways, more collaborative working with the Urgent Treatment Centres, and the establishment of new roles.



2.4 Avoiding Unplanned Admissions

The CCG continues to remain committed to delivering a strong, community based health system which requires close collaboration with partners across the Scarborough and Ryedale health economy. The out of hospital care service continues to provide quality care for our patients as well as reducing the need for admission to the acute services. All partners have been working together to improve pathways for patients and ensure that they are receiving the right care at the right time this includes new pathways for residents in care homes, and those with mental health conditions requiring rapid support.

We continue to work closely with NHS England and NHS Improvement on all commissioning considerations related to this piece of work, which is innovative and forward thinking. Further workstreams to avoid unplanned admissions include: improved support to care homes, improve access to first contact services, innovations in the use of technology, improved pathways and responses for respiratory conditions, improved access to GP services, and introduction of acute hospital initiatives such as Same Day Emergency Care.

Despite the number of new initiatives implemented during the year to support out of hospital care, the CCG continued to see increased levels of demand for unplanned admission into our local hospitals. This increase was consistent with the national picture of growth with many health communities identifying similar peaks in demand for emergency healthcare.

The CCG continues to work with Public Health and other colleagues to continue to make improvements in this area.

2.5 Primary Care

2.5.1 Primary Care Networks

To meet the needs of local communities and in line with the Investment and Evolution five year framework, all 12 practices in Scarborough and Ryedale have joined one of three primary care networks, determined by population health needs and locality, with four practices in each.

PCNs formally came into existence on 1 July 2019 and since then practices have been working together, and with the CCG and community providers, to develop and mature their networks. PCNs are intended to provide stability, generate different roles in general practice to supplement the workforce and contribute to larger, more multi-disciplinary teams, and act as a dedicated investment and delivery vehicle for primary care. The key to PCNs is providing community leadership through local Clinical Directors and integrating with healthcare providers in other settings to ensure better place based health and care.

2.5.2 International GP Recruitment

Across Humber Coast and Vale Health and Care Partnership a pilot recruitment scheme is in the third year of a three year project to recruit 65 international GPs to practices across 5 CCGs (Hull, East Riding, Scarborough and Ryedale, North East Lincolnshire and North Lincolnshire CCGs).

Scarborough and Ryedale CCG is the lead for the HCV STP International GP Recruitment (IGPR) programme with the aim to allocate 12 to CCG practices over this three year period. Four GPs from Spain arrived in Scarborough practices in summer 2019, and are all progressing with individual support plans over a 6 month period, ahead of being assessed so as to ensure they meet the NHSE standards. One more international GP arrived in Quarter 3. In total 14 international GPs may have relocated by January 2020 although over 50 international GPs remain engaged in the process of studying for the Occupational English Test.

A recent recruitment event in Gijon, Spain in October 2019 has seen keen interest from over 80 international GPs and further “taster weekends” are being planned for early 2020 across HCV.

The scheme has developed close links with medical schools in Spain and two practices have hosted externship placements where a student in family medicine undertakes a placement for a month in a local practice with a view that once qualified would complete the recruitment process and relocate to one of our local practices.

One Scarborough and Ryedale CCG practice is now licenced as a Tier 2 employer and has retained a non-EU GP trainee.

2.5.3 Digital

The Strategic Digital Board continues to support the work of the Digital Transformation Programme Board (Scarborough Ryedale and Vale of York CCG) and the Local Digital Roadmap Board (Humber CCGs) and this year commissioned the development of a digital strategy as part of a joint Humber Coast and Vale initiative. Wide stakeholder engagement was undertaken and was used to influence the priorities described within the strategy. This year with the support of the sub-regional boards the strategic digital board will deliver on the priorities described within the strategy.

Work has continued following the award of the funding to the Yorkshire & Humber Care Record (LHCRE) to deploy shared record capability, end of life care planning and broadening of system integration across organisations. This programme will come out of project phase and transition into business as usual from April 2020 and we will continue to support the ongoing mobilisation and development with appropriate data sharing is a high priority development to support system wide benefits.

The sub-regional Digital Transformation Programme Board which represents organisation's delivering health and care to patients within Scarborough Ryedale and Vale of York CCG's continues to receive good support and this year has supported a number of projects supporting integration and sharing with clinical benefit to our populations. Work will continue in line with Long Term Plan and other system wide priorities.

2.6 Research and Development

As commissioners of health care and supporting services for our population, the CCG has statutory duties to:

- Support and promote research and evidence
- Use evidence from research to support commissioning decisions
- Ensure the treatment costs in research are resourced

The CCG also has a mandatory role in ensuring patients have the option of enrolling in research projects as part of their care. Within secondary (hospital) care at our local providers, research projects are planned and delivered by treatment teams using national frameworks to ensure patient safety and academic rigour. Over the last two years there have been several national projects completed and published by staff in our local hospitals.

The CCG has a Research and Development Policy which aims to ensure that the principles of research and development are embedded throughout the organisation and serves to act as a guide to staff on significant themes.

During 2018/19 the CCG entered into a Memorandum of Understanding with North Eastern Commissioning Support Unit (NECs) to provide a research and evidence service to the CCG which would support the CCG to meet its statutory duties. NECS reports to

the CCG on a quarterly and annual basis on progress of this area. In particular we are keen to ensure our patients have the opportunities to participate in research at a level at least as high as in other CCGs, and that we have participation figures to demonstrate those opportunities. Currently patients for whom we commission care have the opportunity to participate in research projects at a level that is good for our population size. In addition, new projects are currently being developed to allow research into various fields of general practice, including mental health.

The executive lead for Research and Development within the CCG lies with the Chief Nurse, Executive Director for Nursing, Quality and Clinical Governance who is supported by the Governing Body Secondary Care Consultant. Reports for activity are fed through the Audit Committee to provide assurance to the Governing Body.

2.7 Delivering Sustainable Services

Clinicians and local health service commissioners have been working to ensure delivery of sustainable services in the region.

The Acute Medical Model (AMM) was implemented to improve patient experience and make future A&E services safer and sustainable. The AMM is part of an NHS England programme to develop systems that help ensure high quality care can be delivered in rural and remote district hospitals.

Patients attending the Emergency Department, either walk in or via ambulance, are initially seen in a First Assessment area by either an Advanced Clinical Practitioner or Emergency Department Specialty Doctor with oversight from Consultants and the Emergency Department senior team.

The model means:

- Investigations, diagnosis and decisions about treatment are taken sooner.
- Where appropriate patients are transferred to the relevant ward or assessment unit for assessment by a specialist.
- Patients are directed to the most appropriate service quicker, including alternative hospitals for more specialist needs.

Work is ongoing to enhance this model by the development of further pathways, and the introduction of initiatives such as Same Day Emergency Care Models and frailty assessments.

2.8 End of Life Care

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.

Following a successful pilot with Saint Michael's Hospice we have introduced an outreach health care assistant service that 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.

2.9 New Care Models

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 Scarborough and Ryedale the Crisis and Intensive Home treatment service is in place, this is in operation seven days a week, 10am – 10pm.

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 is an online counselling tool for young people.

2.10 Workforce

2.10.1 Recruitment Event at CU

In November 2019 Humber, Coast and Vale's Excellence Centre hosted a recruitment event at Coventry University Scarborough aimed at people with aspirations of working in health and social care. Areas represented included mental health, learning disability, community, frail elderly, healthy lifestyle and addiction services as well as a number of apprenticeship opportunities.

Attendees were given the opportunity to find out more about the wide range of jobs and careers available in Scarborough and Ryedale and across the wider Humber, Coast and Vale region. Local health and social care employers attended the event supported by the CCG, to provide information on current vacancies and training programmes within their organisations.

2.10.2 Nursing Courses

Local mental health trust, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has worked with Coventry University Scarborough – part of the Coventry University Group, York Teaching Hospital NHS Foundation Trust and NHS Scarborough and Ryedale CCG to introduce a Registered Mental Health Nursing course and Nursing Associate course.

The first students on the Nursing Associate course started in January 2020, while the Mental Health Nursing course began in September 2019.

It is hoped that the new courses will bring a welcome boost to the number of people choosing to work in local NHS mental health services. The three-year BSc degree programmes will allow students to practice nursing in a range of in-patient and community settings, leading them to achieve registered nursing status with the Nursing and Midwifery Council.

There were 15 spaces available on the Nursing Associate course, and TEWV have offered students on both courses a range of placements in its services, as well as offering apprenticeships on both programmes to a number of its existing staff.

The apprenticeships will allow Trust staff to obtain valuable skills, whilst remaining in employment throughout their studies, which in turn supports the Trust to retain valued staff.

2.11 Mental Health

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

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

- Developed the key objectives and identified how this linked to the principles of North Yorkshire Partnership Mental Health and how they would be delivered:
  - Greater focus on prevention and early intervention
  - Provision of integrated care closer to home
  - Intervening and supporting people earlier and more effectively in their illness to reduce the number of admissions for inpatient treatment

- Better use of resources across the whole pathway
- Supporting people to achieve their self-determined health and well-being goals.
- Delivery of comprehensive mental health and learning disability services, initially prioritising those in the NHS Long Term Plan and the TCP.

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

Early intervention in Psychosis (EIP)

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

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

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

Recommendations from the design event have recommended a 2 team model across North Yorkshire and York which would address the 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 Mental Health 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.

2.11.1 Website for Young People

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

The Go-To
For healthy minds in North Yorkshire

and young people. The website is scheduled for launch at the end of Q4 19/20.

- 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).
- Young people aged 11-18 in Scarborough and Ryedale and across North Yorkshire can now access Kooth, a website offering free online counselling and emotional wellbeing support. Kooth[3] from digital mental health provider XenZone, gives young people instant access to emotional and wellbeing advice and support whenever and whenever they need it. It incorporates self-help articles and online tools such as a mood tracker, as well as professional online therapy and moderated peer-to-peer forums. The Kooth service has been commissioned by local mental health provider Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) as part of its commitment to provide early mental health guidance and support through digital provision. The service is accredited by the British Association for Counselling and Psychotherapy (BACP) and provides a safe environment where young people can chat anonymously and in confidence with qualified counsellors, who are online from noon until 10pm on weekdays and from 6pm until 10pm, 365 days a year. Young people can register on Kooth without having to provide personal details such as their name or address. It provides a safe and non-judgemental place for them to talk, connect and chat with others and know they are not alone.

2.11.2 Mental Health Funding

Tees, Esk and Wear Valleys (TEWV) NHS Foundation services has received over half a million pounds worth of funding from local clinical commissioning groups (CCGs) to help reduce the impact of mental health crisis on both individuals in crisis and wider services, such as the police, ambulance and accident and emergency.

The funding will allow the Trust to maintain specialist 24/7 telephone assessment and crisis support, as well as expanding existing out of hours crisis cafes in York and Scarborough and introducing new crisis cafes in Northallerton, Harrogate and a mental health first aid response into Selby.

Crisis cafes are generally open on an evening and offer people aged 16 and over a safe and comfortable place to go to receive support when they are in distress. The cafes are supported by trained nurses and support staff who have mental health first aid training, whilst also being linked to local crisis and crisis resolution home treatment teams, so café staff can access a specialist response if needed.

[3] www.kooth.com

The Trust's existing crisis cafes, The Haven in York and Scarborough Crisis Café, have been operating since October and August 2018 respectively. Both have been exceptionally beneficial for local people, helping over 200 people a week to access information and support around crisis prevention, as well as signposting them to and facilitating access to other relevant and appropriate services, agencies and activities.

2.11.3 Autism Assessment Service

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 2019/2020 to reduce the waiting list.

The Retreat provides the children's autism assessment service in the Scarborough and Ryedale locality. Following the notice given by the previous Provider, a one year Contract was put in place from June 2019 to June 2020. However, discussions are currently taking place between the Provider and Scarborough and Ryedale CCG to extend the Retreat Contract to December 2020. A Contract Variation will be made once the terms of the Contract extension have been agreed. The Provider is reporting that they expect to clear referrals transferred from the previous Provider by end May 2020, and that new referrals will be seen from June 2020 onwards. Due to the service change in 2019 the Retreat did not start seeing and assessing patients until September 2019.

2.11.4 Dementia Services

In 2019/20 people whose lives have been affected by dementia, their families and carers were able to get free help and support from a new service available across North Yorkshire. The service is provided by Dementia Forward[4] and is funded by North Yorkshire County Council and the Clinical Commissioning Groups (CCGs) covering the county, as part of their work to help people live independent, healthy lives for as long as possible. Dementia Forward has been working with the County Council in the Harrogate and Vale of York CCG areas and they will now also cover Scarborough and Ryedale, Hambleton, Richmondshire and Whitby and Craven CCG areas, previously delivered by Making Space.

The aim of the service is to help people living with dementia and their family, friends or carers to feel empowered and informed so that they have choices following their diagnosis. Information, advice and support is provided through a wide range of local services, including a North Yorkshire Helpline; home visits from a trained dementia support advisor; signposting to other sources of help; education programmes and a range of wellbeing and social activities.

[4] www.dementiaforward.org.uk

2.11.5 STP Award

The Humber, Coast and Vale Mental Health Partnership was shortlisted for the Health Services Journal (HSJ) Award for “System Leadership Initiative of the Year”. The HSJ judging panel, made up of a diverse range of influential figures within the healthcare community, shortlisted the Partnership despite the tough competition from hundreds of excellent applicants.

The Award recognises the progress made since the Partnership was established to improve mental health services by working together. The Mental Health Partnership has achieved many successes by bringing together all the organisations that are responsible for commissioning (“buying”) and providing mental health services across our region to put in place care that is seamless and built around the needs of individuals regardless of which organisation is responsible for each element of that person’s care.

The Partnership’s many successes include the development of specialist mental health services for new and expectant mothers across the region and the launch of the Every Mum Matters campaign; ensuring more people are treated closer to home by significantly reducing the number of patients in “out of area” placements; developing and securing funding for a Partnership-wide suicide prevention strategy and securing over £1 million additional funding to support people with enduring mental health problems into employment.

2.12 Maternity

Following on from NHS England’s National Maternity Review, Better Births, in February 2016 the Humber Coast and Vale Partnership developed a Local Maternity System 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) Board

The key achievements within Scarborough and Ryedale during 2018/19 have been:

- The introduction of the Continuity of Carer model, which has required a wholescale change at Scarborough.
- York Foundation Trust has reported that they have achieved the target of 35% in the January/February 2020 reporting period.

- The continuation of the Maternity Voices Partnership in the Scarborough and Ryedale locality, with attendance and support from the CCG and a service user chairing the group.

The key priorities for 2020 will be a Local Maternity Service wide approach for digitalisation, neonatal critical care transformation and improving postnatal care (see section 6.3.5).

2.12.1 Pregnancy Care Choices Survey

Expectant and new mums in parts of Yorkshire and the Humber region were asked for their views on how information about their pregnancy and childbirth care options should be shared with them and their families.

The Humber, Coast and Vale Maternity Voices Partnership Group is a network of independent, parent-led groups which brings together women and their families with healthcare professionals, clinicians and NHS managers responsible for maternity services in the areas of Hull, East Yorkshire, North Lincolnshire, North East Lincolnshire, Vale of York and Scarborough and Ryedale to develop local maternity care.

The group asked to hear from mums-to-be and new parents in these areas about how they wish to receive information about the options available relating to the care they receive during pregnancy and childbirth – for example, where they can give birth.

The Maternity Voices Partnership Group created a survey on the subject, and encouraged mums-to-be and new parents to share their views in order to determine the best way to share this important information with them in the future.

2.12.2 ICON – Head Trauma

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

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

I – Infant crying is normal;

C –Comforting methods can help;

O – It's OK to walk away;

N – Never, ever shake a baby.

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

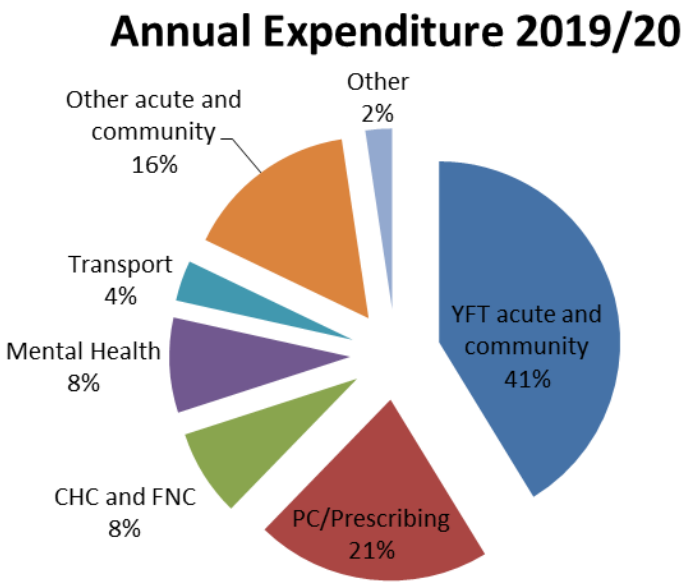
3 Our Financial Position

The CCG's resource allocation in 2019/20 totals £205m which includes £18m for primary medical care and £2.7m to support the running costs of the CCG.

The CCG planned for a £4.8m deficit in 2019/20 which matched the notified control set by NHS England (NHSE). Achievement of this plan attracted Commissioner Support Funding (CSF) enabling the CCG to breakeven in year.

A challenging savings target of £7.9m was required to deliver this plan and the CCG developed a QIPP programme across acute care, primary care prescribing and continuing healthcare to support this.

During 2019/20 the CCG achieved the set plan and therefore received the CSF. Non-recurrent measures helped the CCG to reach this position and the CCG is actually reporting a small year-end surplus of £64k. The CCG has therefore met its statutory duties in year but a cumulative deficit of £20.6m remains.



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 155.

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%	**73.3%**
Maximum 6 weeks diagnostic test waiting times	≤1%	**16.5%**
A&E waits – 4 hours to assessment, treatment and discharge	95%	**79.3%**
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	**87.3%**
Maximum one month (31-day) wait from decision to treat to treatment for all cancers.	96%	**96.1%**
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	85%	**74.7%**

* 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

Waiting time for assessment and treatment remain a key priority for the CCG. The “Incomplete pathway” measures the percentage of patients who are waiting less than 18 weeks at the end of the reporting month and has a targeted standard of 92%.

The delivery of this standard has been a challenge, with CCG performance falling below the required level of performance of 92% throughout the year. In addition to this, the waiting list position has been closely monitored in 2019/20 as part of the Oversight Framework. The waiting list position was planned to be no higher than 6,569 by March 2020. After a good start during the year, the waiting list position has finished at a total of 7,411 which was an increase of 657 patients compared with March 2019. Bed pressures for Non-Elective Admissions at Scarborough Hospital had adversely affected available capacity for elective work. This position has been further hindered by the impact of Covid-19 and the need to cancel various Elective surgeries.

Specialties failing the target are: Cardiology, Dermatology, ENT, Gastroenterology, General Surgery, Neurology, Neurosurgery, Ophthalmology, Plastic Surgery, Respiratory Medicine, Rheumatology, Trauma & Orthopaedics and Urology.

Dermatology and Ophthalmology continue to struggle with capacity issues and both have significant backlogs and identified clinical risk. There has been an Ophthalmology Action Plan implemented to address clinical risk in Glaucoma Follow Up patients and to address cataract backlogs through re-deployment of Trust resource.

6.1.3 Diagnostics

York Trust has seen a further decline against the national 6 weeks diagnostic target in March and this has impacted on the CCG performance for this indicator. Pressures remain in Endoscopy, Echo CT and Non-Obstetric Ultrasound. Recovery plans have been created for all modalities not achieving the 99% standard and progress against these is being monitored with Care Groups on a weekly basis.

The Endoscopy position has been impacted by the sustained increase in fast track demand on the service causing routine patients to be displaced to prioritise these clinically urgent patients. The Trust's new Endoscopy Unit 5th room at York which opened on the 3rd of February is expected to lead to improvement in performance against the diagnostic target. The Trust is working with the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services with a programme of work started in January 2020.

6.1.4 Emergency Care Standard (A&E 4 hour Wait)

The pressure on waiting time in Emergency Department (ED) remains challenge as it has done all year. Considerable increases in attendances in both in Scarborough and York, coupled with constraints in capacity and flow in hospital has led to further pressure within ED. Both Scarborough and York Hospital experienced bed occupancy levels of above 90% for the majority of the year, although this began to reduce in March because of the impact of Covid-19.

Funding has been approved to test a workforce model for 12 hour opening of Medical Same day Emergency Care (SDEC) and Surgical Assessment unit at weekends, to support service expansion to a full 7 day SDEC service, on both York and Scarborough sites. As part of escalation measures instigated to address long waits in ED, York FT have initiated streaming patients from ED to Medical SDEC who do not require specialist assessment, alongside continuing streaming for patients needing specialist opinion with an 80% chance of being assessed, treated and discharged the same day. This should help and support improvement in the flow of patients.

6.1.5 Cancer Waiting Times

28 Days (Faster Diagnosis Standard (FDS))

The new 28 day Faster Diagnosis Standard ensures that patients who are referred for investigation of suspected cancer can find out, within 28 days of referral, if they do or do not have a cancer diagnosis. The standard was introduced in April 2019 and whilst a 'national threshold' has not been determined, the CCG's main provider (York Teaching Hospitals Trust) achieved 69% in March 2020 (against a benchmark of 63% in July). The FDS is particularly challenging for prostate, colorectal and skin pathways.

62 Days (from referral to first treatment)

Whilst the populations served by York Teaching Hospital Trust in general, achieved the shortest 62 day 'waits' across the Humber Coast and Vale Cancer Alliance, both the Trust and the CCG failed to achieve the 85% standard for the majority of the year prior to January 2020. Diagnostic capacity and the management of patients on complex diagnostic and treatment pathways were attributable to the majority of the 'breaches'. Colorectal and Urology (prostate) were the pathways which were most challenged by the 62 day standard.

There has been a concerted focus on supporting the skin cancer pathway supporting and encouraging the use of Teledermatology in primary care.

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

6.2 The Quality Premium

In previous years, as part of the Quality premium, 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 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 to 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	Calendar Year to 2018	Nat Av 51.8%	51.5%
Max 62 day wait for first definitive treatment for cancer following an urgent GP referral for suspected cancer	2019/20 (Apr-Feb)	85%	**74.7%**

Indicator	Data	Target	Position
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%	71.2%
National Cancer Patient Experience Survey	2018	Nat Av 8.80	8.71

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

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

In support of delivery of the CCG's contribution to the national ambitions the organisation has continued to develop an integrated approach to planning and operational delivery with its partners, via the Cancer Delivery Board and Cancer Strategy Group (York District Hospital Trust and Vale of York CCG (VoY)) and all key stakeholder organisations allied to the Humber Coast and Vale Cancer Alliance.

Each year in the CCG, circa 780 individuals are diagnosed with cancer and there are circa 340 cancer deaths.

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

The Rapid Diagnostics Centre for Serious nonspecific symptoms is an early diagnosis initiative to support NHS England's national strategy for earlier and faster cancer diagnosis (28 day Faster Diagnosis Standard). It is envisaged patients coming through the new pathway will experience a rapid diagnostic one stop clinic approach involving a CT TAP and TNE scope and a results consultation all on the same day. A phased roll out of the new pathway and service has commenced across York and Scarborough and Ryedale with recent patients referred from general practice and diagnosed in secondary care between 3 and 5 days.

Rapid Diagnostic Pathways

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

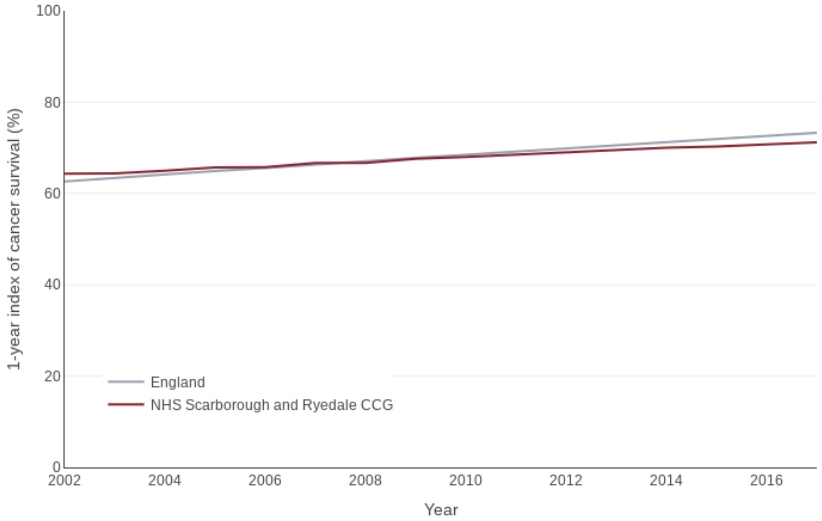
A Rapid Diagnostic Centre for patients who have serious non-specific symptoms has been running since March 2019 and will achieve full coverage of the area's GP practices by the end of April 2020.

On average, patients have seen their GP 3 times prior to referral to the RDC and the median waiting time for the initial outpatient appointment is 8 days (range 2-20 days) see section 6.5.9 for more information.

Improved Survival

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

Whilst 1-year survival rates for cancer patients in SR CCG is not dissimilar to that of England, the rate of increase in survival rates is less that the national rate. Further analysis will be undertaken in 2020/21 to understand this difference – and to review action plans accordingly.



Cancer Champions

Improved survival rates also require individuals to engage in 'healthy' behaviours and to respond appropriately to the signs and symptoms of suspected cancer. In partnership with Humber Coast and Vale Cancer Alliance, as of April 2020, there are now 97 'Cancer Champions' in the Scarborough and Ryedale area. Cancer Champions help to spread messages in their neighbourhoods and workplace about cancer prevention, making people more aware of signs and symptoms of cancer and encouraging people to take up screening opportunities.

Screening

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

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

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

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

Further work in 2020/21 will be undertaken to determine the factors underlying the apparent reduction in proportion of stage 1 and stage 2 cancers diagnosed from 73% in 2017 to 61% in 2018.

6.3.2 Dementia

Indicator	Data	Target	Position
Dementia: Estimated diagnosis rate for people with dementia	March 2020	66.7%	**57.2%**
Dementia: Care planning and post- diagnostic support	2018/19	Nat Av 83.6%	81.0%

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

Living well with dementia also includes helping to avoid unplanned hospital admissions, wherever possible, by ensuring individuals receive continuous care in familiar environments either at home or in community care home settings. The CCG is involved in delivering work programmes that help make sure advanced care plans are in place, and recorded in good time, for individuals when making choices about their future end of life care needs. Additionally, work is underway to provide training and support to

health and care professionals to understand the signs and symptoms of delirium and/or manage the distressing behaviours that people with dementia sometimes experience during difficult times so as to help avoid a hospital admission.

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

6.3.3 Diabetes

Indicator	Data	Target	Position
Diabetes patients that have achieved all the NICE-recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	Jan – Sep 2019	Nat Av 38.8%	38.2%
People with diabetes diagnosed less than a year who attend a structured education course	Jan – Sep 2019	Nat Av 13.2%	7.5%

The rising prevalence of Diabetes remains a challenge nationally. The CCG led a piece of work in conjunction with Vale of York CCG, York Teaching Hospital NHS Trust and Harrogate NHS Foundation Trust for Diabetes Transformation Fund monies. Humber Coast and Vale STP currently leads a piece of work accessing monies to support Diabetes Services, both the provision of prevention, and treatment. Access and attendance to Structured Education for Type 1 and Type 2 patients remains poor for our population, however these figures have shown a small increase in attendance.

6.3.4 Mental Health

Indicator	Data	Target	Position
Improving Access to Psychological Therapies: Access	2019/20 to Feb	19%	13.67%
People with first episode of psychosis starting treatment with a NICE recommended package of care within 2 weeks of referral.	2019/20	50%	41.0%

Indicator	Data	Target	Position
Improving Access to Psychological Therapies: Recovery Rate	2019/20 to Feb	50%	49.0%
The proportion f people that waited 6 weeks or less from referral to their first IAPT treatment	2019/20 to Feb	No target	75.73%
Children and Young People's mental health service transformation	Jan-20	34%	**22.6%**

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[5].

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

Following feedback received from NHSE on the LTP quarterly updates, the NY CCGs arranged a meeting with NHSE to discuss the 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 Humber Coast and Vale Partnership developed a Local Maternity System 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) Board

The key achievements within Scarborough and Ryedale during 2018/19 have been:

- The introduction of the Continuity of Carer model, which has required a wholescale change at Scarborough.
- York Foundation Trust has reported that they have achieved the target of 35% in the January/February 2020 reporting period.

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

- The continuation of the Maternity Voices Partnership in the Scarborough and Ryedale locality, with attendance and support from the CCG and a service user chairing the group.

The key priorities for 2020 will be a Local Maternity Service wide approach for digitalisation, neonatal critical care transformation and improving postnatal care.

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	71.5%	**52.9%**
Completeness of the GP learning disability register	2018/19	Nat Av 50.0%	52.9%

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

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

People aged 14 years and above with a learning disability are entitled to receive an annual health check by their GP. Improving the uptake of those entitled to receive an AHC continues to be a priority area within the wider work programme surrounding Learning Disabilities. As part of the North Yorkshire Learning Disability Strategy – Live Well, Live Longer - the CCG works closely with colleagues from North Yorkshire County Council, community provider services, the voluntary sector and self-advocate groups,

to communicate the importance and value of people with a learning disability receiving an annual health check, and identifies good practice from neighbouring CCGs, other Local Authorities and third sector organisations. The CCG monitors quarterly data closely in order to encourage and lend support to GP Practices with the largest Learning Disability Registers to continuously improve the uptake of annual health checks within the local learning disability community. Please note that the 2019/20 position to date is only 6 month data (i.e. April 2019 – Sept 2019). Additionally, there are plans to have a section devoted to Learning Disabilities, with gold standard tools and easy-read support materials, on the newly developed North Yorkshire CCG website in 2020.

6.4 Sustainable Development

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

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

The CCG has a Sustainability Development Management Plan (2019/2020) approved by its Governing Body. Andy Hudson, Lay Member for Patient and Public Engagement is appointed a Governing Body Sustainability Lead.

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

Emissions	What are we doing?
Pharmaceuticals	• We have successfully campaigned to reduce pharmaceutical waste:
Energy	• We use smarter ways of working, making efficient use of our office space by hot desking, reducing the need for travel. • We have an office recycling programme in place to minimise the amount of waste we generate. • As part of an effort to minimise use of paper, we are moving towards Governing Body and senior management team members accessing documents on tablet computers where appropriate. This reduces the time and resources involved in production of meeting papers. • The buildings are well-used, and do not use heat or power unnecessarily.

Emissions	What are we doing?
	• Staff actively turn off lighting and heating when spaces are not in use. • Staff are regularly reminded to power off PCs and other electrical equipment at the end of the working day, or when not in use. The CCG has communicated to all staff the importance of conserving energy for example in reducing the volume of printing and photocopying which in turn saves on costs.
Travel and Transport	• Staff are encouraged to work from home and hot desk where appropriate. • Teleconferencing facilities are available in the CCG office and most staff have access to Skype reducing the need to travel to attend meetings. • Staff are encouraged to car share when attending meetings. • The CCG has a travel and expenses policy. The use of passenger rate encourages car sharing and there is also a mileage rate for pedal and motor cycle use. • The CCG offices have facilities available to encourage active travel such as cycle parking, showers that are accessible to staff and visitors alike. • The CCG encourages visitors to the headquarters and staff travelling for work to use public transport, providing information on access by trains and park and ride services.
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 Scarborough and Ryedale area, and within the wider North of England region.

We recognise the impact of our purchasing and procurement decisions on the regional economy, and the positive contribution it can make to economic and social regeneration of the Scarborough and Ryedale 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.

Staff at the CCG, in practices and pharmacies have been trained in Making Every Contact Count to keep patients healthy, informed, in control, and independent. The CCG also promotes the importance of a balanced nutritional diet and the benefits to their own health.

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 Hambleton, Richmondshire and Whitby CCG (HRW 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 quality of General Practice primary care services has continued to be a key priority for the CCG and is overseen by the Primary Care Commissioning Committee (PCCC), which in 2019/20 was chaired by a lay member of the CCG's Governing Body. The CCG has developed a range of methods to build a two-way dialogue with its twelve member practices. From July 2019, all practices have been part of a Primary Care Network, and have worked closely with the Primary Care team within the CCG to ensure information flows to and from the respective organisations. In 2019, the CCG embarked on a programme of 'quality assurance visits' with practices, with eight practices having received visits from the CCG as of February 2020, with dates arranged for the remaining four by mid April 2020. The feedback from these visits was fed into the CCGs quality improvement planning work. Outcomes from the visits included raising awareness within practices of a number of service areas, identifying areas communication could be improved, building on and improving strong working relationships between commissioner and provider and the production of a service improvement and development plan, where appropriate.

Since 2016, the CCG has supported the improvement of quality in Primary Care through the provision of organised Protected Time for Learning (PTL) training and

education events for all staff in general practice. These are facilitated three times a year by the CCG, and once a year by practices at their own in-house events. The CCG consults with a general practice-led steering group to identify the topics and training needs, and arranges the speakers to deliver on these requirements. The CCG also arranges and funds the out of hours phone cover to enable practices to close on PTL afternoons. Delegates are invited to provide feedback on each event, and all events are evaluated by the CCG to ensure a continuous cycle of improvement, and to inform future sessions.

6.5.2 Care Quality Commission (CQC) Inspection of GP Practices

Eleven of our twelve practices have been inspected by the Care Quality Commission (CQC) between 2016 and 2019, and all have received a 'Good' rating. The remaining practice was inspected in February 2020, and at the time of writing the rating has not yet been published. Patient satisfaction scores in respect to 'overall experience' of their GP service as being 'Good' are an overall 87% 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 York Teaching Hospital NHS FT and North Yorkshire County Council to change processes to avoid unnecessary delays in discharging older or frail people from hospital. Our principle is 'home first' and how we can support people to remain at home and avoid any decisions being made in hospital regarding long term care. This has been achieved

through implementation of ‘Discharge to Assess’ pathway whereby patients may be transferred from an acute hospital bed to another facility or home to allow time for recovery/ recuperation before their Continuing healthcare assessment is made. We have worked closely with the independent sector and enhanced community bed capacity to support this process.

6.5.5 Continuing Healthcare (CHC)

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

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

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

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

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

6.5.6 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 rising prevalence of Diabetes remains a challenge nationally. The CCG led a piece of work in conjunction with Vale of York CCG, York Teaching Hospital NHS Trust and Harrogate NHS Foundation Trust for Diabetes Transformation Fund monies. Humber Coast and Vale STP currently leads a piece of work accessing monies to support Diabetes Services, both the provision of prevention, and treatment.

6.5.8 Sustaining Stroke Services and Improving Outcomes for Patients

Due to staffing shortages, we have worked with the teams at York Hospital, Hull University Teaching Hospitals and James Cook University Hospital to change the pathway for patients in the Scarborough area who are suspected of having a stroke. The pathway goes live in 20-21 and means that patients who suffer a stroke in the Scarborough and Bridlington area will now receive hyper acute stroke care (typically up to the first 72 hours of care) at York Hospital, Hull Royal Infirmary or James Cook University Hospital rather than receiving initial assessment and care (scan and thrombolysis where appropriate) at Scarborough Hospital.

6.5.9 Early Cancer Diagnosis

Rapid Diagnostic Pathways

In response to national guidance, a Rapid Diagnostic Centre has been developed at York Trust (covering a Primary Care Network in Vale of York CCG and a Primary Care Network in Scarborough and Ryedale CCG) for patients with ‘serious, non-specific symptoms’. The pathway went live in January 2020 and early data suggests an average time from referral to diagnosis of 7 to 10 days. This pathway also supports the efficient use of resources in addition to reducing patient anxiety. Plans are in place to include Upper Gastrointestinal referrals as part of the 5 year plan.

Imaging

Throughout the year, work has continued with the radiology team at York Trust to complete the technical roll out of the radiology workflow solution. This system will enable shared reporting capabilities across HCV, supporting more rapid turnaround of radiology reporting and access to specialist and second opinions. The majority of work has been completed and the system will go live in early 2020/21. The workstations have been tested and approved by the radiologists and IT teams. The team at York have also

benefitted from c£50k investment from Humber Coast and Vale Cancer Alliance to support investment in additional training in areas including: ultrasonography, nuclear medicine, MR, CT and fluoroscopy – which will help to build diagnostic capabilities for the future.

Pathology

The York/ Hull Pathology partnership has carried out significant pieces of work towards developing a future service model for the region. Funding from the Cancer Alliance has enabled work to commence on the digitalisation of services which should support more rapid diagnosis and easier access to specialist and second opinions.

Living With and Beyond Cancer (LWBC)

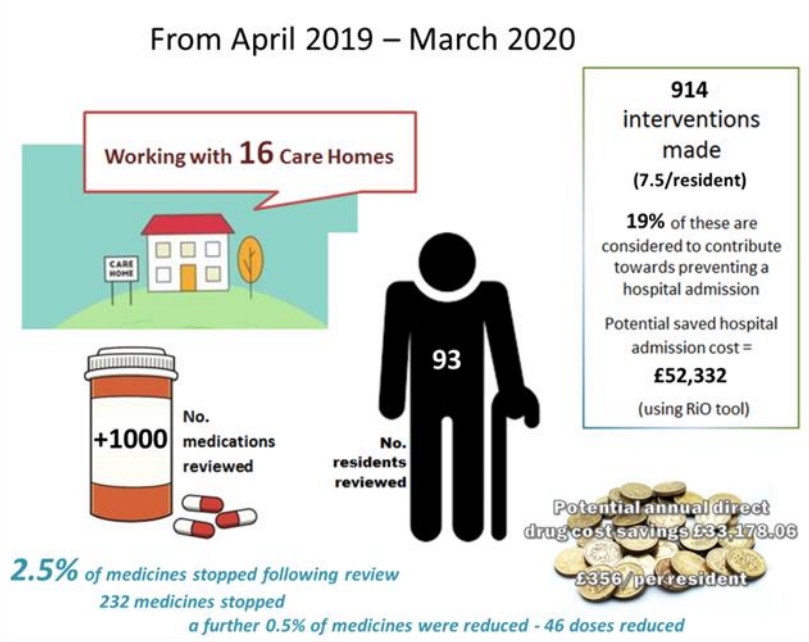
The CCG continues to engage with the Cancer Alliance, Macmillan and other partners around the implementation of personalised care core interventions (ie HNAs, treatment summaries, cancer care reviews and health and well-being) and to help support risk stratified follow up after diagnosis.

6.5.10 Community Based Living Well Coordinators

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 available through referral from GP practices, or self-referral.

6.5.11 Care Homes

There are over 1,300 care home beds within the Scarborough and Ryedale area. While we do not commission services from care homes we recognise the significant contribution our care home providers make



to the health and wellbeing of our local population and the importance of working together.

- The Medicines Management Team has undertaken work to review medications of residents within care homes. This activity has produced clear evidence of savings in prescribing costs, but most importantly has reduced risks (quantified as reductions in hospital admissions) and improved quality of life for patients. This is supplemented by ongoing advice and guidance in the social care setting to support the ongoing safe and effective use of medicines.
- We have been working closely with North Yorkshire County Council's (NYCC) Quality Improvement Team to determine ways in which we can help support and improve approaches to quality of care. Collaborative provider engagement events have been held between NYCC and representatives from care providers (both domiciliary and care homes). These have provided opportunities for clinical updates and support in terms of Care Quality Commission requirements and educational updates.
- The CCG continues to commission the Saint Catherine's Hospice based Care Homes Support Team that provides palliative and end of life care education and support to all care homes across the Scarborough and Ryedale area.

6.5.12 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 staff, with the right skills, are 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%

6.5.13 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.

6.5.14 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.

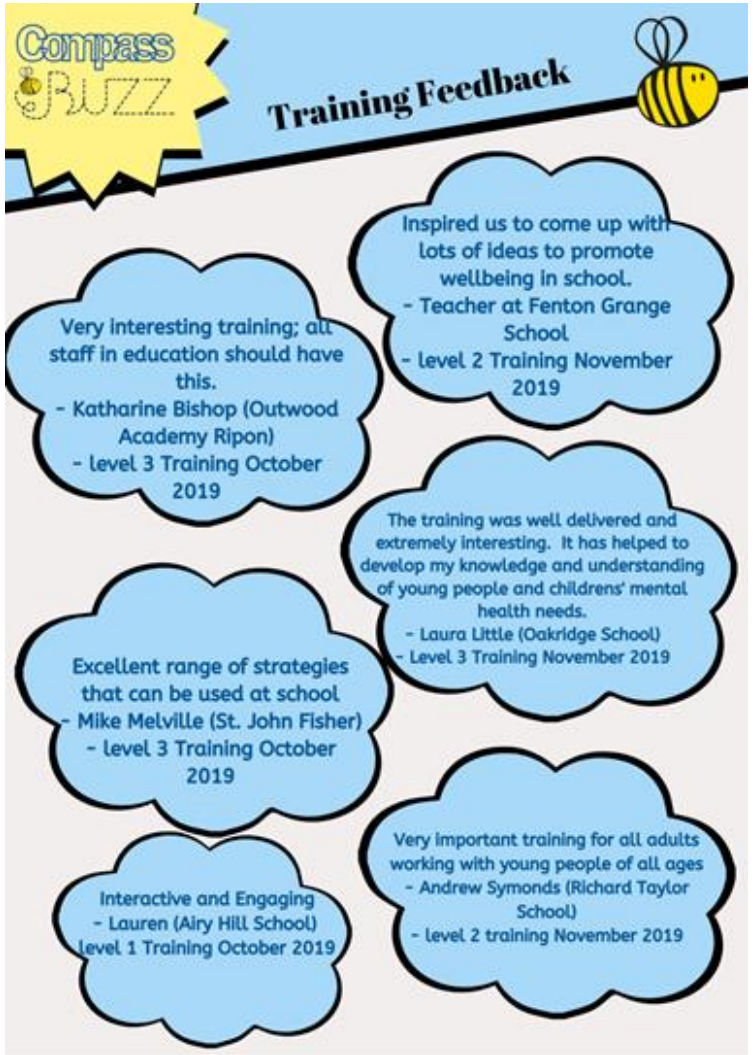
The proposal is to develop a scaled down enhanced community team model (8am-8pm, 7 days a week) and the learning from the community crisis intervention service would be a key element to facilitate discharges, reduce future admissions and to realise the funding required to create a sustainable county 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.

6.5.15 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 Scarborough and Ryedale locality there are a total of 103 schools and of these schools:

- 101 schools received or booked Level 1 training;
- 79 schools received or booked Level 2 training;
- 77 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.



6.5.16 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.

6.5.17 Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity

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

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

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

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

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

The review supports the CCG to assess itself against:

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

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

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

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

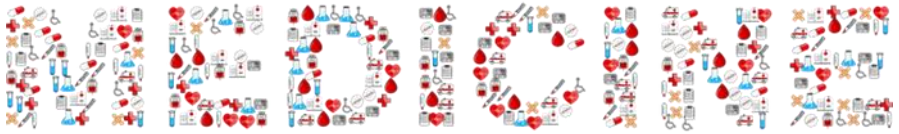
In terms of Business Continuity it was found that the Covid-19 pandemic created an unprecedented situation, with Major Incident Plans being of limited value due to having been created around very different scenarios involving major trauma. Pandemic Flu Plans were also of limited value to the highly contagious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

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

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

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

6.5.18 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 tracking the 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 Harrogate and Rural District showed a reduction in waste of 57% following implementation of on-line ordering and we would expect similar results in Scarborough and Ryedale care homes.
- Working with GP practices to focus on reducing the prescribing of opioid analgesics for management of chronic pain, with a particular emphasis on those patients prescribed high doses of such medication. The Medicines Management Team ran an educational session on this topic as part of a recent ‘protected time for learning’ event for GPs. 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.
- Joint project started between the local hospital trust, community pharmacies and the Yorkshire and Humber Academic Health Science Network in Scarborough and Ryedale to expand the effective use of Transfer of Care Around Medicines scheme. This programme improves patient safety and quality of care by providing targeted medicines support by community pharmacies following discharge from hospital.
- Antimicrobial prescribing: results continue to demonstrate decreasing use during this financial year. Although total antibiotic prescribing remains above the national rate, this is reducing month on month as our GPs work towards achieving the target set by NHSE. Prescribing of broad spectrum antibiotics remains below the national rate in Scarborough and Ryedale.
- 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 94% switch rate as compared to a national rate of 74%.
- Our local programme to reduce prescribing of items of low clinical value demonstrates reduced prescribing of these medicines in the CCG. We have achieved a ‘Green’ rating in the new indictor ‘Optimising prescribing: reducing the rate of low priority prescribing’ set by NHSE.
- A focus on increasing pharmacist led patient medication review at practice level and in care homes. 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. The CCG employs two pharmacists and one pharmacy technician whose role is to carry out

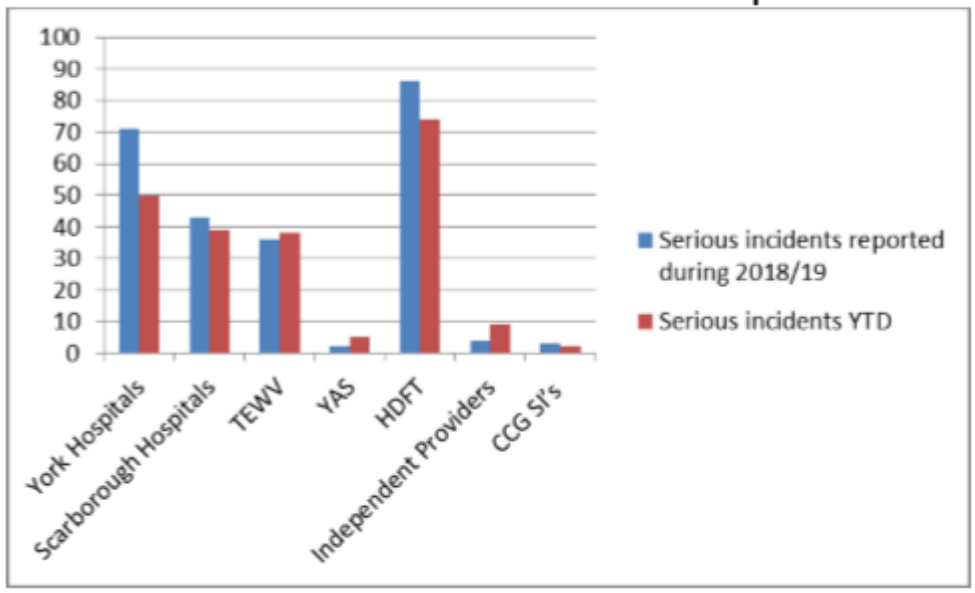
this work. Reviews undertaken by this team and the subsequent interventions have been assessed as preventing a total of 80 admissions to hospital so far this year (as graded by the RiO scoring scale). In addition, collaborative work between the Medicines Management Team and Humber NHS Foundation Trust colleagues has ensured that medication reviews for frail and vulnerable patients and those at risk of falls are prioritised.

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.

6.5.19 Serious Incidents

The CCG remains committed to commissioning services which provide safe care however we acknowledge that systems and processes can break down and lead to errors within the NHS. It is imperative that these are identified and managed appropriately with a robust systematic review. The governance process is supported by the North Yorkshire and York Serious Incident Team. The CCG receives all serious incident reports for review and closure and they attend the Serious Incident panel where all SIs are discussed and lessons learned are shared. The chart below identifies the number of SIs reported by provider in 2019/20 (red) against those reported in 2018/19 (blue):

NUMBER OF SIs REPORTED 2019/20 with 18/19 comparator



The total number of SIs reported for the Scarborough and Bridlington Hospital sites during 2019/20 is 39, and is a reduction on the 43 reported for 2018/19 and 52 for 2017/18, however this does not include any 12 hour trolley breaches where no harm came to the patient as a result of their extended stay. One Never Event was recorded in quarter 2 related to a medication administration error. A thorough investigation was undertaken and key learning was identified and implemented. There was no harm to the patient involved and they were involved in the incident investigation.

A subgroup of the Quality Improvement Board is working with the acute care provider to develop processes to improve the reporting, investigation and learning from SIs

and to support good practice going forward.

All providers of patient care continue to be monitored and the CCG has robust processes in place to manage Serious Incidents through the monthly Collaborative Serious Incident panel, which reviews each investigation report, assesses the robustness of the action plan and provides feedback to providers to request assurance that lessons are learned and disseminated, and actions implemented.

6.5.20 HCA Infections (HCAI)

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

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

In terms of C.diff infections, Scarborough and Ryedale CCG has an annual objective of 20 cases, which is set by NHS Improvement. The position at the end of January 2020 is that we have recorded 55 CCG attributable cases. This is a significant increase in CCG attributed cases in 2019/20 and is associated with a prolonged C.diff outbreak at the local Acute Provider and we have been involved with the provider outbreak control meetings, alongside NHS England/Improvement and Public Health England where an outbreak control plan has been established and is monitored closely. The acute provider has also exceeded its annual C.diff objective by 53 cases to the end of January 2020, which is also as a result of the prolonged hospital outbreak.

C. Diff	To end January 2020
Actual	55
Target	20

There is a zero tolerance level against MRSA and to the end of January 2020 there have been zero MRSA bacteraemia cases recorded against Scarborough and Ryedale CCG. This is an improved position from the 2 cases recorded in 2018/19.

MSSA BSI cases continue to be reported as per Public Health England requirements. At the end of January 2020 Scarborough and Ryedale CCG reported 38 cases. This is an improved position against the 2018/19 annual total of 47 cases.

From April 2017, a CCG objective for the reduction of Gram Negative Blood Stream Infection (GNBSI) has been in place. To date we have been required to monitor rates of Escherichia coli, (E.coli) but this is likely to be extended to other GNBSIs in the future.

Scarborough and Ryedale CCG have recorded 118 attributed cases of E. Coli BSI at the end of January 2020 which is a similar number of cases recorded in 2018/19 where a year end position of 145 cases was recorded. Data demonstrates that the majority of cases occur in primary care, which is reflective of the national picture.

E. Coli BSI	To end January 2020	2018/19
Actual	118	145

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

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

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

6.5.21 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 no breaches reported in 2019/20.

6.5.22 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 and Communities

The CCG embraces the importance of engaging people and communities in the commissioning cycle to support the communication and engagement responsibilities of the CCG.

6.6.1 Our Statutory Duties Explained

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have a statutory duty to involve the public in commissioning under "Section 14Z2". This includes:

- Ensuring the public is engaged in governance arrangements (e.g. through the appointment of Lay Members to the CCG Board).
- Ensuring services are commissioned in a way that encourages and promotes the participation of individuals in making decisions about their care and treatment.
- Listening and acting upon patient and carer feedback at all stages of the commissioning cycle.
- Engaging with patients, carers and the public when redesigning or reconfiguring healthcare services and demonstrating how this has informed decisions.
- Publishing evidence of what patient and public voice activity has been conducted, its impact and the difference it has made.
- Publishing feedback received from local Healthwatch about health and care services in the area served by the CCG.

As well as a commitment to supporting continuous improvement in public participation, NHS England has a legal duty (Section14Z16) to assess how well each CCG has discharged its public involvement duty. This is done retrospectively via "The Improvement and Assurance Framework 2018/19" as 2019/20 results are not available until July 2020. (Indicator 57: Compliance with statutory guidance on patient and public participation in commissioning health and care).

This assessment relates to these five domains, which are identified in NHSE publication: Patient and public participation in commissioning health and care.

Domain A

- *Involve the public in governance*
- *Implement assurance and improvement systems*
- *Hold providers to account for engaging patients*

Domain B

- *Demonstrate public involvement in Annual Reports*

Domain C

- *Explain public involvement in commissioning plans*
- *Promote and publicise public involvement*
- *Assess, plan and take action to involve*

Domain D

- *Feedback and Evaluate*

Domain E

- *Advance equality and reduce health inequality*

The assessments were undertaken by the national NHSE Public Participation team and the outcome highlighted to regional and local office colleagues. For the 2018/19 assessment, Scarborough and Ryedale CCG was awarded a "Green Star". This exercise was a great opportunity for us to reflect on how we engage now and how we can do it better – striving for the best – with a strong focus on improvement.

6.6.2 NHS Scarborough and Ryedale CCG Communications and Engagement Strategy 2016/19

The work to communicate and engage with our population is underpinned by the Communication and Engagement Strategy and the work plan uses a range of methods to inform, consult and engage with our patients and public. The Lay Member of the Governing Body who is responsible for Patient and Public engagement chaired the Communication and Engagement Committee. This committee met monthly for the first half of 2019/20 with representation from three Governing Body members and it reviewed the work of the Communications and Engagement team as well as planning future activity. Once the approval was received for the three North Yorkshire CCGs to be disestablished and the new North Yorkshire CCG created there was a hiatus in these Communications and Engagement Committee meetings while the committee structure was reviewed prior to the formation of the new organisation. It is anticipated that a new Strategy will be developed to underpin the work of the new organisation. Specialist support for Communications and Engagement has been provided by Scarborough Borough Council via a Service Level Agreement since June 2016.

The CCG utilises the Engagement Cycle to help develop and evaluate engagement with patients, public and our communities at both a strategic and operational level. It is a tried and tested, practical resource, used by dozens of Clinical Commissioning Groups (and others) to plan, design and deliver great services for, and with, local people. The model identifies five stages when patients and the public should be engaged in commissioning decisions and we use this model to help us plan engagement at the right stage in the process and improve our planning and delivery of services.

We have used the following methods to communicate with our stakeholders:

- NHS Scarborough and Ryedale CCG Website
- Public Annual General Meeting.
- Patient Representative Group Meetings
- Leaflets and posters
- Media releases

- Screens in GP practices
- Radio and TV interviews
- Social media
- A member of the Health and Wellbeing Board
- Commissioning Maze events
- Liaising with North Yorkshire Healthwatch
- Stakeholder e-bulletins
- North Yorkshire County Council Scrutiny of Health Committee
- Briefings to local councillors
- Working with Voluntary organisations that represent some of the hard to reach groups
- Our Governing Body meetings are held in public
- Our Primary Care Co-Commissioning Committees are held in public

We value patient, stakeholder and staff feedback and use the GP Patient Survey and staff survey results to look at where we can improve and how we can enhance the way we work with all our stakeholders.

6.6.3 Scarborough and Ryedale Patient Representative Group

NHS Scarborough and Ryedale CCG is committed to involving patients and the public in our commissioning decisions and the Scarborough and Ryedale Patient Representative Group enhances the engagement across the locality. Representatives from all GP Practices attend a quarterly meeting. The quarterly meetings are co-produced with its members and for specialist subjects CCG managers and other healthcare representatives are invited, as well as guest speakers from the voluntary sector.

The subjects for discussion included:

- Social prescribing
- The Role of Healthwatch
- Continuing Healthcare / Funded Nursing Care
- Dementia Forward and Alzheimer's Society
- Patient transport
- Primary Care Networks

- Interactive session on the Engagement Model for North Yorkshire CCG
- Patient and Carer Experience Forum Humber Teaching NHS Foundation Trust

What do our Patient Representatives say?

I would like to thank you and everybody involved with Scarborough and Ryedale CCG who have contributed to making it so successful in its aim of meeting the health needs of the Community.

Another interesting meeting, thank you very much, very helpful.

I enjoyed my first meeting.

We have felt involved in the consultative process by workshops, questionnaires and discussion sessions.

Any matters I raise and need further investigation have always been followed up and reported back to me.

Your team has listened to the members and has moved the meetings on so much.

This is a valuable engagement group, as it allows the CCG to share its ideas on service development, gain feedback from members and seek wider involvement prior to the launching campaigns.

We promote sharing of best practice across practice groups and we are keen to ensure all patients know how they can express their views.

6.6.4 The Loop

As an organisation that puts the needs of patients at the heart of everything it does, ensuring that people have the opportunity to have their say is something that we place great importance in.

The CCG has a virtual engagement network called 'The Loop' which anyone can sign-up to in order to get involved in how local health services are commissioned. We seek feedback and keep the members informed. The Loop is designed to allow members the opportunity to influence the development of local health services and work with the CCG to improve them.

We continue to promote the Loop and encourage people to sign up and we continue to slowly increase our membership. This year, The Loop has increased by 20 new members.

6.6.5 'You Said, We Did'

Attention Deficit Hyperactivity Disorder Attention (ADHD) for young people age 6 – 18 years

In order to provide the best possible care in future we will continue to develop the ADHD service with the involvement of patients and their families. We are in the process of recruiting additional positions in the team. Regular clinics in Whitby and Malton, as well as Scarborough are to be scheduled to support patients in these areas by seeing them closer to home. As well as planning parent and service user groups in order to collaborate with and gain feedback from patients and their families, parents/carers were invited to get involved in information sessions to help develop the ADHD service.

"improve access to ADHD services for young people in the Scarborough, Whitby and Ryedale area"

Self-care for Holiday Makers

The objective of this campaign was mainly targeted at holiday makers due to the fact admissions to the emergency department tend to increase over the summer period; and to make people who are visiting the area aware of the options available to them in regards to healthcare. These options included self-care, local pharmacies, Urgent Treatment Centres, NHS 111, NHS online, the local emergency department and 999. As well as informing people of the best medicines to keep a stock of while they are on holiday such as sunscreen, antihistamines, indigestion tablets, rehydration salts, anti-diarrhoea tablets as well as advice on how to best treat cuts, bruises bites and stings.

"We were on holiday, did not know the area or where the walk in centre is"

"I'm on holiday, went to see a Dr, they sent me to the Emergency Department"

Eastern European Communities

"How can you ensure that all members of the EU communities are aware of of the options available to them in regards to healthcare"

It is recognised that Scarborough has a sizeable population of Eastern European migrants (estimated at between 5,000 and 6,000). We have worked with Scarborough Borough Council and members of the EU communities to develop the "Stay Well" leaflet and this is now available in: Romanian, Russian,

Czech, Latvian, Lithuanian, Polish and Bulgarian. The leaflets are available in GP Practices and community centres.

As public servants, whether in a statutory or voluntary sector, it is our responsibility to ensure that we do everything within our power to ensure that all members of the community have access to and are able to benefit from the services that we provide.

The CCG has been working with Scarborough Borough Council (SBC) and other statutory and voluntary sector organisations to better improve access to and the coordination of services for our Eastern European Communities in Scarborough. (Organisations include North Yorkshire County Council (NYCC), Police, NHS SRCCG, Housing, voluntary sector). The project is designed to include advocacy, signposting to services providing advice and assistance for agencies, development of volunteers, the promotion of integration events community capacity building including community leadership, engagement and organisation.

6.6.6 Engagement Events

We have a duty to ensure the public are involved and consulted in the commissioning process including planning of commissioning arrangements and proposed changes to services which may impact on patients. During 2019/2020 the CCG held or supported a number of public engagement activities which included:

- Engaged with the local community to gather feedback on the children autism and attention deficit hyperactivity disorder (ADHA) assessment and diagnostic service.

- Commissioning Maze events with the youth forums.
- The CCG's Annual General Meeting was held on 24 July in Scarborough. 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 the next year.
- Had face-to-face conversation with patients presenting at Urgent Treatment Centre and Emergency Department Scarborough Hospital.
- Worked with the Eastern European communities, produced "Stay Well" leaflets in other languages and took part in an information event on the EU Settlement Scheme.
- Information sessions held with patients and families to help develop the ADHD service.

6.6.7 Stakeholders

The CCG has kept the North Yorkshire County Council Scrutiny of Health Committee informed of our plans and we consider carefully those changes to services which require a full plan of engagement. We utilise the information readily available and aim to make the engagement exercises as accessible and inclusive as possible.

The CCG has engaged with stakeholders and the wider public via briefings and face-to-face presentations as well as via regular stakeholder bulletins, press and social media. For example we circulated 14 news bulletins to stakeholders and provided briefings to local councillors and local MPs to update them on the current and future health landscape. In addition the CCG sent a health-related information leaflet in council tax bills to more than 59,000 households in the area.

During 2019/20 the CCG has proactively issued 30 press releases either individually or with partners on subjects including:

- Diabetes
- Skin Cancer
- Stay well this winter
- Frailty Service
- Right Care First Time
- Dementia Support
- Dying Matters
- Self Care

- New North Yorkshire CCG
- Behavioural Services
- Mental Health service for children and young people
- Autism assessment service
- Over the Counter medicines
- Healthy Hearts website
- Flu and Norovirus
- Mental Health nursing
- ICON programme – “Babies Cry, You can Cope’
- World Antibiotics Week
- Flu
- Community Equipment

In addition, local CCG clinicians contributed to television and radio interviews on topics including the new North Yorkshire CCG and the Healthy Hearts website.

The NHS Scarborough and Ryedale CCG website was redesigned during 2018/19 and was relaunched on 1 June 2019. The new website was designed in conjunction with CCG staff, clinicians and the public to ensure that it was accessible, user friendly and had an improved search facility. More than 104,000 visits were made to the CCG’s website in the 12 months until the end of March 2020. Unsurprisingly, the home page has proven to be the most popular, with information relating to the Referral Support Service and ‘who we are’ the two next most sought after sections. People are spending an average of one minute and 56 seconds on the website with, on average, 30 per cent of visits being made via mobile devices or tablets.

In line with our refreshed Communications and Engagement Strategy we have consolidated our presence on social media as follows:

In the 12 months up until the end of March 2020, we posted 1,753 tweets on Twitter, with our posts re-tweeted 621 times. From 1 April 2019, our posts have earned more than 490,600 impressions, 315 mentions, 790 likes, 17 comments and 178 new followers.

We reached 47,163 people on Facebook and gained 126 new followers. Our page gained 99 new

page likes, received 5,000 page views and earned over 20,000 engagements (likes, comments, shares etc.).

6.6.8 Equality and Diversity

The CCG believes in fairness and equity, and above all values diversity in all matters as a commissioner of health services, and as an employer.

The CCG is committed to eliminating unlawful discrimination and promoting equality of opportunity in the way we commission healthcare services and creating a workforce that is broadly representative of the population we serve. This commitment is supported by ensuring meaningful engagement and consultation with service users, carers, local communities, stakeholders and staff.

- Has in place an Equality and Diversity Plan and Equality Objectives
- Ensures Equality Impact Assessments are completed as part of business cases and changes to CCG policies and procedures.

Equality Objectives and Equality and Diversity Plan

The CCG has an Equality and Diversity Plan 2017 – 2021 which includes the following Equality Objectives:

- **Objective One** – The CCG will increase input from representatives of the protected groups in the commissioning process.
- **Objective Two** – During the development and redesign of services due regard will be made to ensure they are accessible to all service users.
- **Objective Three** – The CCG will continue to embed equality and diversity principles by developing and supporting all staff and Governing Body members to promote and champion all aspects of the CCG's work.

Equality Impact Assessments

The CCG continues to make sure equality is built into our project and business case processes so we recognise the issues faced by protected groups and are able to address these during the planning and commissioning cycle. Equality Impact Assessments (EIAs) continue to be completed as part of all business cases and changes to CCG policies and procedures. The CCG has also implemented systems for completing Quality Impact Assessments (QIAs) on decisions being made by the CCG.

The CCG has recognised that there is a risk to the organisation that whilst EIAs and QIAs assess individual projects for impacts on protected groups of people, the cumulative impact of decisions being made, particularly in relation to funding may have a disproportionate impact on a specific protected characteristic as defined by the Equality Act. This risk has been aligned to the

Business Committee and during 2019/20 it will be mitigated with a log of Equality Impact Assessments summarising where impacts are having the most effect on protected groups.

Understanding our Population

The CCG uses the North Yorkshire Joint Strategic Needs Assessment and other demographic data to make sure that we know our population and we also feature this information on our website

Work Supporting Equality and Diversity during 2019/20

The CCG ensured that Equality and Diversity is an integral part of our Communications and Engagement Strategy and the CCG's Communications and Engagement Committee is responsible for ensuring that the CCG meets its statutory obligations under the Equality Act and makes progress against its Equality objectives and plan.

During 2019/20 the CCG continued to include protected groups in our engagement activities in order to better understand our population needs. We were commended on our work with protected groups in our Customer Service Excellence assessment and continue to develop stronger relationships with those groups who represent specific patient and public groups. In particular we involve patients with learning disabilities, disabled people and those who are elderly in helping us to review services offered.

The Customer Service Excellence assessment highlighted the following areas of good practise:

- The CCG continue to use consultation and engagement with all customer groups to identify service needs and how customers would like services to be delivered.
- The CCG continues to develop excellent insight into the needs of its customers ensuring information is accurate, up-to-date and accessible.
- The CCG is wholly committed to delivering customer focused services and taking the views from patients and public into account within the commissioning process.

Examples of our work in these areas are:

- The Commissioning Maze Activity has been particularly effective as a tool to reach groups of young people, older people, young carers, mental health and LGBTQ voluntary groups and charities.
- Continue to keep the local community updated on local developments, via twitter, Facebook, radio campaigns and media releases.

Accessible Information Standard

In 2015/16 NHS England introduced an Information Standard for accessible information. An easy read version of the standard is available here: https://www.england.nhs.uk/ourwork/accessibleinfo/.

This standard has assisted the CCG's implementation of our equality objective relating to accessible information and ensuring the accessibility of information is incorporated into our Communication and Engagement Strategy. The strategy highlights the CCGs recognition of potential barriers to communication and engagement with service users and stakeholders and that it assesses the intended audience of all communication and engagement exercises to develop individual plans that make it easy for the public and patients to engage in an accessible and appropriate way.

The CCG will always endeavour to ensure that communications and engagement is appropriate, accessible and easy to read and we will provide translations and alternative formats for documents when requested.

The CCG also introduced Browsealoud onto the CCG's website which allows our users to access the website via:

- Text-to-speech
- Translation of web pages into 99 languages and speak translated text aloud in 40 languages
- On-screen text magnifier helps users with visual impairments
- MP3 generator which converts text to audio files for offline listening
- Screen mask which blocks on-screen clutter, letting readers focus on text being read
- Web page simplifier removes which ads and other distracting content for easier reading
- Allowing users to customise settings that are built in to suit individual user needs and preferences

For more information, visit the CCG's equality pages on our website.

Staff Policies

As an employer, the CCG actively works to remove any discriminatory practices in our work, to eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices. The CCG is committed to:

- recruiting, developing and retaining a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals.

- being a fair employer achieving equality of opportunity of outcomes in the workplace.
- using our influence and resources as an employer to make a difference to the life opportunities and health of our local community.

Policies and processes are in place to support this and include:

- Annual Leave Policy
- Bullying and Harassment Policy
- Disciplinary Policy
- Apprenticeship Policy
- Equality and Diversity Policy
- Flexible Working Policy
- Grievance Policy
- Remote Access and Home Working Policy
- Induction and Probationary Periods Policy
- Management of Attendance Policy
- Managing Performance at Work
- Maternity, Maternity Support (Paternity), Adoption and Parental Leave Policy
- Change Management Policy
- Pay Protection Policy
- Professional Registration Policy
- Recruitment and Selection Policy
- Retirement and Flexible Retirement
- Secondment Policy
- Other Leave Policy
- Substance Misuse Policy
- Redeployment Policy
- On Call Policy
- Learning and Development Policy
- Travel and Expenses Policy
- Working Time Regulations Policy
- Recruiting Ex-Offenders Policy
- Dress Code Policy
- Lone Working Policy
- Flexi Time Policy
- Recruitment and Retention Premia Policy
- Whistleblowing Policy
- Temporary Promotion Policy
- Starting Salaries Policy
- Re-location assistance Policy
- Statutory and Mandatory Training Policy
- Objective Setting and Review Policy
- Career Break Policy
- NHS Code of Conduct for Managers
- Job descriptions (including statements regarding equality and diversity expectations)
- Annual appraisals with staff

The CCG actively encourages people with disabilities to apply for positions in our organisation. Applicants applying for roles within the CCG who declare a disability will be eligible for a guaranteed interview, providing they meet the minimum criteria within the

person specification for the particular vacancy. The CCG supports staff by offering Occupational Health Support and reasonable adjustments that may be required within the role in which they are employed.

Equality and Diversity training is routinely offered, is part of the statutory and mandatory training programme and is also included in the induction process.

WRES Information

From 1 April 2015 all NHS organisations are required to demonstrate how they are addressing race equality issues in a range of staffing areas by completing a Workforce Race Equality Standards report.

The CCG collects and has published the indicators of workforce equality on the CCG website at: http://www.scarboroughryedaleccg.nhs.uk/our-approach-to-equality-and-diversity/publishing-information/

Further information regarding staff composition is available in section 11.

We recognise our role in asking providers to report on their performance against the WRES framework, as well as paying due regard to the standard in our own workforce practices. The CCG is assured by its major providers that they capture, record and analyse their workforce data and publish the results.

6.6.9 Parliamentary Affairs

NHS Scarborough and Ryedale CCG is committed to dealing with complaints about the services provided by the CCG and the services we commission. The CCG takes complaints seriously and ensures that complaints, concerns and issues raised by patients, relatives and carers are properly investigated in an unbiased, non-judgemental, transparent and timely and appropriate manner. In 2019/20, 56 complaints were received and responded to.

The CCG received and responded to 11 letters from local MPs between 1 April 2019 and 31 March 2020.

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

The total number of patients registered to practices within the CCG in December 2018 was approximately 120,400. The CCG has about 1,200 births and 1,400 deaths annually though the population continues to increase. The population of Scarborough and Ryedale is ageing with life expectancy being significantly lower than England for males and not significantly different for females. For 2011-2015, female life expectancy in the CCG is 82.8 years (England: 83.1), and male life expectancy is more than four years lower than for females at 78.4 years (England: 79.4). Life expectancy varies for men and women considerably across North Yorkshire. The life expectancy gap at birth in North Yorkshire (between the most affluent and most deprived) is 8.3 years for males

and 6.1 years for females. In Scarborough, this gap is 9.1 years for males and 5.6 years for females. In Ryedale, this gap is 4.5 years for males and 4.3 years for females.

The 2015 Index of Multiple Deprivation (IMD) identifies 15 Lower Super Output Areas (LSOAs) out of a total of 69 across the CCG which are amongst the 20% most deprived in England, and 8 out of these 15 LSOAs are amongst the 10% most deprived in England. These 8 LSOAs are all in the Woodlands, Eastfield, Castle and North Bay areas in Scarborough. A further 7 LSOAs, in Ramshill, Central, Woodlands, Falsgrave Park, Filey and Northstead wards (all in Scarborough District) are amongst the 15 LSOAs (20% most deprived in England).

These 15 LSOAs form about two-thirds (65%) of the 23 LSOAs in North Yorkshire which are amongst the 20% most deprived in England. SCR CCG has the highest concentration of deprived neighbourhoods in North Yorkshire, predominantly located in Scarborough town, but also in Eastfield and Filey. Almost 24,000 people live in these areas.

A substantial number of children grow up in relative poverty. In 2015, there were 19.8% of children aged 0-15 years living in low income families, compared with 19.9% in England. Children living in poverty is a significant issue for the CCG area with rates in Scarborough being significantly higher than the national average. The CCG has more than 3,800 children living in poverty (i.e. in “low income families” as defined by the Department for Work and Pensions) within its boundaries.

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

Many people have longstanding health problems. The census in 2011 showed 23,500 people living with long-term health problems or disability (21.3% compared to 17.6% in England). Almost one in four residents in Scarborough District are economically inactive, and approximately 6,000 individuals are classified as “long term sick”. This equates to 38.8% of the economically inactive population within the district and compares with 23.5% across the wider region. This demonstrates the generally poorer health experienced by many residents within the district and the impact this has on wider socio-economic outcomes and is reflected in higher rates of premature mortality (346 per 100,000 in 2012-14) than elsewhere in the County. By comparison, in Ryedale in the same period the rate was 308 per 100,000).

Scarborough and Ryedale are above the national and regional average for fuel poverty and in parts of Scarborough one in five households can be classified as fuel poor. Merely tackling poverty would not necessarily relieve the fuel poverty issue as often housing type and access to affordable sources of energy are important in this area. Tackling the fuel poverty issue should in turn improve winter health, improving excess winter mortality and the pressure on the health and care system over the winter months.

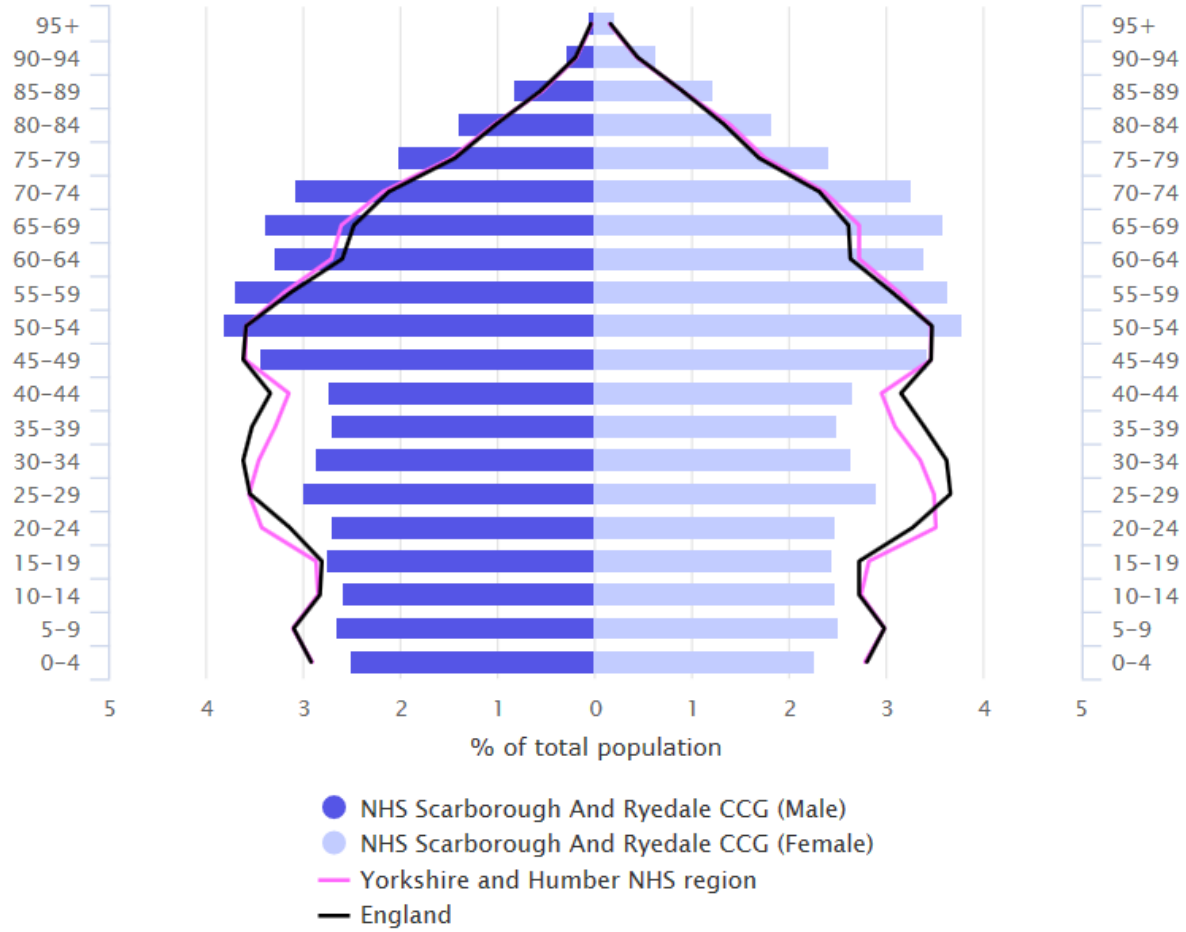
The economic importance of tourism and seasonal nature of some employment leads to transient elements of the population and a higher proportion of multi-occupancy homes in comparison with other parts of the County. Pressures on services arising from homelessness in Scarborough district are reflected in the rate of households in temporary accommodation, which is significantly worse than the regional or county rate.

6.7.1 Health profile

The health of people in Scarborough and Ryedale is varied compared with the England average.

Public Health England produces a summary health profile which compares more than 50 indicators with national data and highlights those which are significantly different from England. This is used to help inform focused improvement work in the CCG. In particular, the report highlighted the following as being significantly worse than England:

- Child Development at age 5
- GCSE Achievement (5A* to C including English and Maths)
- General Health - bad or very bad
- Limiting long term illness or disability
- Deliveries to teenage mothers
- Emergency and A&E admissions in under 5s
- Binge drinking adults
- Deaths from circulatory disease, circulatory disease coronary heart disease, stroke and respiratory diseases.



		NHS Scarborough and Ryedale CCG	England
Life expectancy is significantly lower for men and women	Men (2011-15)	78.4 Years	79.4 Years
	Women (2011-15)	82.8 Years	83.1 Years
There is a high proportion of older people (2017)		24.2% aged over 65 3.2% aged over 85	17.3% aged over 65 2.3% aged over 85
A substantial number of children grow up in relative poverty. Children aged 0-15 years living in low income families		19.8%	19.9%
There are areas of deprivation.		The 2015 Index of Multiple Deprivation (IMD) identifies 15 Lower Super Output Areas (LSOAs) out of a total of 69 across the CCG which are amongst the 20% most deprived in England, and 8 out of these 15 LSOAs are amongst the 10% most deprived in England.	
People living with long-term health problem or disability (2011).		21.3%	17.6%

6.7.2 Child Health

	NHS Scarborough and Ryedale CCG	England
Reception children classified as over weight (obese) %	22.1% (8.9%)	22.2% (9.3 %)
Year 6 children classified as over weight (obese) %	30.7% (16%)	33.6% (19.3%)
Estimated prevalence of any mental health disorder GP registered population aged between 5 – 16	9.6%	9.2%

6.7.3 Adult Health

The lifestyle choices that people make and behaviours they follow in their lifetime can all have an impact on both their current and future health. Lifestyle diseases are defined as diseases linked with the way people live their life. These are commonly caused by alcohol, drug and smoking abuse as well as lack of physical activity and unhealthy eating.

6.7.4 Lifestyle and Behaviours

Disease Prevalence

In the CCG, hypertension, obesity and depression are the most common health problems, followed by asthma and diabetes.

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 Cardiovascular Disease, and diabetes. From these results clinicians can offer lifestyle advice or pharmaceutical intervention to reduce this risk when required. NYCC has collated the figures for 2019/20 which demonstrates that the CCG practices managed to invite 22.5% (n= 7284) of the eligible population for the NHS Health Check programme this is marginally better than North Yorkshire average (20.5% n=33094). Of those offered an NHS Health Check 51.5% of patients received the Health Check, this is slightly higher than North Yorkshire (50.4%) which meets the North Yorkshire Target of 50%, however it is below the nationally aspirational target of 75%.

22.2% (n=832) of those who received an NHS Health Check across Scarborough and Ryedale were identified as having a 10% or more CVD risk score. This suggests 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.

Smoking

NHS Scarborough and Ryedale CCG has the highest estimated rate of smoking in 2019/20 in North Yorkshire and the rate is higher than the England average.

Smoking cessation is commissioned by North Yorkshire County Council (NYCC) and the CCG works alongside Primary Care encouraging patients to be referred into the specialist service intervention.

Adult Obesity

There is a higher rate of adult obesity in the CCG compared with England, with 12,901 adults having a recorded body mass index above 30 kg/m2. Ten practices have rates which are significantly higher than England, and one practice which is significantly lower. Tackling obesity remains on the national agenda and a priority for the CCG.

Obesity remains a significant risk for Cardiovascular Disease and Diabetes and recent evidence suggests obesity is now the second biggest risk for cancer after smoking. North Yorkshire County Council currently commission Humber Teaching NHS Foundation Trust to provide Tier 2 weight management for our population. This service has been successful in both achieved weight loss and the number of referrals that the service has received to help people tackle weight loss.

Hypertension

In NHS Scarborough and Ryedale CCG, there are 20,789 people with a known hypertension prevalence rate; this is higher than the England average. Ten general practices have rates significantly higher than England whilst one practice has a significantly lower prevalence rate to England. The CCG is supporting hypertension screening with the NHS Health Check programme and the CCG has also taken extra steps to add reminders onto clinical systems.

Depression

There are more than 10,700 adults with a record of depression in the CCG. This rate of incidence is higher than the average for England. Three practices have rates which are significantly higher than England, while three practices have significantly lower rates.

Section 2.11 highlights work the CCG has undertaken during 2019/20 for mental health services.

Coronary heart disease

Coronary heart disease (CHD) prevalence is higher in the CCG compared with England with 5,743 people with diagnosed CHD. Eight of the 12 general practices have prevalence rates significantly higher than England. Three practices have significantly lower prevalence rates than England.

The CCG possesses a cardiovascular disease strategy which informs and prioritises the cardiovascular disease work streams for the organisation. Increasing AF prevalence and ensuring effective management remains a priority for the CCG. Tackling mortality for hypercholesterolaemia is high on the agenda; current work involves looking at potential statin switches to higher doses and more effective brands to further reduce cholesterol for those at risk of a cardiovascular event. The CCG continues to commission a familial hypercholesterolaemia service which will identify those with the condition and perform genetic testing to enable tracing and screening of relatives who may potentially be affected and enable early treatment where indicated.

Diabetes

The rising prevalence of Diabetes remains a challenge nationally. The CCG led a piece of work in conjunction with Vale of York CCG, York Teaching Hospital NHS Trust and Harrogate NHS Foundation Trust for Diabetes Transformation Fund monies. Humber Coast and Vale STP currently leads a piece of work accessing monies to support Diabetes Services, both the provision of prevention, and treatment. Access and attendance to Structured Education for Type 1 and Type 2 patients remains poor for our population, however there has been a small increase in attendance.

6.7.5 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.

6.7.6 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.

6.7.7 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 Scarborough and Ryedale 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 Scarborough and Ryedale 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 2.11.1) 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 2.11.1), 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 York Teaching Hospital NHS Foundation Trust, North Yorkshire County Council, Mental Health, Tees, Esk and Wear Valleys NHS Foundation Trust, Continuing Healthcare and voluntary sector partners. There are a number of voluntary sector schemes supporting patients with an agreed care plan when discharged from hospital to keep them safe at home. The package of support includes escorts with shopping, preparing meals and completing daily tasks such as washing.

NHS Scarborough and Ryedale Clinical Commissioning Group

Accountability Report - Corporate Governance

7 Members Report

7.1 The Governing Body

Governing Body Members	
	**Dr Phil Garnett** **Clinical Chair (Voting) – April 2013 to January 2020** (see page 5) Phil worked for 5 years in secondary care with a focus on paediatrics attaining DCH and MRCP. He spent 39 years as a GP and took the lead in fund holding. He had previously been PCG chair, PCT PEC chair, PbC chair, GP trainer for 29 years and Hospice Trustee and Board member for 32 years and held an MSc in Quality Improvement, Innovation and Leadership.
	**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 Amanda enjoys yoga and running and spending time walking in the Yorkshire countryside with her family and two dogs.
	**Dr Peter Billingsley** **Associate Chair (Voting) and Lead for Mental Health – April 2017 to March 2020** Peter has lived in Scarborough for over 20 years. It is his hometown and he is a stakeholder in its future. He has an in depth knowledge of local care provision, where it excels and where it falls short.

Dr Greg Black

GP Member (Voting) and Lead for prescribing, Cardiovascular Disease and ENT – April 2013 to March 2020

Greg has been working as a GP in Practice in Ryedale for 18 years. He moved to Yorkshire in 1995 and completed GP training in Scarborough and York. He spent two years working as a locum in North Yorkshire before taking a partnership in practice.

Dr Omnia Hefni

GP Member (Voting) and Lead for Secondary Care – April 2013 to March 2020

Omnia started her career in General Practice in Lincoln in 2004 where she trained as a GP registrar. She has had involvement within the management aspect of Primary Care as well as involvement in undergraduate teaching for medical students. Omnia has a special interest in diabetes, family planning and sexual health.

Dr Christopher Ives

GP Member (Voting) and Lead for Paediatrics, Respiratory Medicine, Diabetes, Maternity – April 2017 to March 2020

Chris graduated from Hull York Medical School (HYMS) and has remained mainly in the area working in various specialties. He has spent time as a tutor at HYMS before then becoming a local Ryedale GP. He has gained a good range of experience of how the local health system works and how best we can provide care for patients who live in the area. He has interests in many aspects of medicine including both respiratory medicine and palliative care.

Carolyn Liddle

Primary Care Manager (Voting) – April 2013 to March 2020

Carolyn had experience in various aspects of business particularly in Accountancy and IM&T before joining the Health Service. She has been a Practice Manager for 21 years covering all aspects of management within a healthcare setting. Prior to joining the CCG as a Governing Body member Carolyn was a member of the local Practice Based Commissioning Committee for several years. She gained a 1st class Business and Management Degree in 2003.

Dr Ian Woods

Secondary Care Doctor (Voting) – April 2016 to March 2020

Ian qualified in Medicine in 1979, and after specialist training became a Consultant Anaesthetist in 1988. His special interests included Intensive Care and also Patient Safety, he became the Specialty Advisor at the National Patient Safety Agency. During the latter part of his clinical career he was Medical Director of a Foundation Trust for 4 years, and now at the CCG sits on the Audit Committee in addition to the Governing Body. Ian lives with his family in North Yorkshire, and enjoys walking and photography.

Dr Jenni Lawrence

Associate GP (Non-Voting) – April 2017 to March 2020

Jenni has been working in Scarborough since 2002. She works as both an in hours and out of hours GP as well as working for Saint Catherine's hospice. She has worked at SRCCG since April 2015 as the Macmillan GP Lead and is involved in projects to do with cancer care across the Yorkshire and Humber area. Since April 2015 she has also expanded her portfolio into Learning Disability and End of Life Care.

Governing Body Lay Members

Andy Hudson

Lay Member (Voting) Patient and Public Engagement – April 2013 to March 2020

An Environmental Health Officer by profession, Andy was previously Assistant Director for Neighbourhoods and Community Safety at the City of York Council. Holding a Law degree and an MBA, he is passionate about protecting citizens' rights. Formerly Chief Executive of the Scarborough Citizens Advice Bureau, he is now Chair of the Board of Trustees.

Philip Hewitson

Lay Member (Voting) Chair of Audit and Governance Committee – April 2013 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.

Ken Readshaw

Lay Member (Voting) Vice Chair of Primary Care Co-Commissioning Committee – October 2016 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.

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.

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.

	Iain Dobinson **Interim Chief Finance Officer – January 2018 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 Scarborough and Ryedale 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.
	**Carrie Wollerton** **Executive Nurse (Voting) – April 2013 to August 2019** Carrie is a registered nurse with a community nursing qualification and an MSc in Health Services Research. She started her career as a District Nurse, and has worked for several years as a health service commissioner, and more recently for the Parliamentary and Health Service Ombudsman. She has particular interests in safeguarding, and in the development of community services.
	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.

7.2 Council of Clinical Representatives

Chaired by the Clinical Chair of the Governing Body, the Council of Clinical Representatives is made up of the Lead Commissioning GPs from each of the 12 GP Practices who each send a GP or Practice Manager representative. 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. The Senior Management Team (SMT) also provides the Council of Clinical Representatives 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 Clinical Representatives throughout 2019/20 and up to the signing of the Annual Report and Accounts is as follows:

- Ampleforth Surgery
- Brook Square Surgery
- Castle Healthcare
- Central Healthcare
- Derwent Surgery
- Eastfield Medical Centre
- Filey Surgery
- Hackness Road Surgery
- Hunmanby Surgery

- Scarborough Medical Group
- Sherburn and Rillington Practice
- West Ayton and Snainton 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 at: https://www.scarboroughryedaleccg.nhs.uk/who-we-are/publications/

8.2 Personal Data Related Incidents

I can confirm that NHS Scarborough and Ryedale 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 Scarborough and Ryedale CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2020 is published on our website at https://www.scarboroughryedaleccg.nhs.uk/who-we-are/publications/

8.5 Statement of the Accountable Officer's Responsibilities

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

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

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

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and

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

Disclosures:

- No Disclosures issued

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.
- that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Amanda Bloor

Accountable Officer

23 June 2020

9 Annual Governance Statement 2019/20 by the Chief Officer as the Accountable Officer of the NHS Scarborough and Ryedale Clinical Commissioning Group (03M)

9.1 Introduction and context

NHS Scarborough and Ryedale 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 12 member practices across Scarborough and Ryedale (at 1 April 2019). The Council of Members is comprised of one GP representative from each member practice.

The Constitution includes:

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

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

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

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

9.3.2 Governing Body and Committee Structure

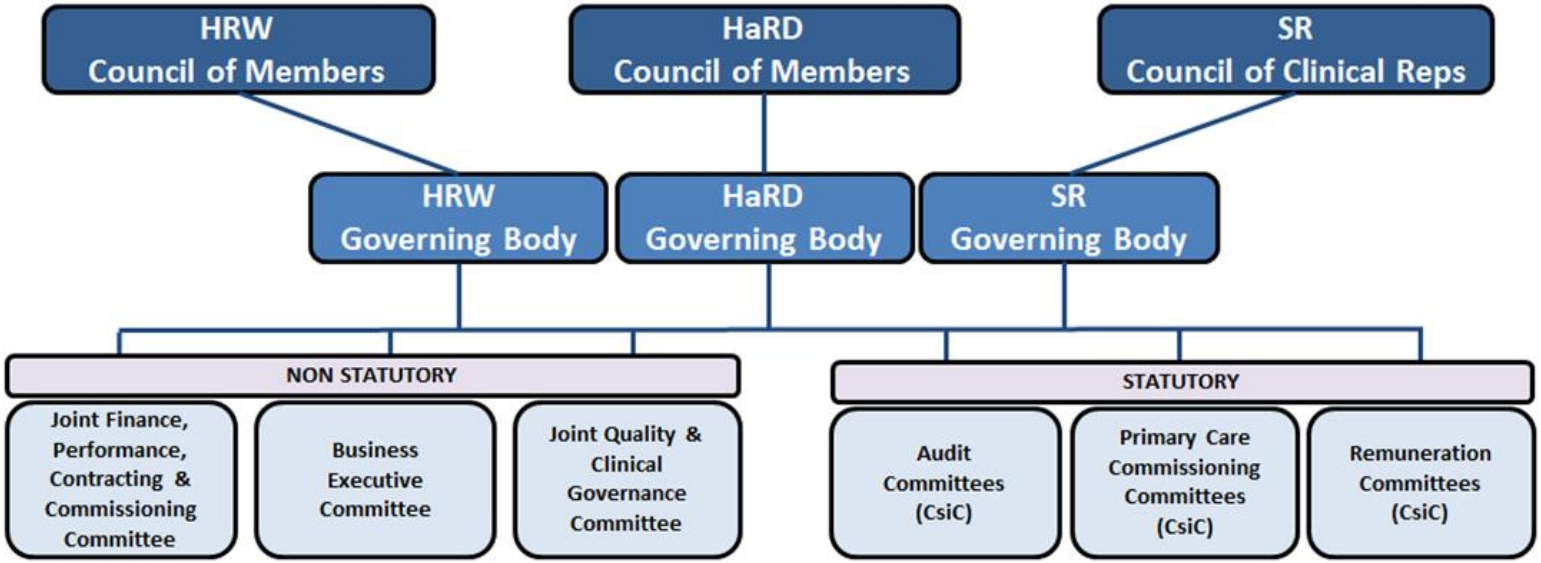
The Governing Body is responsible for the functions conferred on it through the constitution. In summary these are:

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

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

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

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



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

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

Committee / Meeting	Role
	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.
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 SR 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 / Meeting	Role
	Committee focuses on quality, efficiency, sustainability, productivity and new models of primary care.
STP for Humber, Coast and Vale	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 Clinical Representatives 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 Representatives has met regularly throughout 2019/20 and had a rotating Chair from its Membership. 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 Representatives 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 Representatives 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, the Governing Body received a number of questions from members of the public.

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

Governing Body Workshop	Governing Body Workshop Topic

April 2019	• North Yorkshire CCGs – Joint Governance Arrangements
	  ○ Capsticks LLP provided a presentation around the legal implications on the journey to merger
	  ○ Discussed and supported the decision to make a recommendation to the CCG Council of Members/Representatives to approve a merger request in June 2019 to NHSE for the 3 CCGs to be operational as one NY CCG from April 2020.
	  ○ Made a commitment that the Governing Bodies will work together to help determine the transitional arrangements and to support the development of the operating and governance model during 2019/20.

June 2019	• North Yorkshire CCGs – Joint Governance Arrangements
	  ○ Discussed and approved the NY CCGs Interim Governance Structure and destabilised previous ways of working as single CCGs (with the exception of statutory committees and the Governing Body who were determined to meet as Committees in Common where possible).
	  ○ Discussed and supported the decision to make a recommendation to the CCG Council of Members/Representatives to approve a merger request in June 2019 to NHSE for the 3 CCGs to be operational as one NY CCG.
	• Financial Recovery Plan

September 2019	• North Yorkshire CCGs – Joint Governance Arrangements
October 2019	• North Yorkshire CCG – Joint Governance Arrangements • Finance Update – Spending Approach

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

9.3.5 UK Corporate Governance Code

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

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

Leadership

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

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

Accountability

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

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

The CCG has a Conflict of Interest Policy and Standards of Business Conduct Policy which have been approved by the Governing Body. The Audit Chair held the position of Conflicts of Interest Guardian throughout 2019/20 and has been supported by the Corporate Team in the day to day management of managing conflicts of interest throughout 2019/20.

In February 2020, Internal Audit completed an audit of how the CCG manages conflicts of interest and provided an opinion of high assurance.

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

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

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

9.3.6 Discharge of Statutory Functions

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

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

9.4 Risk Management Arrangements and Effectiveness

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

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

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

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

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

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

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

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

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

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

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

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

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

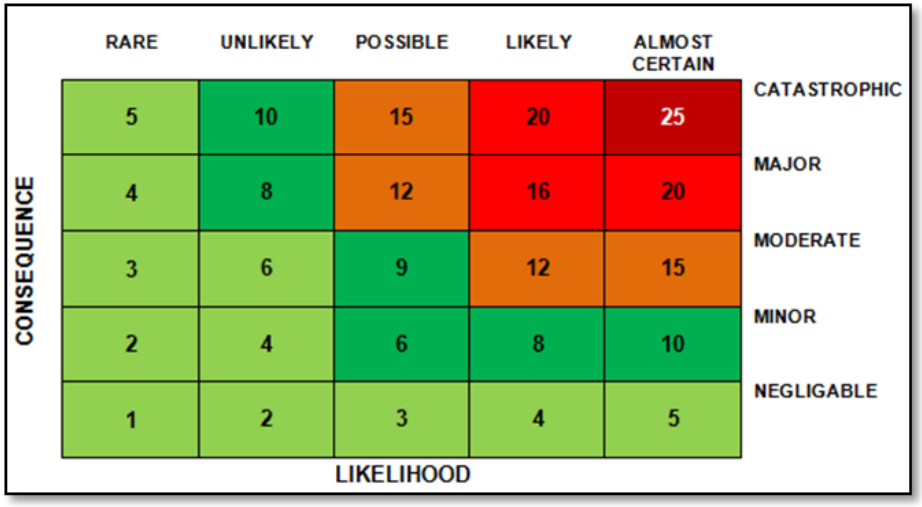
All committee and Governing Body papers carry a specific section within the executive summary page to identify high level risks arising from the area under discussion.

The Governing Body has 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 Scarborough and Ryedale 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:

- Unable to Commission sustainable, high-quality services within the available resources
- Unable to create a stronger community system and integrate care across the whole health
- Unable to improve health and reduce health inequalities

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

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

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

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

Covid-19 Risks

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

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

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

9.5 Other Sources of Assurance

9.5.1 Internal Control Framework

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

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

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

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

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

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

9.5.2 Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016 and revised in June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

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

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

Internal Audit offered an opinion of High Assurance that the CCG has in place arrangements to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on managing conflicts of interest for CCGs. The internal audit opinion of significant assurance was replicated across the three North Yorkshire CCGs.

9.5.3 Data Quality

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

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

9.5.4 Information Governance

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

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

There are processes in place for incident reporting and investigation of serious incidents, involving breaches of confidentiality and Data Protection Legislation.

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

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG's Chief Finance Officer is the Senior Information Risk Owner (SIRO) and the

Chief Nurse is the Caldicott Guardian. The CCG has an Information Governance Steering Group that reports to the Audit Committee and addresses information governance matters for the CCG.

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

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

9.5.5 Business Critical Models

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

9.5.6 Third Party Assurances

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

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

The CCG receives payroll services from Victoria Pay Services. Service auditor reports are also received on an annual basis and gives assurance on this business arrangement.

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

9.6 Control Issues

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

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

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

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

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

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

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

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

9.7.1 Delegation of Functions

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

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

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

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

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

9.7.2 Counter Fraud Arrangements

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

The standards are as follows:

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

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

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

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

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

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

9.8 Head of Internal Audit Opinion

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

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS SCARBOROUGH AND RYEDALE 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.

SR 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 SR 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 SR CCG is compliant with the NHSE Oversight Framework 2019/20 CCG Metrics Technical Annex.

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

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

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

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

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

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

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

Audit Area	Assurance Level
Combined Governance Assurance	On hold – Covid 19
Business Continuity Planning	Significant
Equality & Diversity	Limited
Quality Strategy & Assurance Processes	Deferred to 2020/21 – due to change in priorities with the merger of NY CCG.
Primary Care Commissioning	Substantial
Contract Management	Significant
Handling Complaints	High
Continuing Healthcare	Significant
Hosted Services	Limited
Personal Healthcare Budgets	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, two policies 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 Safeguarding Service. Without this MOU in place we were unable to fully assess the accuracy of the financial recording and provision of financial summaries to partner CCG's. Our understanding is that the MOU is currently being revised and this process should be completed once the three North Yorkshire CCGs have merged (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 three audit reports were awarded a limited assurance opinion, one related to Data Cleansing within the Continuing Heathcare System, one related to numerous risks present within the Continuing Heathcare System as a whole, whilst the third related to joint commissioning.

Risks relating to the two Continuing Healthcare limited assurance audits were described in the previous year's Head of Audit Opinion 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

The Joint Commissioning audit report identified risks around the governance arrangements in place for the new Aligned Incentive Contract for acute system transformation between SR CCG, Vale of York CCG, East Riding of Yorkshire CCG and York Teaching Hospital Foundation Trust. These related to a lack of any Memorandum of Understanding (MOU) and a lack of any performance indicators together with no risks being identified within risk registers.

Follow up work has confirmed that risks are now considered within operational and corporate risk registers but that work on the MOU has been slow due to the additional pressures of merging the 3 North Yorkshire CCG's into one new CCG. The risk therefore remains outstanding and will continue to be followed up as part of the action tracking report that goes to the Audit Committee.

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 as usual practice

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 Scarborough and Ryedale 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

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

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

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

10.2.2 Senior Managers Service Contracts (not subject to audit)

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

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

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

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

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

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

Salaries and Allowances 2019/20								
Name and title	**Start Date (if applicable)**	**End Date (if applicable)**	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £**	**c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension-related benefits (bands of £2,500) £000**	**TOTAL (a to e) (bands of £5,000) £000**
A Bloor Accountable Officer (see note 1)			40 - 45	0	0	0	35 – 37.5	**75 - 80**
W Balmain Director of Strategy and Integration (see note 2)	01/05/19		30 - 35	0	0	0	5 – 7.5	**35 - 40**
SN Cox Director of Acute Commissioning (see note 3)			30 - 35	0	0	0	10 - 12.5	**40 - 45**
S Peckitt Chief Nurse (see note 4)	28/06/19		15 - 20	0	0	0	35 - 37.5	**55 - 60**
J Warren Director of Corporate Services (see note 5)	15/07/19		20 - 25	0	0	0	0	**20 - 25**
J Hawkard Chief Finance Officer (see note 6)	01/11/19		15 - 20	0	0	0	20 – 22.5	**35 - 40**
CA Wollerton Executive Nurse (see note 7)		07/08/19	30 - 35	0	0	0	0	**30 - 35**
The following members have opted out of the NHS pension scheme and therefore pensions disclosure is not required:								
Dr P Billingsley GP Governing Body member			75 - 80	0	0	0	0	**75 - 80**
Dr G Black GP Governing Body Member			40 - 45	0	0	0	0	**40 - 45**

Salaries and Allowances 2019/20								
Name and title	**Start Date (if applicable)**	**End Date (if applicable)**	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £**	**c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension-related benefits (bands of £2,500) £000**	**TOTAL (a to e) (bands of £5,000) £000**
J Lawrence Governing Body Member			40 - 45	0	0	0	0	**40 - 45**
Dr C Ives GP Governing Body Member			40 - 45	0	0	0	0	**40 - 45**
I Dobinson Interim Chief Finance Officer (see note 8)		31/10/19	30 - 35	0	0	0	0	**30 - 35**
Dr JFP Garnett Chair		29/01/20	55 - 60	0	0	0	0	**55 - 60**
Dr O Hefni GP Governing Body member			40 - 45	0	0	0	0	**40 - 45**
A Hudson Lay member			15 - 20	0	0	0	0	**15 - 20**
PC Hewitson Lay member, Chair of Audit Committee			10 - 15	0	0	0	0	**10 - 15**
Dr I Woods Lay Member			15 - 20	300	0	0	0	**15 - 20**
K Readshaw Lay Member			5-10	0	0	0	0	**5-10**
C Liddle Governing Body member			15 - 20	0	0	0	0	**15 - 20**

Notes

Pensions information for GP members relates to all officer employment in the NHS but does not include practitioner contributions

1. A Bloor - For the financial year 2019/20 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG had a single Accountable Officer. The figures disclosed in the table above represent NHS Scarborough and Ryedale CCG's proportional share of the total cost for 2019/20. Mrs Bloor's total salary for the period falls within the bands of £145,000 to £150,000 and her pension related benefits fall within the bands of £150,000 to £155,000.
2. W Balmain - From 1st May 2019 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Director of Strategy and Integration. The figures disclosed in the table above relate to NHS Scarborough and Ryedale CCG's proportional share of the cost for the period 1st May 2019 to 31st March 2020. Mrs Balmain's total salary for the period falls within the bands of £105,000 to £110,000 and her pension related benefits fall within the bands of 30,000 to £35,000.
3. S Cox - For the financial year 2019/20 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG has a single Director of Acute Commissioning. The figures disclosed in the table above represent NHS Scarborough and Ryedale CCG's proportional share of the cost for 2019/20. Mr Cox's total salary for the period falls within the bands of £115,000 to £120,000 and his pension related benefits fall within the bands of £40,000 to £45,000.
4. S Peckitt - From 28th June 2019 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Chief Nurse. The figures disclosed in the table above relate to NHS Scarborough and Ryedale CCG's proportional share of the cost for the period 28th June 2019 to 31st March 2020. Mrs Peckitt's total salary for the period falls within the bands of £70,000 to £75,000 and her pension related benefits fall within the bands of £130,000 to £135,000.
5. J Warren - From 15th July 2019 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Director of Corporate Services. The figures disclosed in the table above relate to NHS Scarborough and Ryedale CCG's proportional share of the cost for the period 1st July 2019 to 31st March 2020. Mrs Warren's total salary for the period falls within the bands of £70,000 to £75,000.
6. J Hawkard - From 1st November 2019 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Chief Finance Officer. The figures disclosed in the table above relate to NHS Scarborough and Ryedale CCG's proportional share of the cost for the period 1st November 2019 to 31st March 2020. Mrs Hawkard's total salary for the period falls within the bands of £50,000 to £55,000 and her pension related benefits fall within the bands of £95,000 - £100,000.
7. CA Wollerton - A proportion of the Executive Nurse costs are charged to Children's Safeguarding which is a hosted arrangement on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Vale of York CCG and NHS Scarborough and Ryedale CCG, to which net accounting principles apply. Only this Clinical Commissioning Group's share of costs is shown above. Mrs Wollerton's total salary for the period falls within the bands of £35,000 to £40,000. Mrs Wollerton has taken her pension entitlement during the year therefore there are no pension benefits to report.
8. I Dobinson - From 1st July 2019 NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG appointed a single Interim Chief Finance Officer. The figures disclosed in the table above relate to NHS Scarborough and Ryedale CCG's proportional share of the cost for the period 1st July 2019 to 31st October 2019. The costs relating to 1st April 2019 to 30th June 2019 are included in full as they they relate to NHS Scarborough and Ryedale CCG entirely. Mr Dobinson's total salary for the period falls within the bands of £50,000 to £55,000.

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)	TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
SN Cox Accountable Officer*		30/11/18	75 – 80	500	0	0	17.5 – 20.0	90 – 95
Amanda Bloor Accountable Officer **	01/12/18		10 – 15	0	0	0	10 – 12.5	25 – 30
R Mellor Chief Finance Officer		04/01/19	75 – 80	0	0	0	35 – 37.5	110 – 115
CA Wollerton Executive Nurse***			90 – 95	0	0	0	57.5 – 60	145 – 150
Dr P Billingsley GP Governing Body Member			75 – 80	2,200	0	0	35 – 37.5	115 – 120
The following members have opted out of the NHS pension scheme and therefore pensions disclosure is not required:								
Dr G Black GP Governing Body Member			40 – 45	0	0	0	0	40 – 45
J Lawrence Governing Body Member			40 – 45	0	0	0	0	40 – 45
Dr C Ives GP Governing Body Member			40 – 45	700	0	0	0	40 – 45
I Dobinson Chief Finance Officer	09/01/19		15 – 20	0	0	0	0	15 – 20
Dr JFP Garnett Chair			65 – 70	1,300	0	0	0	65 – 70
Dr O Hefni GP Governing Body Member			40 – 45	0	0	0	0	40 – 45

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)	TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Dr K Halloran GP Governing Body Member			40 – 45	0	0	0	0	40 – 45
A Hudson Lay member			15 – 20	1,300	0	0	0	15 – 20
PC Hewitson Lay member, Chair of Audit Committee			10 – 15	0	0	0	0	10 – 15
Dr Ian Wood Governing Body member for Secondary Care			15 – 20	1,400	0	0	0	15 – 20
K Readshaw Lay Member			5 – 10	0	0	0	0	5 – 10
C Liddle Governing Body member			15 – 20	0	0	0	0	15 – 20

Notes

Pensions information for GP members relates to all officer employment in the NHS but does not include practitioner contributions

* SN Cox – 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 Scarborough and Ryedale CCG ceased in this role from the 30th November 2018. The figures in the table therefore represent this time in post from 1 April 2018 to 30 November 2018.

** A Bloor – 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 Scarborough and Ryedale CCG's proportional share of the total cost for 1 December 2018 to 31 March 2019. 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.

***CA Wollerton – A proportion of the Executive Nurse costs are charged to Children's Safeguarding which is a hosted arrangement on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Vale of York CCG, and NHS Scarborough and Ryedale CCG, to which net accounting principles apply. Only this Clinical Commissioning Group's share of costs is shown above. Annual whole time equivalent salary is £95,000 - £100,000.

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
A Bloor Accountable Officer	5 – 7.5	10 – 15	55 – 60	130 – 135	933	122	1,099	0
W Balmain Director of Strategy and Integration	0 – 2.5	0 – 2.5	15 - 20	35 – 40	346	22	392	0
S N Cox Director of Acute Commissioning	2.75 – 3	0 – 5	45 – 50	60 – 65	669	38	740	0
S Peckitt Chief Nurse	4.75 – 5	10 – 15	35 – 40	110 – 115	653	106	823	0
J Warren Director of Corporate Services	0	0	35 – 40	80 – 85	713	0	698	0
J Hawkard Chief Finance Officer	1.5 – 1.75	1.5 – 2	40 – 45	95 – 100	748	26	848	0
CA Wollerton Executive Nurse *	0	0	0	0	0	0	0	0
The following members have opted out of the NHS pension scheme and therefore pensions disclosure is not required:								
Dr P Billingsley: GP Governing Body member								
Dr G Black: GP Governing Body Member								

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
J Lawrence: Governing Body Member								
Dr C Ives: GP Governing Body Member								
I Dobinson: Interim Chief Finance Officer								
Dr JFP Garnett: Chair								
Dr O Hefni: GP Governing Body member								
A Hudson: Lay member								
PC Hewitson: Lay member, Chair of Audit Committee								
Dr I Woods: Lay Member								
K Readshaw: Lay Member								
C Liddle: Governing Body member								

Notes

The pension benefits and related CETVs disclosed in the above table do not allow for a potential future adjustment arising from the McCloud judgement.

During 2019/20 a single Director team was established across NHS Hambleton Richmonshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG. The figures shown in the pensions table account for the pension benefits in full of the single Director team.

* CA Wollerton - Member benefits taken in 2019/20.

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)

There have been no payments made by the CCG in respect of early retirement or for loss of office.

10.9 Payments to past members (subject to audit)

There have been no payments made by the CCG to past members

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 member of the Membership Body/Governing Body in the clinical commissioning group in the financial year 2019/20 was £175,000 - £180,000 (2018/19 £180,000 - £185,000).

This was 4.62 (2018/19 4.55) times the median remuneration of the workforce, which was £38.6k (2018/19 £39.7k).

The range of staff remuneration (per 1 whole time equivalent) was £15 - £20 thousand to £175 - £180 thousand.

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

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

11 CCG Staff Information

11.1 Number of Senior Managers (subject to audit)

Pay band	Number	Pay band	Number
Band 8a	8	Band 9	0
Band 8b	9	VSM	2
Band 8c	2	Governing Body	14
Band 8d	2	Any other Spot Salary	1

11.2 Staff Numbers and Costs (subject to audit)

	2019-20			2018-19		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits						
Salaries and wages	2,108	139	**2,247**	2,190	200	**2,389**
Social security costs	226	-	**226**	232	0	**232**
Employer Contributions to NHS Pension scheme	446	-	**446**	289	0	**289**
Other pension costs	-	-	**-**	0	0	**0**
Apprenticeship Levy	1	-	**1**	2	0	**2**
Other post-employment benefits	-	-	**-**	0	0	**0**
Other employment benefits	-	-	**-**	0	0	**0**
Termination benefits	68	-	**68**	61	0	**61**
Gross employee benefits expenditure	**2,849**	**139**	**2,988**	**2,773**	**200**	**2,973**
Less recoveries in respect of employee benefits	-	-	**-**	0	0	**0**
Total - Net admin employee benefits including capitalised costs	**2,849**	**139**	**2,988**	**2,773**	**200**	**2,973**
Less: Employee costs capitalised	-	-	**-**	0	0	**0**
Net employee benefits excluding capitalised costs	**2,849**	**139**	**2,988**	**2,773**	**20**	**2,973**

11.3 Staff Composition

As at 31 March 2020, 82 staff (total headcount) were employed by NHS Scarborough and Ryedale CCG.

Please note the numbers below are based on whole time equivalents of the average number of people employed by the CCG. Net accounting principles are in place where staff work for services that NHS Scarborough and Ryedale CCG host on behalf of other Organisations.

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

Headcount			WTE		
Total Number	Permanently Employed	Other	Total Number	Permanently Employed	Other
82	68	14	52.86	2.17	55.03

Assignment category	
Permanent	68
Fixed term	6
Statutory office holders	7
Bank	1
Honorary	0

Staff group	
Female	59
Male	23

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 3.9%. This equates to approximately 941.5 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 https://www.scarboroughryedaleccg.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 Scarborough and Ryedale CCG does not employ any trade union representatives.

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

The total spend on external consultancy in 2019/20 was £115,812.20.

11.9 Off-payroll Engagements

	Number
Number of existing engagements as of 31 March 2020	1
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

During 2019/20, the CCG had one Governing Body member that was not on payroll. This arrangement has been in place for more than 4 financial years. The CCG has received salary recharges from the employing practices in respect of this member. The Practice Manager was seconded from the organisation to fulfil the role as a Governing Body member. The individual was selected by election and the CCG has assessed the method of remuneration and it is reasonable.

11.9.1 Table 2: New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
Number assessed as caught by IR35	n/a
Number assessed as not caught by IR35	n/a
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	n/a
Number of engagements reassessed for consistency / assurance purposes during the year	n/a
Number of engagements that saw a change to IR35 status following the consistency review	n/a

11.9.2 Table 3: Off-payroll engagements/senior official engagements

The following table includes any off-payroll engagements of CCG Governing Body members and / or senior officials with significant financial responsibility, between, 1 April 2018 and 31 March 2019.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	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. This figure should include both on payroll and off-payroll engagements. (2)	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 4.3 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 Scarborough and Ryedale 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 below.

13 Independent Auditor's Report to the Governing Body of NHS Scarborough and Ryedale Clinical Commissioning Group

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS Scarborough and Ryedale Clinical Commissioning Group ('the CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Conclusions relating to going concern

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

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

Other information

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of the Accountable Officer's Responsibilities the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material

misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

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

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

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

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

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

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

Use of the audit report

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

Mark Kirkham, Partner
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

Data entered below will be used throughout the workbook:

Entity name:	NHS Scarborough & Ryedale Clinical Commissioning Group
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

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(1,721)	(782)
Other operating income	2	(6)	(593)
Total operating income		**(1,727)**	**(1,375)**
Staff costs	4	2,988	2,973
Purchase of goods and services	5	202,944	195,927
Depreciation and impairment charges	5	26	10
Provision expense	5	-	-
Other Operating Expenditure	5	396	457
Total operating expenditure		**206,354**	**199,367**
Net Operating Expenditure		**204,627**	**197,993**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**204,627**	**197,993**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**204,627**	**197,993**
Comprehensive Expenditure for the year		**204,627**	**197,993**

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	13	(0)	8
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		(0)	8
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	2,982	4,704
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	-	130
Total current assets		**2,982**	4,834
Non-current assets held for sale	21	-	-
Total current assets		**2,982**	4,834
Total assets		**2,982**	4,842
Current liabilities			
Trade and other payables	23	(17,671)	(13,819)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	20	(280)	-
Provisions	30	-	-
Total current liabilities		**(17,951)**	(13,819)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(14,969)**	(8,977)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(14,969)**	(8,977)
Financed by Taxpayers' Equity			
General fund		(14,969)	(8,977)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(14,969)**	(8,977)

The notes on pages 5 to 35 form part of this statement

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

Amanda Bloor
Accountable Officer

Jane Hawkard
Chief Finance Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(8,977)	0	0	**(8,977)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(8,977)**	**0**	**0**	**(8,977)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(204,627)			**(204,627)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(204,627)**	**0**	**0**	**(204,627)**
Net funding	198,636	0	0	**198,636**
Balance at 31 March 2020	**(14,969)**	**0**	**0**	**(14,969)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(5,948)	0	0	**(5,948)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(5,948)**	**0**	**0**	**(5,948)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Impact of applying IFRS 9 to Opening Balances	0			0
Impact of applying IFRS 15 to Opening Balances	0			0
Net operating costs for the financial year	(197,993)			(197,993)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(197,993)**	**0**	**0**	**(197,993)**
Net funding	194,963	0	0	194,963
Balance at 31 March 2019	**(8,977)**	**0**	**0**	**(8,977)**

The notes on pages 5 to 35 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		(204,627)	(197,993)
Depreciation and amortisation	5	26	10
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	1,722	1,432
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,851	1,681
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(199,028)**	(194,870)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(18)	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(18)**	0
Net Cash Inflow (Outflow) before Financing		**(199,046)**	(194,870)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		198,636	194,963
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**198,636**	194,963
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(410)**	94
Cash & Cash Equivalents at the Beginning of the Financial Year		**130**	36
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		**(281)**	130

The notes on pages 5 to 35 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts 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) will formally merge on the 1st April 2020 to establish NHS North Yorkshire Clinical Commissioning Group .
The CCG does not believe that this will affect the CCG's ability to operate as a going concern as services will still 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.

1.4 **Subsidiaries**

Entities over which the clinical commissioning group has the power to exercise control are classified as subsidiaries and are consolidated. The clinical commissioning group has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not coterminous.

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

1.5 **Associates**

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

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

1.6 **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.

1.7 **Pooled Budgets**

From the 1st April 2015 the CCG entered into a pooled budget with North Yorkshire County Council and the following CCGs for the Better Care Fund (note 35):

Airedale, Wharfedale and Craven CCG
Hambleton, Richmondshire and Whitby CCG
Harrogate and Rural District CCG
Scarborough and Ryedale CCG
Vale of York CCG

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

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

Consideration has been given as to whether IFRS 12 - Disclosure of Interests in Other Entities applies to this pooled budget arrangement, the majority of this standard is deemed irrelevant on the basis that no individual organisation has sole control over the fund and no individual organisation has full or joint control over another entity or significant influence over another entity however as IFRS 11 applies we have considered disclosure requirements for joint arrangements and these have been met through this policy note and note 35 of the accounts.

Notes to the financial statements

1.8 **Operating Segments**

The clinical commissioning group only has one operating segment; Commissioning of Healthcare.

1.9 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received. The clinical commissioning group has no other material income.
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.

1.10 **Employee Benefits**

1.10.1 **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.

1.10.2 **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.
For employees who are not members of the NHS Pension Scheme an auto-enrolment pension provided by NEST is available. The employers contribution in 2019/20 is 8%.

1.11 **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.

1.12 **Grants Payable**

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

1.13 **Property, Plant & Equipment**

1.13.1 **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.

1.13.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.13.3 **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.

Notes to the financial statements

1.14 **Intangible Assets**

1.14.1 **Recognition**

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

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

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

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

1.14.2 **Measurement**

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.14.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
During 2019/20 a capital acquisition of IT equipment was fully depreciated in year. This represents a change from the previous treatment whereby IT equipment was depreciated over an estimated useful life of 5 years. The reason for this change is to be consistent with NHS Hambleton Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG ahead of the merger on 1st April 2020.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.16 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

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

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

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the financial statements

1.18 **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.

1.18.1 **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.

1.18.2 **The Clinical Commissioning Group as Lessor**

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

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

1.19 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the CCG . In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

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

• payment for the fair value of services received

• repayment of the finance lease liability, including finance costs, and

• payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 **Services Received**

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

1.19.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at current value in existing use.

1.19.3 **PFI Liability**

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

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

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

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

1.19.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

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

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

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

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

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

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

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.20 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.21 **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. Cash, bank and overdraft balances are recorded at current values.

1.22 **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 0.50% (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.

The organisational restructure associated with the merger of NHS Hambleton Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG is underway and there are no significant costs of restructuring that would give rise to requirement for a restructuring provision.

Notes to the financial statements

1.23 **Clinical Negligence Costs**

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) 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 the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the clinical commissioning group.

1.24 **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.

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 poooled 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 initally by the Department of Health and Social Care and more recently by NHS England, and has asserted that the indexation element of these redress payments constitutes yearly interest for income tax purposes. For this type of interest there is a requirement for the paying organisation (the CCG) to deduct 20% income tax before making the payment. HMRC intend to seek retrospective tax settlements from CCGs for tax amounts not deducted, starting with the tax year 2013/14.

NHS England have disputed this assessment on behalf of CCGs and have accounted for the potential liability up to and including March 2018. The CCG has accounted for the tax liability in 2019/20 and has paid over tax due to HMRC in respect of previously unassessed periods of care that have been settled during 2019/20.

The CCG has considered whether any post PUPoC claims would give rise to a liability in 2019/20 and has determined, using the NHS England methodology that any potential non PUPoC liability would be immaterial in nature.

1.25 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme was a mandatory cap and trade scheme for non-transport CO2 emissions. The scheme was closed as of 31 March 2019. The clinical commissioning group was registered with the CRC scheme, and was therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year.

Allowances acquired under the scheme were recognised as intangible assets.

1.26 **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.

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at 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.

1.27.1 **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.

1.27.2 **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.

1.27.3 **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.

Notes to the financial statements

1.27.4 **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.

1.28 **Financial Liabilities**

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

1.28.1 **Financial Liabilities at Fair Value Through Profit and Loss**

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

1.28.2 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.30 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

1.33 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.
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. The CCG has made estimations in respect of expenditure on acute contracts and continuing healthcare expenditure where actual full year costs are not yet known. Estimations are made with reference to actual part year costs and historic expenditure patterns. Estimates for Primary Care prescribing expenditure are included for the final two months of the financial year which are based on the previous ten months data and historic prescribing patterns.

Notes to the financial statements

1.34 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

- IFRS 16 Leases – The Standard is effective from 1 April 2021 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

It is expected that the application of IFRS 16 will bring building leases held by the CCG onto the balance sheet in 2021/22 per NHS Policy. This would result in an increase to property, plant and equipment in the balance sheet offset by a corresponding liability to represent the financing. The amount is not yet quantifiable as the detailed guidance on the application of the standard has not yet been published. The application of the other standards as revised are not expected to have a material impact on the accounts for 2019/20, were they applied in that year.

1.36 **Gross/Net Accounting Arrangements for Hosted Services**
NHS Scarborough & Ryedale Clinical Commissioning Group acts as host CCG on behalf of Hambleton, Richmondshire & Whitby CCG and Harrogate & Rural District CCG in respect of the following services:

i) Continuing Healthcare/Funded Nursing Care	**2019/20**	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	32.71%	£ 17,058,571	27.07%	£ 15,038,481
Harrogate & Rural District CCG	38.81%	£ 20,238,536	34.53%	£ 19,186,980
Scarborough & Ryedale CCG	28.48%	£ 14,854,171	38.40%	£ 21,337,047
TOTAL		**£ 52,151,279**		**£ 55,562,508**

ii) Finance Team	**2019/20**	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	33.66%	£ 94,466	25.00%	£ 3,558
Harrogate & Rural District CCG	38.18%	£ 107,151	25.00%	£ 3,558
Scarborough & Ryedale CCG	28.16%	£ 79,030	25.00%	£ 3,558
Vale of York CCG	0.00%	£ -	25.00%	£ 3,558
TOTAL		**£ 280,647**		**£ 14,232**

iii) Continuing Healthcare Team Costs
Staff and associated non-pay costs in relation to the provision of the above hosted services are apportioned between the CCGs on a weighted capitation basis. There is a proportion of non-pay expenditure recharged to Vale of York CCG in 2019/20.

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	33.46%	£ 625,626	27.44%	£ 581,583
Harrogate & Rural District CCG	45.32%	£ 847,278	36.65%	£ 776,694
Scarborough & Ryedale CCG	16.40%	£ 306,581	25.87%	£ 540,421
Vale of York CCG	4.82%	£ 90,074	10.04%	£ 212,828
TOTAL		**£ 1,869,558**		**£ 2,111,526**

NHS Scarborough & Ryedale CCG also hosts the following:
iv) Childrens Safeguarding services on behalf of Scarborough & Ryedale CCG, Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG and Vale of York CCG
v) Primary Care Safeguarding services on behalf of Scarborough & Ryedale CCG, Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG and Vale of York CCG
vi) Adult Safeguarding services on behalf of Scarborough and Ryedale CCG, Harrogate and Rural District CCG, Hambleton, Richmondshire and Whitby CCG and Vale of York CCG.
vii) Strategic Clinical Network on behalf of Scarborough & Ryedale CCG, Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG, Vale of York CCG, East Riding of Yorkshire CCG and North Lincolnshire CCG.
viii) Legal Team on behalf of Scarborough and Ryedale CCG, Harrogate and Rural District CCG, Hambleton, Richmondshire and Whitby CCG and East Riding of Yorkshire CCG.

The costs of these hosted services are apportioned between the CCGs as follows:

iv) Childrens Safeguarding

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	18.67%	£ 68,196	19.17%	£ 73,332
Harrogate & Rural District CCG	22.48%	£ 82,119	23.02%	£ 88,020
Scarborough & Ryedale CCG	16.77%	£ 61,287	16.40%	£ 62,705
Vale of York CCG	42.08%	£ 153,751	41.41%	£ 158,384
TOTAL		**£ 365,352**		**£ 382,441**

v) Primary Care Safeguarding

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	18.27%	£ 23,863	18.35%	£ 16,011
Harrogate & Rural District CCG	20.72%	£ 27,073	20.77%	£ 18,123
Scarborough & Ryedale CCG	15.28%	£ 19,960	15.35%	£ 13,394
Vale of York CCG	45.73%	£ 59,736	45.53%	£ 39,727
TOTAL		**£ 130,632**		**£ 87,255**

vi) Adult Safeguarding

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	18.37%	£ 54,015	18.38%	£ 47,296
Harrogate & Rural District CCG	20.54%	£ 60,396	20.71%	£ 53,292
Scarborough & Ryedale CCG	15.29%	£ 44,959	15.35%	£ 39,499
Vale of York CCG	45.80%	£ 134,670	45.56%	£ 117,237
TOTAL		**£ 294,039**		**£ 257,325**

vii) Strategic Clinical Networks

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	11.31%	£ 19,733	11.47%	£ 24,980
Harrogate & Rural District CCG	12.83%	£ 22,382	12.94%	£ 28,182
Scarborough & Ryedale CCG	9.46%	£ 16,505	9.54%	£ 20,782
Vale of York CCG	28.32%	£ 49,399	28.13%	£ 61,255
East Riding of Yorkshire CCG	23.97%	£ 41,810	24.11%	£ 52,505
North Lincolnshire CCG	14.12%	£ 24,629	13.81%	£ 30,084
TOTAL		**£ 174,458**		**£ 217,788**

viii) Legal Team

	2019/20	**(Actual Costs)**	**2018/19**	**(Actual Costs)**
Hambleton, Richmondshire & Whitby CCG	26.38%	£ 25,251	25.00%	£ 16,381
Harrogate & Rural District CCG	23.56%	£ 22,558	25.00%	£ 16,381
Scarborough & Ryedale CCG	26.94%	£ 25,790	25.00%	£ 16,381
East Riding of Yorkshire CCG	23.13%	£ 22,141	25.00%	£ 16,381
TOTAL		**£ 95,740**		**£ 65,524**

Scarborough & Ryedale CCG also receives recharges for the following:

Notes to the financial statements

ix) Specialist Neurological Rehab which is hosted by Vale of York CCG.
x) Medicines Management which is hosted by Harrogate & Rural District CCG
xi) Referral Support Service which is hosted by Vale of York CCG
xii) Mental Health (Adults) Commissioning which is hosted by Harrogate & Rural District CCG. Expenditure is recharged on a risk share basis.
xiii) Childrens CHC Team which is hosted by Hambleton, Richmondshire & Whitby CCG. Expenditure is recharged on a risk share basis.
xiv) Childrens & Young Peoples Commissioning which is hosted by Hambleton, Richmondshire & Whitby CCG. Expenditure is recharged on a risk share basis.
xv) Serious Incidents which is hosted by Vale of York CCG. Expenditure is recharged on a weighted basis.
xvi) Infection Prevention and Control hosted by East Riding of Yorkshire CCG

xvii) Primary Care Co-commissioning team hosted by Harrogate and Rural District CCG.
xviii) Other Mental Health Services hosted by Harrogate and Rural District CCG

ix) Specialist Neurological Rehab
In 2015/16 the CCG's agreed an arrangement to charge Hambleton Richmondshire & Whitby CCG based on actual costs incurred, whilst all remaining costs are risk shared between Scarborough & Ryedale CCG, Harrogate and Rural District CCG, and Vale of York CCG. This agreement is unchanged during 2019/20.

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Hambleton, Richmondshire & Whitby CCG	13.60%	£ 434,412	13.27%	£ 326,369
Harrogate & Rural District CCG	21.90%	£ 699,523	22.06%	£ 542,350
Scarborough & Ryedale CCG	16.15%	£ 515,868	16.30%	£ 400,908
Vale of York CCG	48.34%	£ 1,543,925	48.36%	£ 1,189,220
TOTAL		**£ 3,193,728**		**£ 2,458,846**

x) Medicines Management

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Hambleton, Richmondshire & Whitby CCG	16.21%	£ 146,805	15.61%	£ 123,547
Harrogate & Rural District CCG	21.74%	£ 196,907	22.97%	£ 181,848
Scarborough & Ryedale CCG	28.45%	£ 257,607	28.47%	£ 225,423
Vale of York CCG	5.86%	£ 53,113	5.81%	£ 45,969
Airedale Wharfedale & Craven CCG	27.74%	£ 251,181	27.15%	£ 214,913
TOTAL		**£ 905,612**		**£ 791,700**

xi) Referral Support Service

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Hambleton, Richmondshire & Whitby CCG	6.77%	£ 40,248	8.08%	£ 43,881
Harrogate & Rural District CCG	6.77%	£ 40,248	8.08%	£ 43,881
Scarborough & Ryedale CCG	30.41%	£ 180,796	33.63%	£ 182,729
Vale of York CCG	56.05%	£ 333,261	50.22%	£ 272,844
TOTAL		**£ 594,553**		**£ 543,335**

xii) Mental Health (Adults) Commissioning

	2019/20	(Risk Share)	2018/19	(Risk Share)
Hambleton, Richmondshire & Whitby CCG	30.56%	£ 75,914	30.44%	£ 72,867
Harrogate & Rural District CCG	35.58%	£ 88,382	30.73%	£ 73,553
Scarborough & Ryedale CCG	29.81%	£ 74,056	30.06%	£ 71,951
Vale of York CCG	4.05%	£ 10,069	8.76%	£ 20,971
TOTAL		**£ 248,422**		**£ 239,341**

xiii) Childrens CHC Team

	2019/20	(Risk Share)	2018/19	(Risk Share)
Hambleton, Richmondshire & Whitby CCG	18.27%	£ 24,256	18.35%	£ 19,973
Harrogate & Rural District CCG	20.72%	£ 27,508	20.77%	£ 22,607
Scarborough & Ryedale CCG	15.28%	£ 20,286	15.35%	£ 16,708
Vale of York CCG	45.73%	£ 60,712	45.53%	£ 49,557
TOTAL		**£ 132,762**		**£ 108,846**

xiv) Childrens & Young Peoples Commissioning

	2019/20	(Risk Share)	2018/19	(Risk Share)
Hambleton, Richmondshire & Whitby CCG	26.39%	£ 22,035	26.46%	£ 27,697
Harrogate & Rural District CCG	29.93%	£ 24,992	29.94%	£ 31,344
Scarborough & Ryedale CCG	22.07%	£ 18,430	22.13%	£ 23,169
Vale of York CCG	21.60%	£ 18,037	21.47%	£ 22,474
TOTAL		**£ 83,494**		**£ 104,683**

xv) Serious Incident

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Harrogate & Rural District CCG	33.33%	£ 30,305	33.33%	£ 29,326
Scarborough & Ryedale CCG	33.33%	£ 30,305	33.33%	£ 29,326
Vale of York CCG	33.33%	£ 30,305	33.33%	£ 29,326
TOTAL		**£ 90,916**		**£ 87,979**

xvi) Infection Prevention and Control

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Scarborough & Ryedale CCG - split equally between 5 CCGs		£ 14,141		£ 13,343

xvii) Primary Care Co-commissioning Team

	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Hambleton, Richmondshire & Whitby CCG	34.00%	£ 8,873	34.00%	£2,495.90
Harrogate & Rural District CCG	38.00%	£ 9,917	38.00%	£2,789.53
Scarborough & Ryedale CCG	28.00%	£ 7,307	28.00%	£2,055.45
TOTAL		**£ 26,097**		**£7,340.88**

xviii) Other Mental Health**	2019/20	(Actual Costs)	2018/19	(Actual Costs)
Hambleton, Richmondshire & Whitby CCG	39.12%	£ 4,359,000	45.55%	£ 4,513,836
Harrogate & Rural District CCG	39.29%	£ 4,377,856	33.83%	£ 3,351,584
Scarborough & Ryedale CCG	21.59%	£ 2,405,000	20.62%	£ 2,043,132
TOTAL		**£ 11,141,856**		**£ 9,908,552**

The comparator relates to the full year costs but was split hosted in 2018/19.
*** This budget includes expenditure for several small value contracts.*

IAS 18 determines that the nature of these hosted arrangements constitutes an agency relationship, and therefore 'net' accounting principles are applicable. Only this clinical commissioning groups' share of costs and staff numbers are represented in these accounts.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**41**	-
Non-patient care services to other bodies	**1,546**	671
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**134**	111
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**1,721**	**782**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**6**	593
Total Other operating income	**6**	**593**
Total Operating Income	**1,727**	**1,375**

The main source of revenue within non-patient care services relates to recharges for continuing healthcare packages of care and hospice services.

Revenue within this note does not include cash from NHS England which is drawn down directly into the bank account of the CCG and credited to the General Fund.

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	41	1,415	-	-	-	-	1	-
Non NHS	-	131	-	-	-	-	133	-
Total	**41**	**1,546**	**-**	**-**	**-**	**-**	**134**	**-**

	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	-	-	-	-	-	-	-	-
Over time	41	1,546	-	-	-	-	134	-
Total	**41**	**1,546**	**-**	**-**	**-**	**-**	**134**	**-**

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 yet completed at the reporting date

	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	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

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	**2,108**	**139**	**2,247**
Social security costs	**226**	**0**	**226**
Employer Contributions to NHS Pension scheme	**446**	**0**	**446**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**1**	**0**	**1**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**68**	**0**	**68**
Gross employee benefits expenditure	2,849	139	2,988
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	2,849	139	2,988
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	2,849	139	2,988

4.1.1 Employee benefits — Total — 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**2,190**	**200**	**2,389**
Social security costs	**232**	**0**	**232**
Employer Contributions to NHS Pension scheme	**289**	**0**	**289**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**2**	**0**	**2**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**61**	**0**	**61**
Gross employee benefits expenditure	2,773	200	2,973
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	2,773	200	2,973
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	2,773	200	2,973

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	**-**
Social security costs	**-**	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	**-**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

During 2019/20 a single executive management structure has been in operation ahead of the merger of NHS Scarborough and Ryedale CCG, NHS Hambleton Richmondshire and Whitby CCG and NHS Harrogate and Rural District CCG to NHS North Yorkshire CCG. The CCG's share of these costs are included in this note.

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	**52.86**	**2.17**	**55.03**	**58.16**	**3.05**	**61.21**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	15,556	-	-	1	15,556
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	52,800	-	-	1	52,800
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**68,356**	**-**	**-**	**2**	**68,356**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	2	7,518	-	-	2	7,518
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	53,333	-	-	1	53,333
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**3**	**60,851**	**-**	**-**	**3**	**60,851**

	2019-20 Departures where special payments have been made		2018-19 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

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

During 2019/20 NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG and NHS Scarborough and Ryedale CCG have established a single executive Director team ahead of the merger to NHS North Yorkshire CCG on 1st April 2020. As a result the Chief Nurse for NHS Scarborough and Ryedale CCG and the Chief Nurse for NHS Harrogate and Rural District CCG were made redundant and the Clinical Commissioning Group's share of the termination costs is included in these accounts.

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

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

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 Pension costs

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

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019 updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 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 £282,807 were payable to the NHS Pensions Scheme (2018-19: £289,148) at the rate of 14.38% of pensionable pay. NHS England paid an additional 6.3% of £162,906, 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 goods and services		
Purchase of healthcare from NHS bodies:		
- Services from other CCGs and NHS England	664	285
- Services from foundation trusts	114,267	106,737
- Services from other NHS trusts	12,618	11,770
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	26,929	30,789
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	21,500	20,696
Pharmaceutical services	-	-
General Ophthalmic services	57	36
GPMS/APMS and PCTMS	19,972	19,279
Supplies and services – clinical	282	123
Supplies and services – general	5,785	5,259
Consultancy services	116	329
Establishment	456	311
Transport	24	33
Premises	172	162
Audit fees	43	43
Other non statutory audit expenditure		
· Internal audit services	30	34
· Other services	-	10
Other professional fees	-	-
Legal fees	10	3
Education, training and conferences	19	31
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**202,944**	**195,927**
Depreciation and impairment charges		
Depreciation	26	10
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets		
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**26**	**10**
Provision expense		
Change in discount rate	-	-
Provisions	-	-
Total Provision expense	**-**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	391	452
Grants to Other bodies	-	-
Clinical negligence	4	4
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	1	1
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**396**	**457**
Total operating expenditure	**203,366**	**196,395**

Other services within Other non statutory audit expenditure is in respect of Mental Health Investment Standard assurance that NHS England 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. This relates to assurance for 2018-19 and this note has been restated to reflect this.

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	9,478	67,963	12,376	98,033
Total Non-NHS Trade Invoices paid within target	8,996	60,016	11,430	87,950
Percentage of Non-NHS Trade invoices paid within target	**94.91%**	**88.31%**	**92.36%**	**89.71%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,984	154,548	2,171	131,873
Total NHS Trade Invoices Paid within target	2,855	153,737	2,079	130,142
Percentage of NHS Trade Invoices paid within target	**95.68%**	**99.48%**	**95.76%**	**98.69%**

The Better Payment Practice Code (BPPC) requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2019-20 £'000**	2018-19 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

The CCG has not made any payments under this legislation.

7 Income Generation Activities
The CCG does not undertake any income generation activities.

8. Investment revenue
The CCG does not have any investment revenue.

9. Other gains and losses
The CCG does not have any other gains or losses.

10.1 Finance costs
The CCG does not have any finance costs.

10.2 Finance income
The CCG does not have any finance income.

11. Net gain/(loss) on transfer by absorption
The CCG does not have any net gain/loss on transfer by absorption.

12. Operating Leases

12.1 As lessee

The CCG has signed a lease with NHS Property Services (NHSPS) for the occupancy of York House at Scarborough Town Hall. This 5 year lease runs from 1 June 2016 to 28 May 2021 with a fixed annual rent of £54,754.

Rental costs for York House and the CCG's share of Amy Johnson Way and Kingswood Surgery are reflected in note 12.1.1. Additionally rental payments to Vale of York CCG for the RSS team in West Offices and to Hambleton District Council in respect of accommodation in the Civic Centre are included in note 12.1.1.

12.1.1 Payments recognised as an Expense

	2019-20				2018-19			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	-	114	3	**116**	-	110	2	**112**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**114**	**3**	**116**	**-**	**110**	**2**	**112**

12.1.2 Future minimum lease payments

	2019-20				2018-19			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	-	55	-	**55**	-	57	-	**57**
Between one and five years	-	9	-	**9**	-	64	-	**64**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**64**	**-**	**64**	**-**	**121**	**-**	**121**

Whilst our arrangements with NHS Property Services Limited and York Teaching Hospital Facilities Management (YTHFM) fall within the definition of operating leases, rental charge for future years has not yet been agreed in respect of Kingswood Surgery. The CCG vacated Amy Johnson Way in November 2019 and as such does not have a current lease agreement with YTHFM. Consequently this note does not include future minimum lease payments for these arrangements.

12.2 As lessor

The CCG does not receive any rental income as a lessor.

13 Property, plant and equipment

2019-20	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	-	-	-	-	-	-	50	-	50
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	18	-	18
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**68**	**-**	**68**
Depreciation 01 April 2019	-	-	-	-	-	-	42	-	42
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	26	-	26
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**68**	**-**	**68**
Net Book Value at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**
Purchased	-	-	-	-	-	-	(0)	-	(0)
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**
Asset financing:									
Owned	-	-	-	-	-	-	(0)	-	(0)
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment
The CCG does not hold a revaluation reserve.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction
The CCG does not have any assets under construction.

13.2 Donated assets
The CCG does not have any donated assets.

13.3 Government granted assets
The CCG does not have any government granted assets.

13.4 Property revaluation
The CCG does not have any property.

13.5 Compensation from third parties
The CCG has not received any compensation from third parties.

13.6 Write downs to recoverable amount
The CCG has not written down any assets.

13.7 Temporarily idle assets
The CCG does not hold any temporarily idle assets.

13.8 Cost or valuation of fully depreciated assets

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

	2019-20 £'000	**2018-19** £'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	-	-
Furniture & fittings	-	-
Total	**-**	**-**

13.9 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	10
Furniture & fittings	0	0

14 Intangible non-current assets
The CCG does not have any intangible current assets.

15 Investment property
The CCG does not have any investment property.

16 Inventories
The CCG does not have any inventories.

17.1 Trade and other receivables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	1,356	-	4,111	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	304	-	304	-
NHS accrued income	892	-	-	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	8	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	41	-	(1)	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	165	-	153	-
Non-NHS and Other WGA accrued income	35	-	20	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	86	-	35	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(2)	-	(1)	-
VAT	104	-	25	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	0	-	50	-
Total Trade & other receivables	**2,982**	**-**	**4,704**	**-**
Total current and non current	**2,982**		**4,704**	
Included above:				
Prepaid pensions contributions	-		-	

The majority of NHS receivables are for amounts outstanding with partner CCGs for activities where Scarborough and Ryedale CCG acts as the host organisation.

17.2 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	85	-	118	1
By three to six months	1,525	-	213	3
By more than six months	715	(3)	634	(21)
Total	**2,325**	**(3)**	**965**	**(17)**

17.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2019	(1)	-	**(1)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(1)	-	**(1)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(2)**	**-**	**(2)**

18 Other financial assets
The CCG does not hold any other financial assets.

19 Other current assets
The CCG does not have any other current assets.

20 Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	130	36
Net change in year	(410)	94
Balance at 31 March 2020	**(280)**	**130**
Made up of:		
Cash with the Government Banking Service	-	129
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**0**	**130**
Bank overdraft: Government Banking Service	(280)	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(280)**	**-**
Balance at 31 March 2020	**(280)**	**130**

The CCG does not hold any patients' money.
The negative bank balance in 2019/20 relates to a payment made but not yet cleared.

21 Non-current assets held for sale
The CCG does not have any non-current assets held for sale.

22 Analysis of impairments and reversals
The CCG does not have any impairments or reversals.

23 Trade and other payables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	957	-	1,319	-
NHS payables: Capital	-	-	-	-
NHS accruals	631	-	704	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	4,976	-	4,522	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	10,764	-	6,787	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	46	-	49	-
VAT	-	-	-	-
Tax	55	-	96	-
Payments received on account	-	-	-	-
Other payables and accruals	242	-	341	-
Total Trade & Other Payables	**17,670**	**-**	**13,819**	**-**
Total current and non-current	**17,670**		**13,819**	

Trade and other payables includes amounts outstanding on behalf of partner CCG's activities where Scarborough and Ryedale CCG acts as the host organisation.

Other payables and accruals includes £151k outstanding pension contributions at 31 March 2020 of which £70k relates to GP contributions and the remaining £81k relates to CCG staff.

24 Other financial liabilities
The CCG does not have any other financial liabilities.

25 Other liabilities
The CCG does not have any other liabilities.

26 Borrowings
The CCG does not have any borrowings.

27 Private finance initiative, LIFT and other service concession arrangements
The CCG does not have any private finance initiatives, LIFT or other service concession arrangements.

28 Finance lease obligations
The CCG does not have any finance lease obligations.

29 Finance lease receivables
The CCG does not have any finance lease receivables.

30 Provisions

The CCG has not made any provisions as at the 31 March 2020.

Legal claims are calculated from the number of claims currently lodged with NHS Resolution (formerly the NHS Litigation Authority) and the probability provided by them. There are no current claims held by NHS Resolution.

Under the accounts direction issued by NHS England on 12th February 2014 NHS England is responsible for the accounting of liabilities relating to NHS continuing healthcare claims for periods of care before the establishment of the clinical commissioning group however the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare claims accounted for by NHS England on behalf of this CCG in the financial year is £158,639.

NHS Scarborough & Ryedale Clinical Commissioning Group has been made aware that HMRC is considering challenging the VAT recovery treatment in respect of out-sourced support services provided by entities sitting outside of the NHS family.

NHS England, the regulatory body for Clinical Commissioning Groups, is fully supportive of the current VAT recovery treatment position, which is applied nationally. At the time of completing the accounts, this had not been resolved.

31 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 remaining 2 were not found to be eligible although they do have the right to appeal and these 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.

32 Commitments

32.1 Capital commitments
The CCG does not have any capital commitments.

32.2 Other financial commitments
The CCG does not have any other financial commitments.

33 Financial instruments

33.1 Financial risk management

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

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.

33.1.1 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.

33.1.2 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.

33.1.3 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.

33.1.4 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.

33.1.5 Financial Instruments

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

33 Financial instruments cont'd

33.2 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		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	2,214		2,214
Trade and other receivables with other DHSC group bodies	35		35
Trade and other receivables with external bodies	163		163
Other financial assets	-		-
Cash and cash equivalents	-		-
Total at 31 March 2020	**2,411**	**-**	**2,411**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	559		**559**
Trade and other payables with other DHSC group bodies	1,029		**1,029**
Trade and other payables with external bodies	15,831		**15,831**
Other financial liabilities	280		**280**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2020	**17,699**	**-**	**17,699**

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare	206,354	(1,727)	**204,627**	2,982	(17,951)	**(14,969)**
Total	**206,354**	**(1,727)**	**204,627**	**2,982**	**(17,951)**	**(14,969)**

34.1 Reconciliation between Operating Segments and SoCNE

	2019-20 £'000
Total net expenditure reported for operating segments	204,627
Total net expenditure per the Statement of Comprehensive Net Expenditure	204,627

34.2 Reconciliation between Operating Segments and SoFP

	2019-20 £'000
Total assets reported for operating segments	2,982
Total assets per Statement of Financial Position	**2,982**

	2019-20 £'000
Total liabilities reported for operating segments	(17,951)
Total liabilities per Statement of Financial Position	**(17,951)**

35 Joint arrangements - interests in joint operations

The clinical commissioning group has entered into a pooled budget arrangement with partner organisations.

This pooled budget, known as the North Yorkshire Better Care Fund is hosted by North Yorkshire County Council and overseen by the relevant Health and Wellbeing Board (HWB).

The NHS clinical commissioning group's shares of the income and expenditure handled by the pooled budget in the financial year are shown in the table below:

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2019-20				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**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
North Yorkshire Better Care Fund (BCF)	Airdale Wharfedale & Craven CCG, Hambleton Richmondshire & Whitby CCG, Harrogate & Rural District CCG, Scarborough & Ryedale CCG, Vale of York CCG, North Yorkshire County Council	Pooled budget arrangement for the delivery of the Better Care Fund	0	0	0	8,164	0	0	0	7,994
Mental Health Commissioning in North Yorkshire	Hambleton Richmondshire & Whitby CCG, Harrogate & Rural District CCG, Scarborough & Ryedale CCG, Tees Esk & Wear Valley NHS Foundation Trust	Formal joint arrangement for the commissioning of Mental Health Services in North Yorkshire	0	0	0	14,397	0	0	0	13,752

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11
The CCG does not have any interest in entities not accounted for under IFRS 10 or IFRS 11.

36 NHS Lift investments
The CCG does not have any NHS Lift investments.

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ampleforth Surgery	1,271	0	53	
Brook Square	1,524	0	70	0
Castle Health Centre	854	0	19	0
Central Healthcare	4,931	0	212	0
Derwent Practice	2,873	0	91	0
Eastfield Medical Centre	1,289	0	158	0
Filey Surgery	1,700	0	131	0
Hackness Road Surgery	773	0	60	0
Hunmanby Surgery	586	0	35	0
Scarborough Medical Group	2,261	0	108	0
Sherburn Surgery	1,676	0	104	0
West Ayton Surgery	2,146	0	140	0
St Catherines Hospice*	1,956	0	0	0
Yorkshire Doctors	2,939	0	0	0
Humber Teaching NHS Foundation Trust	11,404	0	65	0
Tees, Esk & Wear Valley NHS Foundation Trust	14,355	0	43	0

*Transactions shown with St Catherine's Hospice represent the full value of the hospice service for Scarborough & Ryedale. A proportion of this cost (17% in total) is recharged to Vale of York CCG and Hambleton, Richmondshire and Whitby CCG, for the provision of services to the Ryedale and Whitby localities.

The 12 primary care practices listed above are included as a related party as each practice is represented at the NHS Scarborough & Ryedale CCGs Council of Members

St Catherine's Hospice is listed as a related party because one of the CCGs Governing Body works as a Sessional GP for them, one Governing Body member is an Advocate and Board Member and one of the Governing Body's wives is employed by them

Yorkshire Doctors is listed as a related party because one of the Governing Body works as a Sessional GP for them

Humber Teaching NHS Foundation Trust is listed as a related party because one of the Governing Body's wives works for them

Tees, Esk & Wear Valley NHS Foundation Trust is listed as a related party because one of the Governing Body's wives works for them and one of the CCG's employees daughters works for them

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. For example:

• NHS England;

• NHS Foundation Trusts;
York Teaching NHS Foundation Trust
South Tees NHS Foundation Trust

• NHS Trusts;
Hull University Teaching Hospitals NHS Trust
Leeds Teaching Hospitals NHS Trust
Yorkshire Ambulance Service NHS Trust

• NHS Litigation Authority; and,
• NHS Business Services Authority.

The clinical commissioning group has also had transactions with NHS Hull CCG.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central government bodies, which includes transactions with North Yorkshire County Council and City of York Council in respect of provision of Continuing Healthcare services. The clinical commissioning group hosts this service on behalf of Scarborough & Ryedale CCG, Harrogate & Rural District CCG and Hambleton, Richmondshire & Whitby CCG.

Also to note:
- Amanda Bloor is the Accountable Officer for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.
- Simon Cox is the Director of Acute Commissioning for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.
- Wendy Balmain is the Director of Strategy and Integration for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.
- Julie Warren is the Director of Corporate Services for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.
- Sue Peckitt is the Chief Nurse for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.
- Jane Hawkard is the Chief Finance Officer for NHS Scarborough & Ryedale CCG, Hambleton Richmondshire & Whitby CCG and Harrogate & Rural District CCG.

- P Hewitson and K Readshaw are lay members of the Governing Bodies for both Scarborough & Ryedale CCG and Hambleton Richmondshire & Whitby CCG
- Dr I Woods is the Secondary Care Doctor for Scarborough & Ryedale CCG and Harrogate & Rural District CCG
- Dr P Billingsley is a GP Governing Body member for NHS Scarborough and Ryedale CCG and Mental Health Lead for NHS Harrogate and Rural District CCG

38 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.

39 Third party assets

The CCG does not hold any third party assets.

40 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	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	247,848	247,784	229,835	241,300
Capital resource use does not exceed the amount specified in Directions	18	18	-	-
Revenue resource use does not exceed the amount specified in Directions	204,691	204,627	186,528	197,993
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	2,653	2,648	2,508	2,476

The CCG has met its statutory financial duty in 2019/20 therefore the cumulative deficit of £20.577m reported in 2018/19 remains.

41 Analysis of charitable reserves

The CCG does not have any charitable reserves.