NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	**NY CCG Governing Body**	**Agenda Item: 8.1**
Date of Meeting:	**23 June 2022**	
Paper Title:	**Annual Report Annual Governance Statement and Accounts 2021/22**	

Session (Tick)	
Public	X
Private	
Development Session	

Responsible Governing Body Member Lead Jane Hawkard, Chief Finance Officer Julie Warren, Director of Corporate Services, Governance and Performance	**Report Author and Job Title** Sasha Sencier, Board Secretary and Senior Governance Manager

Purpose – this paper is for:

Decision	Discussion	Assurance	Information
		X	

Has the report (or variation of it) been presented to another Committee / Meeting?

If yes, state the Committee / Meeting: Yes. The Annual Report and Accounts was approved by the Audit Committee on 6 June 2022.

Executive Summary

The CCG has a statutory requirement to produce and publish the Annual Report and Accounts each year, the contents of which is largely mandated by the Department of Health and Social Care.

The form and content of the Annual Report, Annual Governance Statement and Statutory Accounts is directed by NHS England and CCGs must meet the requirements of the Department of Health and Social Care's (DHSC) Manual for Accounts (the 'manual') and the HM Treasury Financial Reporting Manual (FReM). The 2021/22 report for NHS North Yorkshire CCG has been prepared in line with these national requirements.

The process of compiling the Annual Report and Accounts 2021/22 was completed in stages with due diligence checks throughout from the Accountable Officer, Executive Directors, the Clinical Chair, the Board Secretary, Auditors, and NHS England.

The draft Annual Report and Accounts 2021/22 was reviewed by the Audit Committee and was submitted to NHS England and Improvement for checking on 26 April 2022. Feedback was subsequently received from NHS England and Improvement highlighting any areas requiring additional clarity. All of these were minor and were addressed. Feedback was also received by external auditors, Mazars, highlighting any areas requiring additional clarity. All of these were minor and were addressed.

As delegated by the Governing Body, the Audit Committee received and approved the final report on 6 June 2022. The final report was then resubmitted to NHS England for final approval on 22 June 2022.

The Annual Report and Accounts 2020/21 will be published on the CCG website once formal approval has been received from NHS England and Improvement, which is expected in the coming weeks.

Recommendations

The Governing Body is being asking to: Note the NHS North Yorkshire CCG Annual Report and Accounts for 2020/21 (which includes the Annual Governance Statement).

Monitoring

No monitoring is applicable for the Annual Report and Accounts as this is an annual requirement.

CCG Strategic Objectives Supported by this Paper

	CCG Strategic Objectives	X
1	**Strategic Commissioning:** • To take the lead in planning and commissioning care for the population of North Yorkshire by providing a whole system approach and to support the development of general practice. • To make the best use of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care. • To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition.	
2	**Acute Commissioning:** We will ensure access to high quality hospital-based care when needed.	
3	**Engagement with Patients and Stakeholders:** We will build strong and effective relationships with all our communities and partners.	
4	**Financial Sustainability:** We will work with partners to transform models of care to deliver affordable, quality and sustainable services.	
5	**Integrated / Community Care:** With our partners and people living in North Yorkshire we will enable healthy communities through integrated models of care.	
6	**Vulnerable People:** • We will support everyone to thrive [in the community]. • We will promote the safety and welfare of vulnerable individuals.	
7	**Well-Governed and Adaptable Organisation:** In supporting our objectives we will be a well-governed and transparent organisation that promotes a supportive learning environment.	**X**

CCG Values underpinned in this paper

	CCG Values	X
1	Collaboration	**X**
2	Compassion	**X**
3	Empowerment	**X**
4	Inclusivity	**X**
5	Quality	**X**
6	Respect	**X**

Does this paper provide evidence of assurance against the Governing Body Assurance Framework?

YES		NO	X

Any statutory / regulatory / legal / NHS Constitution implications	The CCG has a statutory requirement to produce and publish an Annual Report each year. The form and content of the Annual Report and Annual Governance Statement is directed by NHS England and CCGs must meet the requirements of the Department of Health and Social Care's (DHSC) Manual for Accounts (the 'manual') and the HM Treasury Financial Reporting Manual (FReM). The Governing Body has responsibility to approve the Annual Report and Accounts however at the meeting in public in March 2022, this was delegated to the Audit Committee to approve due to timing issues to submit to NHS England and Improvement.
Management of Conflicts of Interest	No conflicts of interest have been identified prior to the meeting.
Communication / Public & Patient Engagement	There is a requirement from NHS England and Improvement for the CCG to publish the Annual Report and Accounts on the CCG website within 5 days of the final report being approved by NHS England and Improvement.
Financial / resource implications	No financial implications have been identified.
Outcome of Impact Assessments completed	Not applicable.

NHS North Yorkshire Clinical Commissioning Group

North Yorkshire
Clinical Commissioning Group

Annual Report 2021/2022






Introduction

Welcome from Amanda Bloor, Accountable Officer
NHS North Yorkshire Clinical Commissioning Group

Welcome to our annual report for the year which ends 31 March 2022. This report highlights our work to drive better healthcare outcomes for the people of North Yorkshire and to support and empower local people to take informed decisions about their own health and wellbeing in partnership with health professionals during this most extraordinary year.

We achieved a great deal in our second year as NHS North Yorkshire Clinical Commissioning Group (NYCCG). This year has seen the NHS deliver exemplary care for COVID-19 patients, implement robust COVID-19 secure measures to ensure all services could be delivered safely, and roll out the largest national vaccination programme the country has ever seen, with the COVID-19 vaccination programme.

What has been most inspiring to me over the last year is the way in which partner organisations have collaborated across health, social care, local authorities, and community groups, together with the public, to respond to the pandemic. It has truly been a joint response with a shared aim – to keep people safe and well and to save lives.

Since we came together as NYCCG two years ago to provide a single healthcare commissioning voice for the people of North Yorkshire we have been able to:

- Provide consistent, responsive, decision-making across North Yorkshire
- Work more strategically on a larger footprint with our local and regional partners
- Harmonise our approaches to remove variation and help reduce health inequalities
- Eliminate unnecessary duplication and bureaucratic boundaries to work more efficiently with our partners
- Reduce administrative costs to enable more investment in front line health services.

The year to come will see us build on these achievements, and the step change in partnership working and agile decision-making which helped us respond to the COVID-19 pandemic as a health care system. Conversations are underway across national and regional health and care, local authorities, and delivery partners to actively transform the way that health and care is planned and delivered to better integrate services and improve people's experience at all stages of health and care. This work is part of a national transformation

programme for healthcare to integrate decision making, The Health and Care Bill 2021 (expect to become law this summer) will create a statutory framework for Integrated Care Systems (ICSs) to serve all areas of England. The ICSs are expected to achieve four aims: (1) improve outcomes in population health and healthcare; (2) tackle inequalities in outcomes, experience, and access; (3) enhance productivity and value for money; (4) help the NHS support broader social and economic development.

Our local ICS – Humber and North Yorkshire – will succeed the Humber Coast and Vale Health and Care Partnership and the framework set out in the Health and Care Bill will provide new opportunities to work together more closely to identify, plan and deliver health and care services to help people across the region start well, live well, age well and end life well. You can learn more about the development of integrated care systems here.

I am strongly encouraged by the developments, building on the experience of the pandemic, and the transformation agenda underway which will enable us to work differently with our partners to deliver healthcare collaboratively and consistently for local people. I am looking forward to continuing our work to build strong partnerships, bring patient-centred healthcare into the community, and empower healthy choices in the year ahead as we emerge from the pandemic and look to the future.

Amanda Bloor

Table of Contents

1 Performance Overview

1.1 Introduction

This report is designed to give an overview of the CCG's priorities and achievements in 2021/22.

In this ‘Performance Overview’ section you will learn more about our responsibilities, how the CCG works and our key achievements this year. In the sections that follow, the report looks in more detail at the significant work the CCG has undertaken, including not only responding to the COVID-19 pandemic and delivering a robust COVID-19 vaccination programme, but also the efforts to ensure healthcare continuity through the pandemic and recovery as the pandemic eased.

In the accountability report, which can be found on page 128, you can find out about the CCG's Members, the senior leadership team and how the CCG makes decisions. Finally, from page 201, you will find the CCG's annual accounts which are produced each year and submitted to NHS England. Throughout this report there are signposts to where you can view or find more information.

1.2 What we do

The CCG is responsible for purchasing (or ‘commissioning’) healthcare services for around 427,000 people in the North Yorkshire area. The services commissioned include the majority of healthcare services that local people may need to access either in hospital or in the community.

The CCG commissions:

- Primary health care which includes General Practice (GP) services
- Planned hospital care, which includes non-emergency surgery and maternity services
- Urgent and emergency care, including ambulances
- Mental Health services
- Children’s services
- Rehabilitation care
- Community health services, such as occupational health and physiotherapy.

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

1.3 Equality of Service Delivery

Equality lies at the heart of the NHS, and we also have duties under the Equality Act 2010 to promote the fair treatment of people regardless of any “protected characteristic”, such as race, gender, religion, sexuality, or disability. We also take account of the Equality Delivery System for the NHS (EDS) which is a tool that helps us understand how equality can drive improvements and strengthen the accountability of services to patients and the public. For further information please see section 8.1.

1.4 Our Vision

Our work is driven by a clear vision:

Working together for healthier lives in North Yorkshire

This central vision helps us improve health outcomes for the people of North Yorkshire by ensuring high quality healthcare in the right place at the right time delivered by the right people.

1.5 Our Values

We have a strong commitment to our values, which run through everything we do. The CCG's values are:

- Collaboration
- Compassion
- Empowerment
- Inclusivity
- Quality
- Respect

1.6 About us, Our Community and How We Work

We are a clinically led membership organisation comprised of 51 local GP practices. This means that health professionals with patient experience are leading the decisions we make. Our Council of Members meet 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 Mental Health, Quality, Hospital Based Care, Health Inequalities and Population Health, 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 made regarding local services.

We actively involve the local population and patients in decisions which impact them and have adapted our approach this year to respond to pandemic restrictions. You will read more about how we have continued to involve patients and the public 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 and Primary Care Commissioning Committee 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 can find detail of this within the Constitution and also within the Governance Handbook[1]. You can also see papers and minutes from our Governing Body[2] and Primary Care Commissioning Committee[3] on our website.

1.7 Working with our Partners

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

1.7.1 Patient Participation Groups (PPGs)

GP Practice patient participation groups represent the patient voice and provide meaningful input into proposed projects and service developments, as well as providing feedback and insight. They are invaluable to the work we do. You can read more about them and how you can get involved in sections 2.5.1 and 7.

[1] https://www.northyorkshireccg.nhs.uk/about/
[2] https://www.northyorkshireccg.nhs.uk/about/governing-body/governing-body-meetings/
[3] https://www.northyorkshireccg.nhs.uk/about/primary-care-commissioning-committee/

1.7.2 Primary Care Organisations and Primary Care Networks

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.

Primary Care Networks (PCNs) were established as a national initiative in 2019 aimed to increase capacity and resilience of GP practices and primary care services by providing additional funding for clinical roles and service specifications for the delivery of new patient focussed services. Each PCN covers a group of practices with the objective of working together at scale and sharing back office functions and clinical services where possible. For more information on PCNs please see section 2.1.1.

1.7.3 NHS Providers

Six NHS trusts provide the majority of services to our patients. These are: Harrogate and District NHS Foundation Trust (HDFT); Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV); York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTFT); County Durham and Darlington NHS Foundation Trust (CDDFT); Humber Teaching NHS Foundation Trust (HFT); and Hull University Teaching Hospitals NHS Trust (HUT). Leeds Teaching Hospitals NHS Trust (LTFT) and South Tees Hospitals NHS Foundation Trust (STHFT) provide more specialist care when needed. Our ambulance services are provided by Yorkshire Ambulance Service NHS Trust[4] (YAS) who is also the provider for our region.

1.7.4 Local Authorities

The CCG works in partnership with public health colleagues and jointly with North Yorkshire County Council, Harrogate Borough Council, Hambleton District Council, Richmondshire District Council and Scarborough Borough Council to commission a number of services, such as: the mental health crisis service; befriending and respite support for carers; community step-up and step-down beds; medical equipment; weight management; support for people affected by dementia; and community equipment.

1.7.5 Local Elected Members

CCG colleagues meet regularly with 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 Humber, Coast and Vale Health and Care Partnership (Integrated Care System)

The Humber, Coast and Vale Health and Care Partnership (Integrated Care System) is a collaboration of around 30 health and social care organisations who are working together to improve health and care across our area and a population of 1.7 million.

[4] https://www.yas.nhs.uk/

The Humber, Coast and Vale Health and Care Partnership was renamed the Humber and North Yorkshire Health and Care Partnership on 1 April 2022.

1.7.7 Community and Voluntary Sector

The CCG works closely with the active community and voluntary sectors that make significant contributions to local health care across the North Yorkshire region.

1.7.8 NHS England/Improvement

The CCG works closely with NHSE&I 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 updated on engagement activities and service proposals through attendance at formal and informal meetings and via the stakeholder newsletter.

1.7.10 Healthwatch North Yorkshire

The CCG works with Healthwatch to support their work, deliver joint projects and enhance engagement with members of the public. Healthwatch also attend the CCG's Quality and Clinical Governance Committee.

1.8 Multi-organisation Partnership Boards

The CCG actively participates 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 partnership boards 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[5], which considers the needs of our residents collectively. Through a 'joint needs assessment' we are able to set the priorities for integrated working, get

[5] More on the Joint Health and Wellbeing Strategy can be found at http://www.nypartnerships.org.uk/jhws

the best offer for people across the region and achieve the strategic priorities across North Yorkshire[6]. For more information, please see section 9.

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[7]. 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 enables 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 Harrogate Public Sector Leadership Board

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

1.8.4 Learning Disability and Autism Programme including Transforming Care

North Yorkshire CCG and key partners[8] have worked closely together since the programme commenced in 2016. Over the last year NYY have evolved the transforming care partnership into a learning disability and autism programme to support the whole of the Learning Disability and Autism population, there is still a strong focus on Transforming Care (TCP) within that programme. The programme has worked collaboratively to ensure that key elements of the programme have been implemented and delivered, through a confirm and challenge approach to the Assuring Transformation Platform.

Throughout 2021/22, the focus has been on the development of a local and multi-agency led 'Dynamic Support System' for both Adults and Children and Young People (CYP) that informs the various workstreams involved. For more information see sections 2.9.7, 2.9.8 and 6.14.

1.9 COVID-19

The COVID-19 pandemic that started in March 2020 continued to present challenges for health care provision in 2021/22. The CCG continued to support GP Practices by providing regular COVID-19 Briefings, advice and guidance on treatment of patients,

[6] More information on the Health and Wellbeing Board and the full joint needs assessment can be found at: https://www.northyorks.gov.uk/joint-strategic-needs-assessment

[7] Members of the board include North Yorkshire CCG, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), North Yorkshire County Council (NYCC) Adult Social Care, NYCC Children’s Services, NYCC Public Health.

[8] Key partners include Health colleagues, Local Authority, NHS England, families, children and young people.

managing staff with COVID-19 and those who are contacts of COVID-19 positive cases as well as access to Infection Prevention and Control (IPC) guidance, see section 7.4.

The COVID-19 pandemic continued to have an impact on the way that clinical services were provided with increased telephone and video consultations and a reduction in face-to-face appointments. After an initial drop in demand for GP appointments these are now at levels similar to those seen prior to the COVID-19 pandemic in March 2020.

The policy of triage first was also relaxed where clinically appropriate to enable patients to be booked directly into an appointment with the right clinician. 2021 saw a considerable rise in patient demand for appointments. GP Practices gradually increased face to face appointments, where safe to do so, while maintaining a level of digital, video and telephone appointments to maximise capacity. At end of March 2022 the total number of GP appointments was 249,256 this was nearly 20% above pre-pandemic levels.

The CCG continues to maintain an incident control hub supported by regular incident control calls attended by the CCG leads for all the key health functions to share information and take actions required to maintain safe patient care and maintain staff wellbeing. The regularity of the calls is adjusted based on the demands being placed on the system and over winter the calls were an essential and effective tool in responding to the Omicron wave, see section 4.4.2.

The CCG continued to provide a COVID-19 vaccination programme across North Yorkshire with a mix of community pharmacy sites, primary care sites and 'pop-up' clinics. In the autumn of 2021, the Joint Committee on Vaccination and Immunisation (JCVI) advised that that all people in cohorts 1-9 (over 50s, Health & Social Care Workers and the at-risk groups) should receive a booster dose of the COVID-19 vaccination. NHS England guidance allowed for some routine primary care work to be paused to release capacity for the vaccination programme as a priority. GP Practices responded quickly and willingly to provide booster vaccination capacity prior to Christmas 2021. For more information on the COVID-19 vaccination programme, see section 2.2.3.

Throughout the programme there has a been a focus on reducing inequalities and ensuring that hard to reach groups can access vaccinations and understand the benefits. This has included pop-up clinics in the right place to make access easier, marketing to specific population groups, interpreters on site, information available in languages other than English, contacting patients directly by phone and the use of various social media channels to reach people not yet vaccinated. For more information see sections 6.21 and 7.4.

1.10 Our CCG's Key Strategic Objectives

The CCG has seven strategic objectives that were developed by the Governing Body and approved by the Council of Members and updated in February 2021. These strategic objectives describe what the CCG needs to focus on in order to realise our vision to improve health outcomes for the people of North Yorkshire.

The CCG's strategic objectives are:

Strategic Commissioning:

- To take the lead in planning and commissioning care for the population of North Yorkshire by providing a whole system approach and to support the development of general practice
- To make the best use of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care
- To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition.

Acute Commissioning: We will ensure access to high quality hospital-based care when needed.

Engagement with patients and stakeholders: We will build strong and effective relationships with all our communities and partners.

Financial Sustainability: We will work with partners to transform models of care to deliver affordable, quality and sustainable services.

Integrated/Community Care: With our partners and people living in North Yorkshire we will enable healthy communities through integrated models of care.

Vulnerable People:

- We will support everyone to thrive in the community
- We will promote the safety and welfare of vulnerable individuals.

Well-Governed and Adaptable Organisation: In supporting our objectives we will be a well-governed and transparent organisation that promotes a supportive learning environment.

2 Delivering Our Strategic Objectives

2.1 Strategic Commissioning: To take the lead in planning and commissioning care for the population of North Yorkshire by providing a whole system approach to support the development of general practice

2.1.1 Developing Primary Care: Primary Care Networks

Primary Care Networks (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 have worked extremely hard to support practices with the vaccination programme in response to JCVI advice and government guidance regarding the cohorts eligible for vaccination. 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.

The focus of work for Primary Care in 2021/22 has continued to be managing the COVID-19 pandemic and ensuring that patients can still access primary health services, as well as delivering local COVID-19 vaccination services. Ensuring continuity of services has resulted in new ways of working including continued use of digital appointments and further use of clinicians other GPs. Primary Care Networks (PCNs) have been key to supporting GP practices to respond to the rapidly changing environment and new ways of working. PCN Clinical Directors were funded for additional time to enable them to provide leadership to local systems.

PCNs have increased capacity and resilience amongst GP practices and primary care workforce through additional roles within primary care and service specifications for the delivery of new patient focussed services.

North Yorkshire CCG has eleven PCNs, these are detailed below (correct as of 31 March 2022):

Name of PCN and PCN List Size	Clinical Director	Practice name	
Hambleton North 44,377	**Dr Mark Duggleby** Stokesley Health Centre	Stokesley Health Centre	Great Ayton Health Centre
		Mowbray House Surgery	Mayford House Surgery
Hambleton South 28,457	**Dr Sally Tyrer** Glebe House Surgery	Lambert Medical Centre	Thirsk Health Centre
		Glebe House Surgery	Topcliffe Surgery
Richmondshire 43,391	**Dr Richard James** Harewood Medical Practice	Scorton Medical Centre	Central Dales Surgery
		Quakers Lane Surgery	Friary Surgery

Name of PCN and PCN List Size	Clinical Director	Practice name	
		Catterick and Colburn Surgery	Harewood Medical Practice
		Leyburn Medical Practice	Aldbrough St. John
Whitby Coast and Moors 26,822	**Dr Simon Stockill** Whitby Group Practice	Sleights and Sandsend Medical Practice	Egton Surgery
		Danby Surgery	Staithes Surgery
		Whitby Group Practice	
Knaresborough and Rural 54,084	**Dr Chris Preece** Church Lane Surgery	Church Lane Surgery	Eastgate Medical Group
		Springbank Surgery	Beech House Surgery
		Nidderdale Group Practice	Stockwell Road Surgery
Heart of Harrogate 51,359	**Dr David Taylor** Dr Moss & Partners	Dr Moss & Partners	Church Ave. Med Grp
		The Leeds Rd Practice	Kingswood Surgery
Mowbray Square 30,076	**Dr Ian Dilley** East Parade Surgery	The Spa Surgery	Park Parade Surgery
		East Parade Surgery	
Ripon and Masha 29,000	**Dr Richard Fletcher** Dr Ingram and Partners	North House Surgery	Ripon Spa Surgery
		dir. Ingram & Partners	Dr Akester & Partners
North Riding Communities 38,677	**Dr Greg Black** Ampleforth and Hovingham Surgeries	Ampleforth and Hovingham Surgeries	Sherburn Surgery
		Ayton and Snainton Medical Practice	Derwent Practice
Scarborough CORE 51,517	**Sally Brown** Central Healthcare	Central Healthcare	Eastfield Medical Centre
		Brook Square Surgery	Castle Health Centre
Filey and Scarborough Healthier Communities 30,857	**Dr Catherine Chapman** Filey Surgery	Filey Surgery	Hackness Road Surgery
		Scarborough Medical Group	Hunmanby Surgery

PCNs continue to recruit to the Additional Roles Reimbursement Scheme (ARRS)[9] and we now have approximately 120 additional clinical staff employed through PCNs. Services established through PCNs in 2021/22 include Social Prescribers, Clinical Pharmacists working in GP practices, First Contact Practitioners (FCPs), Mental Health Workers and Physician's Associates.

[9] For more information on Additional Roles Reimbursement Scheme see https://www.england.nhs.uk/gp/expanding-our-workforce/

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

2.1.2 International GP Recruitment

The International GP Recruitment for the Humber and North Yorkshire region has continued despite the national programme ending in July 2020. In the financial year 2021/22 a further four International GPs (IGPs) have been recruited to the region with a further two arriving before the end of March 2022. This will bring the total to 21 overall.

As a result of the pandemic two of the IGPs returned home to be closer to family and four moved outside of the Humber and North Yorkshire Region. However, there are another three IGPs who are completing the Health Education England International Induction Programme with the intention of relocating to the UK in the first quarter of 2022/23.

Work continues with the Haxby Group with the aim of recruiting five IGPs for the group who will be supported via their training hub.

The current community of IGPs already in the UK offer a fabulous support network for anyone planning to relocate. Many of them offer temporary accommodation and even childcare for people moving to the region which is a huge help. They also offer support when preparing for the Health Education England assessments or General Medical Council registration.

A gathering was organised prior to Christmas which most of the IGPs and their families attended along with colleagues from Health Education England. This was the first social event for the IGPs that had been arranged due to COVID-19 restrictions and it was a great opportunity to get together with everyone and gain some mutual support.

2.1.3 GP Extended Access Service

The GP Extended Access capacity has been used to support the COVID-19 vaccination programme and specifically the booster programme prior to Christmas 2021. Since January 2022 Extended Access Services have returned to contracted levels of activity to support business as usual demand and is fully operational across North Yorkshire. This provides additional evening and weekend appointments with a range of primary care clinicians including GPs; nurses, clinical pharmacists and also provides dressing clinics, cervical cancer screening and phlebotomy.

The contracts for this service are currently held by the CCG. Responsibility for commissioning Extended Access will be transferred to PCNs in October 2022, delayed from April 2022. PCNs and CCGs can agree an earlier transfer if appropriate. The CCG is working with PCNs to develop plans for the contract changes and will submit draft plans to NHSE in July 2022.

2.1.4 Digital

The Humber and North Yorkshire (HNY) Strategic Digital Board co-ordinates investment and prioritises system-wide transformational change using digital tools and technologies. North Yorkshire and York CCGs continue to play a key role on the Strategic Digital Board driving digital change in the region.

The North Yorkshire and Vale of York Digital Transformation Collaborative which represents organisations delivering health and care to patients continues to receive good support and this year has played a key role in a number of integration projects delivering clinical benefit to our populations.

For instance, we have seen a successful implementation of a 'GP Portal' for practices in Harrogate using the Yorkshire and Humber Care Record (YHCR). This portal enables GPs to see relevant patient data from different care settings as they work with their patients to help provide high quality care.

The YCHR system can help with end-of-life care planning and is broadening system integrations across health and social care organisations in North Yorkshire.

Throughout the COVID-19 pandemic the CCG has had a strong focus on promoting options for accessing healthcare services, such as via NHS 111 online, the NHS App, and video consultations. A programme of face-to-face support from the voluntary sector to encourage people to download the App was commissioned by the Digital team at NYCCG as part of an ICS-wide programme of work to maintain good access to primary care over winter. The take-up of the NHS App by people in North Yorkshire continues to increase and as of January 2022 approximately 40% of patients registered with a GP practice have downloaded the App.

Over the winter period NYCCG commissioned 20,000 additional appointments using online, virtual access to real GPs and clinicians. The CCG also led on commissioning more virtual appointments for other areas across the HNY area, which has enabled the Primary Care system to provide a resilient service in the face of ongoing pressures through waves of infections during the pandemic.

Digital Inclusion continues to be a key focus for North Yorkshire CCG and the CCG chairs the HNY Digital Inclusion Group which brings together key digital inclusion leaders from across the ICS to drive forward opportunities for addressing and reducing Digital Inclusion. A new set of Digital Inclusion Principles has been developed through this group which is being used across Humber and North Yorkshire to help identify Digital Inclusion requirements as part of the ongoing roll-out of digital transformation.

2.2 Strategic Commissioning: To make the best us of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care

2.2.1 Worked Closely with our Health and Social Care Partners

The CCG has continued to strengthen partnership working to ensure a unified and agile response to the COVID-19 pandemic and recovery planning as we move through the pandemic. This includes collaborative working with NHS England / Improvement regional, relevant integrated care systems, North Yorkshire County Council and NHS Vale of York CCG. To learn more about our partners and our collective work please see sections 1.7, 1.8, 2.7, 2.8.1, 6.12, 6.14, 7 and 9.

2.2.2 Commitment to Integration

During 2021/22, we have continued to work closely with each of our NHS provider organisations, NHS Vale of York CCG as well as North Yorkshire County Council, City of York Council and voluntary services, to increasingly develop and commission services in an integrated way, as we build an integrated health and social care model across North Yorkshire. For more information on the work undertaken see section 2.7.

2.2.3 COVID-19 Vaccination Programme

The Accountable Officer of the CCG is the Senior Responsible Officer for the Humber and North Yorkshire Health and Care Partnership (Integrated Care System) Vaccination Programme with the Chief Nurse as the Senior Responsible Officer for the North Yorkshire and York system. As of 23 March 2022, vaccination uptake across each footprint was as follows:

	Humber and North Yorkshire		North Yorkshire CCG	
	Vaccinations	**% of population**	**Vaccinations**	**% of population**
First vaccination	1,362,660	80%	350,865	83.3%
Second vaccination	1,289,962	75.7%	333,667	79.3%
Third / booster vaccinations*	1,067,986	72.1%	288,000	78.2%
Total vaccinations	3,720,608		972,532	

** includes Spring booster vaccinations in progress*

An evergreen COVID-19 vaccination offer remains open to all eligible people, with vaccination bookings available via the National Booking Scheme or advertised on the CCG website. The Spring booster campaign commenced in March 2022 as per the Government Guidelines and the healthy 5 to 11 year-old programme started in early April. For further information please see sections 1.9, 6.21 and 7.4.2.

2.2.4 Long Term Conditions

Diabetes

Diabetes improvement workstreams have continued across all areas of North Yorkshire during 2021/22. We also continue to join the Humber and North Yorkshire Elective Diabetes Steering Group which leads the programme of work and drives transformation across the ICS geography. For more detailed information on the diabetes improvement workstreams please see section 6.7.

Respiratory Conditions

COVID-19 is a respiratory disease, so a series of innovations and developments have been put in place this year by respiratory teams in response. These include Post-COVID-19 services for adults and children, virtual wards for people who have COVID-19 to enable earlier discharge to a home setting, pulmonary rehabilitation services for Chronic Obstructive Pulmonary Disease (COPD) sufferers and FeNO (Fractional exhaled Nitric Oxide) testing to improve Asthma diagnosis and management. For more information on the improvement programmes for respiratory conditions please see section 6.8.

2.3 Strategic Commissioning: To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition

The CCG is a member organisation of the Humber and North Yorkshire Health and Care Partnership (Integrated Care System) and during 2021/22 has engaged in the development of a number of initiatives to support the recovery and restoration of planned care including:

- Optimisation of referrals into hospital services by offering specialist advice and guidance at the point of referral
- Maximising the use of virtual appointments where it is safe and sensible to do so
- Enabling patients to manage their own follow-up care (patient initiated follow-up)
- Identification of specialty redesign priorities
- Supporting patients who are waiting for their treatment by developing an approach to address health inequalities and avoid deterioration.

The CCG is working with the Collaborative of Acute Providers (CAP) of the HNY Partnership (ICS) to develop a standardised approach to clinical prioritisation and optimisation of capacity to support recovery of the waiting list position and is working closely with the Vale of York CCG as a key partner in the North Yorkshire and York strategic partnership.

2.4 Acute Commissioning: We will ensure access to high quality hospital based care when needed

The COVID-19 pandemic has continued to impact the delivery of acute hospital based care during 2021/22. Our acute trusts continued to address the backlog and to plan for recovery of the waiting list position during the year however capacity continues to be compromised by infection, prevention and control measures, isolation and social distancing combined with increased referrals into secondary care. All of these factors have impacted on recovery with people waiting longer for their routine treatment and care.

All waiting lists continue to be reviewed clinically to prioritise patients using a nationally designed framework ensuring that those with the most urgent clinical need are treated soonest.

2.4.1 111 First

The 111 First programme continues to work to connect people with the right care first time, every time when they have an urgent or emergency care need. This year the programme was further developed to include the clinical triage of 111 Emergency Department or A&E referrals through a GP to ensure their appropriateness and where safe to do so, offer alternative options for treatment. This has helped manage flows of patients through A&E departments ensuring that only patients who need emergency care are seen in A&Es.

To achieve this, clinical assessment of the patient's requirements takes place as close to their first contact with the NHS as possible. To deliver this increased clinical assessment capacity a local Clinical Advisory Service (CAS) remains operational across the Humber and North Yorkshire region with the aim of making this process increasing the number of clinical assessments that take place.

The local CAS commenced operation in December 2020. During April 2021 to March 2022 shows that where patients were referred to the local CAS (these patients would otherwise all have been directed to A&E) over 70% were safely redirected to alternative services and the remainder continued on with their A&E department referral. Assessment of patients using the CAS continues to show a high satisfaction rate. Work is now underway to consider the commissioning options for 2022/23.

2.4.2 A&E 4-hour Performance

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

The graph below shows demand and 4-hour performance during 2020/21 and 2021/22.

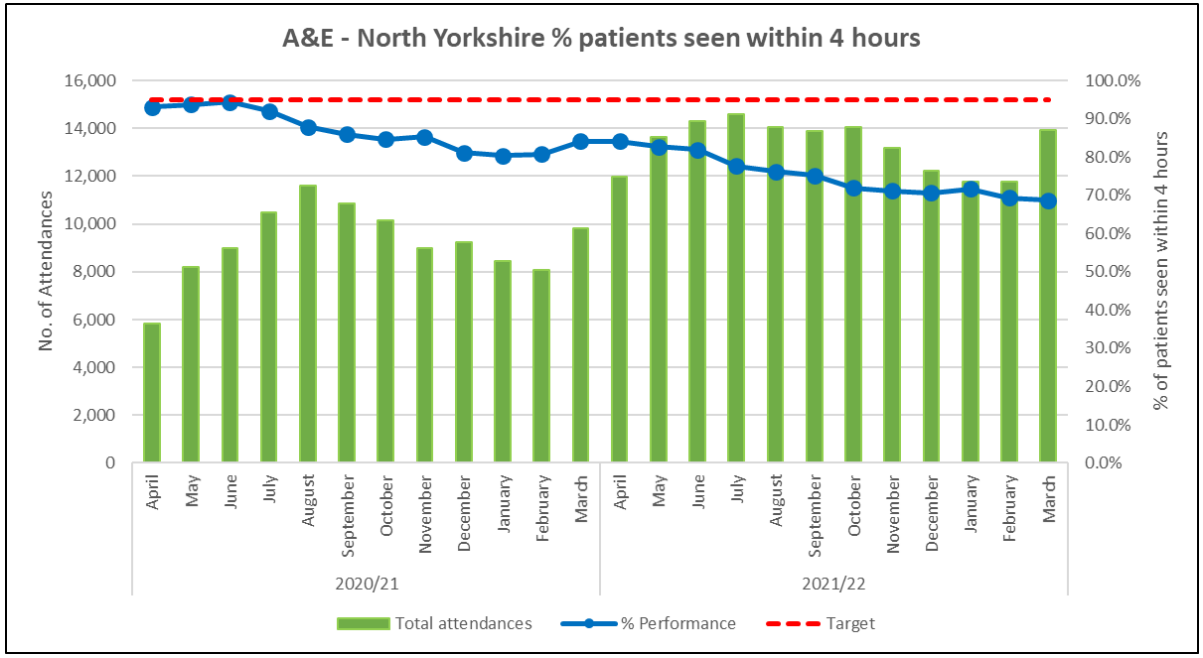
Significant challenges impacted on the overall 4-hour performance with increase in A&E demand in 2021/22 above 2020/21 levels.

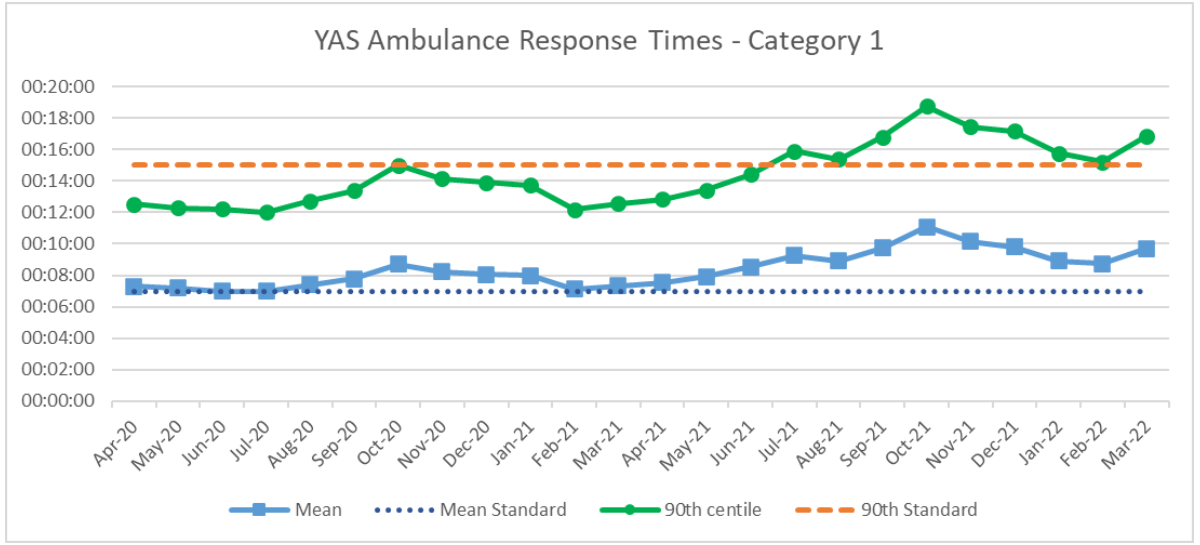
The local picture has been reflected nationally and regionally and includes:

- increased COVID-19 positive admissions
- higher acuity of patients attending by ambulance
- high bed occupancy
- bed closures due to necessary infection prevention and control measures, and
- significant workforce challenges due to COVID-19 and other related absences.

2.4.3 Yorkshire Ambulance Service – Ambulance Response Times

The three graphs opposite and below show the performance of Yorkshire Ambulance Service (YAS) NHS Trust against their trust-based Category 1 (the most life threatening priority calls), Category 2 (life threatening calls) and Category 3 and 4 (lower priority calls) response time targets during 2020/21 and 2021/22. For life threatening calls the target is to respond to Category 1 calls within an average of seven minutes and Category 2 calls within an average of 18 minutes.



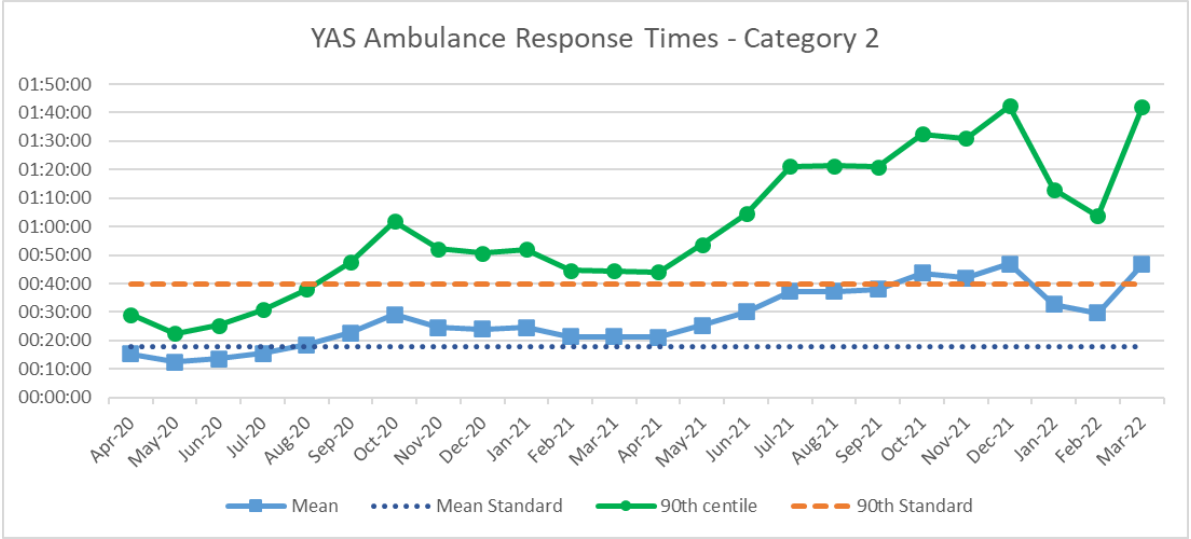


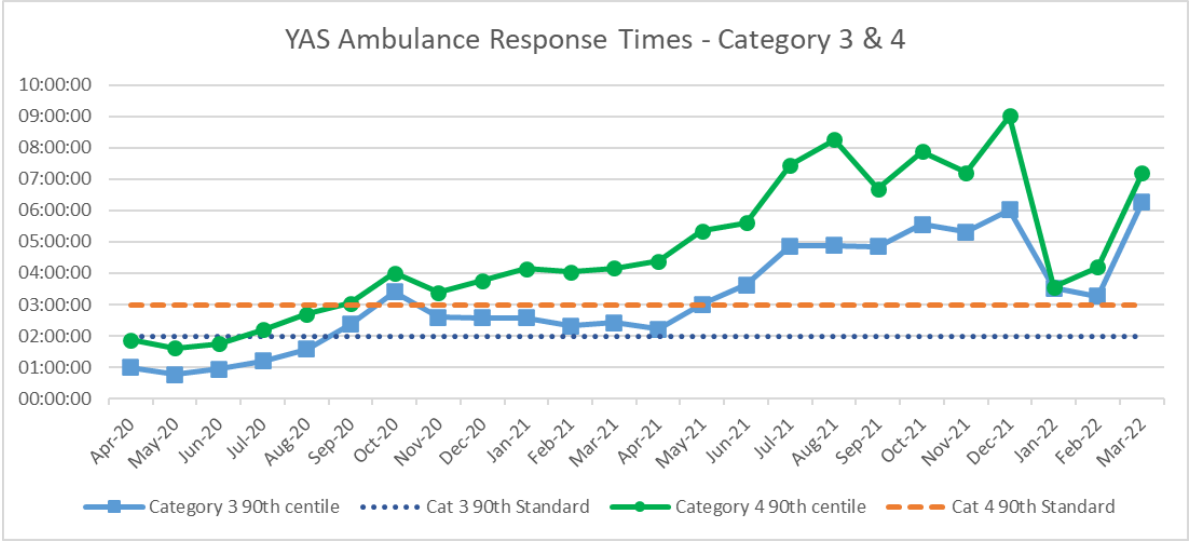
As 999 demand increased during 2021/22 response times to Category 1 calls achieved an average performance of around 9 minutes.

In response to Category 2 calls the target of 18 minutes was not met throughout 2021/22 with an average performance of around 36 minutes.

The target for Category 3 is for 90% of calls to be responded to within 2 hours and Category 4 is for 90% of calls to be responded to within 3 hours. Performance for Category 3 was not met throughout 2021/22 with an average of just below 4½ hours and for Category 4 an average performance of just below 6½ hours.

The charts demonstrate the increased demand on ambulance services during 2021/22 particularly to Category 1 and 2 life threatening calls and reflect the pressures encountered by hospitals as the country emerged from the pandemic.





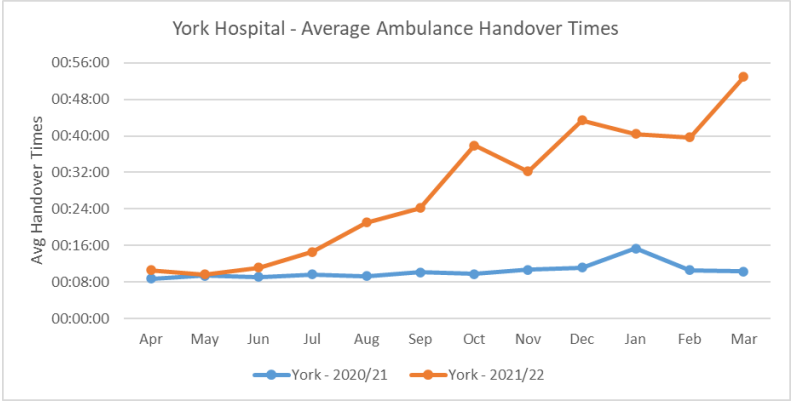
2.4.4 Yorkshire Ambulance Service (YAS) – Average Hospital Ambulance Handover Times

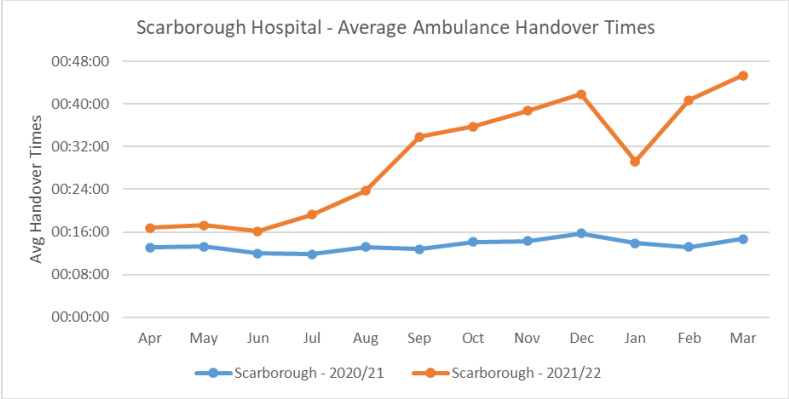
Patient handover is where the professional responsibility and accountability for the care of the patient is transferred from the ambulance crew to the medical/nursing staff at the hospital. Timely handover of patient care helps improve 999 response times to patients waiting in the community and as a consequence their clinical outcomes.

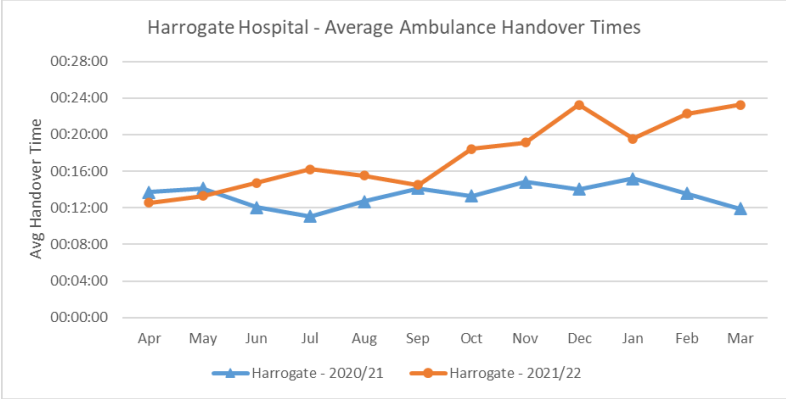
Turnaround time is the overall time taken for the ambulance crew to handover the patient, and then clean, restock and make the vehicle available to respond to another call. This is important as it affects the number of patients that YAS can respond to in a timely manner. Delivering and maintaining good handover times are dependent on a number of factors including surges of emergency activity, flow throughout A&E (particularly where patients require admission) and workforce.

The graphs opposite show ambulance handover times recorded at York, Scarborough and Harrogate hospital sites during 2020/21 and 2021/22.

The national target time for ambulance handovers is set at 15 minutes. While a significant amount of work was undertaken to improve ambulance handovers at both the York and Scarborough hospital sites during 2020/21 and 2021/22, as can be seen during Q1 of 2021/22, the pressures encountered by all hospital sites have resulted in rising ambulance handover times from Q2 onwards at York and Scarborough and from Q3 onwards at the Harrogate site.







2.4.5 Cancer Services

National and Local Ambitions

Throughout 2021/22, transformations to cancer pathways across North Yorkshire have continued to address the challenge set by the National Long-Term Plan for Cancer:

- By 2028, 55,000 more people each year will survive their cancer for five years or more, and
- By 2028, 75% of people with cancer will be diagnosed at an early stage (stage one or two).

However, the key priority throughout this year has been the recovery of cancer services impacted by the pandemic. The three national measures which have been used to monitor recovery are: referral rates, treatment rates and the number of patients waiting for more than 62 days for diagnosis or treatment.

Transformation of Cancer Services

Funding for the more substantive transformations have been directed via Cancer Alliances – three of which cover the North Yorkshire population (West Yorkshire; Humber and North Yorkshire, and Northern Cancer Alliance). Examples of such transformations include:

- **Rapid Diagnostic Pathways**: aim to promote faster diagnosis by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible. These initiatives include diagnostic pathways for serious non-specific symptoms and the design and implementation of optimal pathways for lung, prostate and lower gastro-intestinal cancers. All three trusts which provide a service for North Yorkshire patients have diagnostic pathways in place for patients who have serious non-specific symptoms. As these pathways have proved effective in providing timely diagnoses – trusts are considering which other cancer pathways could benefit from this approach. In addition, our trusts have/will be working towards implementation of the skin, head and neck and gynaecology optimal pathways. All optimal pathways are designed to provide a diagnosis by day 28 from referral.
- **Diagnostic Capacity/ Imaging**: Diagnostic services across the country are challenged by the demands associated with an increasing incidence of cancer (as a result of an ageing population) and the fluctuation in demand afforded by the pandemic. Provider trusts are working in partnership to develop 'network' services, enabling them to share images – providing a more resilient reporting service between them. Similar partnerships are developing regarding pathology and endoscopy services.
- **Introduction of new diagnostic technologies**: new diagnostic technologies which can be utilised alongside existing procedures e.g., capsule endoscopy which uses a small camera inside a pill-shaped capsule to take pictures of your gastro-intestinal tract. It is used to detect and diagnose conditions like gastro-intestinal bleeding, Crohn's disease, and coeliac disease. This initiative has been implemented at Harrogate, South Tees and York Hospital trusts.
- **Personal Stratified Follow Ups (PSFU)**: PSFU is an effective way of adapting care to the needs of patients after cancer treatment. The ambition for breast, colorectal and prostate cancer patients is that a significant proportion of patients have moved to supported self-management pathways with remote surveillance and guaranteed access back to their cancer team when needed. Work progresses across all three providers to secure PSFU pathways for breast, prostate and colorectal cancers

with ambitions to include at least two other pathways (to include endometrial cancer). Providers are also considering digital solutions which can enhance follow up care for patients.

- **Teledermatology**: Teledermatology refers to the application of photographs of skin lesions taken in primary care settings which are then viewed by dermatologists in secondary and tertiary settings. Whilst these services are currently available in York and Scarborough and Cancer Alliances are supporting wider implementation of this initiative.

Impact of COVID-19

At the start of the pandemic, we saw a reduction in the number of people coming forward to have their symptoms clinically evaluated, and disruptions to cancer diagnostics and treatment. In summary, patient footfall into primary care has increased, resulting in referral rates for suspected cancers at rates higher than pre-pandemic rates. As a consequence, there has been a detrimental impact on performance – for example the numbers of patients waiting in excess of 62 days for a diagnosis/ treatment of their cancer. This experience has been replicated in trusts and cancer alliances across the country. Throughout the year there has been a will continue to be a focus on reducing the numbers of patients who are waiting for more than 62 days. However, it is important to note that there may be valid clinical reasons why patients experience prolonged waits. For example, they may be waiting to recover from other illnesses or treatments before cancer treatment can commence.

Actions taken to improve the uptake of cancer services and ensure safe provision of cancer treatment and care have included:

- National and local campaigns to restore public confidence in accessing services during the pandemic, for example, there has been a recent national campaign to support early awareness of prostate cancer.
- Use of technology to provide, where possible and appropriate, virtual consultations with medical/ nursing staff in primary and secondary care
- Ensuring the workforce 'aligned to cancer' are protected from transfer to other services throughout the pandemic
- Ensuring those patients at highest risk of cancer have access to services via clinical triage of referrals (e.g., lower gastrointestinal referrals), continual risk assessment of those individual who are waiting for diagnostic procedures and/ or treatments and 'safety netting' of those individuals in primary care and secondary care who have been unable to attend health services during the pandemic
- Diagnostic pathways have evolved on some cancer pathways to manage patients on cancer referral pathways more effectively and efficiently. For example, the expanded use of FIT (a stool test designed to identify possible signs of bowel disease by detecting minute amounts of blood in faeces) has been used to risk stratify lower gastrointestinal cancer referrals.

COVID-19, Cancer and Inequalities

As a key stakeholder engaged in the commissioning and provision of cancer services, the CCG has a duty to support and ensure equity of access to services and there is focussed attention at national and local level to detect and address inequalities which may have been exacerbated by the pandemic. Cancer alliances are working with North Yorkshire CCG to identify and design services which address identified inequalities, see also section 8.2.3.

2.4.6 Stroke Services

National Ambition

The NHS Long Term Plan sets out the ambitions for the NHS over the next 10 years, identifying stroke as a clinical priority. It describes how partners will work together to improve stroke care along the full pathway from symptom onset to ongoing care. This includes prevention, treatment and rehabilitation.

A selection of the specific aims of the national programme include:

- Improve post-hospital stroke rehabilitation models for stroke survivors
- Deliver a ten-fold increase in the proportion of patients who receive a clot-removing thrombectomy (surgical removal of clot) so that each year 1,600 more people will be independent after their stroke
- Deliver clot-busting thrombolysis to twice as many patients, ensuring 20% of stroke patients receive it by 2025
- Ensure three times as many patients receive 6 month reviews of their recovery and needs – from 29% today to 90%.

Meeting the ambitions in the Long Term Plan would result in the NHS having the best performance in Europe for people with stroke.

Humber and North Yorkshire Integrated Stroke Delivery Network (HNY ISDN)

During 2021/22, the HNY ISDN was established to support and enable the local contribution to the national targets and ambitions for stroke. Membership of the HNY ISDN includes clinical and managerial colleagues from across the integrated care system who have an interest and/ or a responsibility in the delivery of stroke services.

A Senior Responsible Officer (Director Lead), Clinical leads and a Programme Lead have been appointed and a work programme has been agreed. For more information on the HNY ISDN work programme please see section 6.10.

2.4.7 Ophthalmology

The existing Minor Eye Conditions Service has been reprocured to a Community Eye Care Service, which is an enhanced and extended service available across all of North Yorkshire and Vale of York. The new model commenced on 1 December 2021 in Vale of York and Ryedale areas and 1 February 2022 in Hambleton, Richmondshire, Whitby and Harrogate areas. This model will avoid unnecessary hospital attendances, improve patient access to ophthalmology services closer to home and give early patient advice where self-management is appropriate.

We have also joined the Humber and North Yorkshire Eyecare Steering Group with further information on their work priorities detailed in section 6.9.

2.4.8 Orthopaedics and Musculoskeletal

Local orthopaedic pathways are continually being reviewed against current best practice guidance and to move in line with national evidence-based interventions policies.

Work has continued with our acute hospitals to implement new and/or improved pathways with orthopaedic consultant colleagues, musculoskeletal clinicians and musculoskeletal radiologists regarding spinal, hip, knee and shoulder radiology diagnostic pathways across North Yorkshire, see also section 2.6.5.

2.5 Engagement with patients and stakeholders: We will build strong and effective relationships with all our communities and partners

Everyone has a stake in the health of their community. Health matters to people and we put effective communication and engagement at the heart of what we do. We want to listen to our patients, their carers and representatives to make sure we secure the best quality services we can with the resources we have available.

Our engagement aims are to:

- Uphold our commitment to “no decision about me, without me”
- Listen and take patient experiences into account when we are developing local healthcare services
- Communicate to ensure our staff, partners and patients are kept informed, with access to information people need, when they need it
- Involve people in decisions which affect them at the right time
- Recognise potential barriers to communication and engagement and be open and accessible to all of our communities.

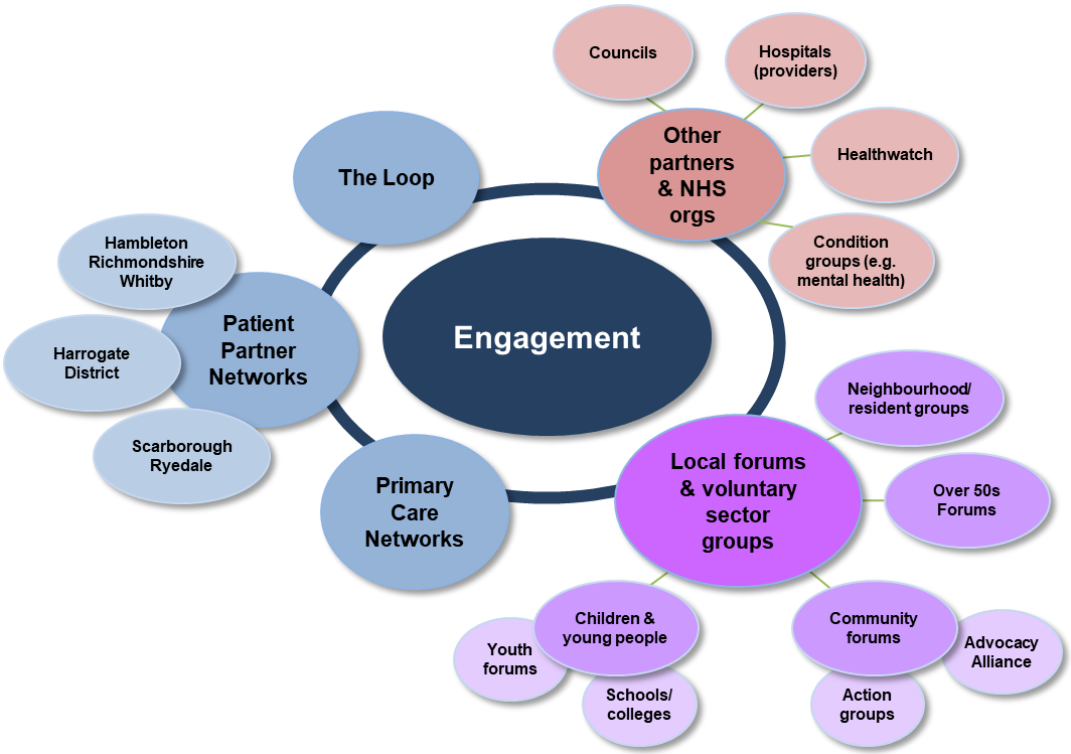
This approach to engagement helps ensure patient and community perspectives and experiences improve the quality of our commissioning and health outcomes as well as increased awareness and understanding of the CCG and its role. We have a five-year Communications and Engagement Strategy which helps shape our work, which is underpinned by an action plan. You can find our Communications and Engagement strategy on our website[10].

COVID-19 shaped our activities this year, but it did not prevent us from communicating fully and effectively with patients and our communities or engaging with the people who use our services. You can read more about our key activities this year below.

2.5.1 Our Patient Partner Network

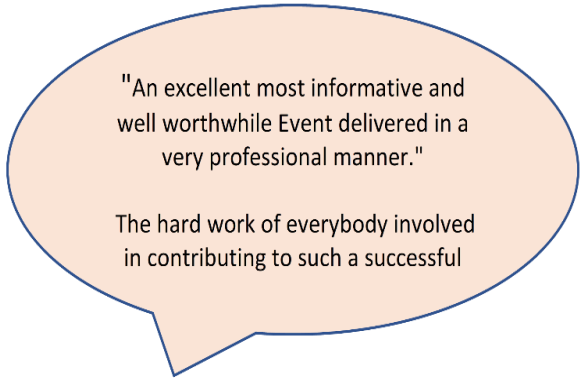
The CCG Patient Partner Network is made up of two members of each practice's patient participation group. The Network has three locality chapters: Harrogate and Rural District; Hambleton, Richmondshire and Whitby; and Scarborough and Ryedale.

The network is designed to act as a conduit for communication between the CCG and practice patient participation groups and represent patients, carers and the wider public, ensuring that the patient and public voice is heard and informs the commissioning of local healthcare. The network meets four times a year – in spring and winter in locality meetings and in summer and autumn across the network.



[10] https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/08/NYCCG-communications-and-engagement-strategy-FINAL.pdf

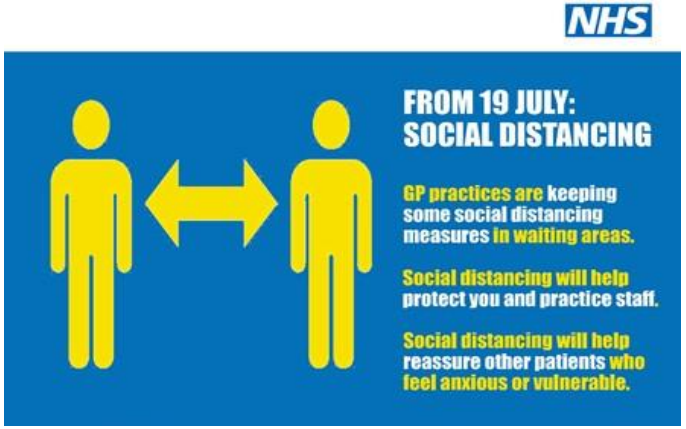
This year we have made significant strides in embedding and strengthening this network. October 2021 saw our first annual conference, designed and led in partnership with patient partners. This conference brought together members from across North Yorkshire to share experiences and discuss current issues of interest. The patient partners have discussed primary care during the COVID-19 pandemic, self-care and pharmacy provisions, the integrated care transformation across the NHS and local government, CCG finances, primary care networks and a number of other important topics over the last year. You can find out more about the North Yorkshire CCG Patient Partner Network, including notes of past meetings, on our website[11].



2.5.2 Keeping People Connected

Website

In May 2021 we launched the new CCG website. This website ensures members of the public, clinical partners and colleagues have access to current information about healthcare and services in North Yorkshire. COVID-19 safety, information about the COVID-19 vaccination programme, and safe access to healthcare services during the pandemic, have all featured on our website this year.



The number of unique users and page views has increased rapidly since the website went live, from 5,400 users who accessed the website in the month following its launch to around 19,000 users in the month to date in January 2022.

During November and December, when demand for booster and third jabs was particularly high, approximately 74,000 unique individuals accessed the website, generating almost 160,000 page views, including 90,647 visits to the page containing information about walk-in clinics and 11,278 visits to the page about booster jab opportunities.

We have continued to build the site over time and now have over 435 published pages. We have also developed a bespoke clinical portal to meet the needs of primary care colleagues and a staff portal to bring together key policies, templates, resources and opportunities for staff in one place.

[11] https://www.northyorkshireccg.nhs.uk/get-involved/patient-partner-networks-ppns/

Information is available for speakers of languages other than English and in easy read formats for those who may benefit from those additional resources. Our website features 'Browse aloud' and 'Google Translate' features to both provide adaptive technology and access to information for non-English speakers. We have added Pashto to the list of languages available for translation as part of the humanitarian effort in North Yorkshire to resettle Afghan families given asylum status in the UK into the local area.

Stakeholder newsletter

We produce a stakeholder email each month. This is distributed to roughly 400 people and covers news about the CCG's activities and developments in the broader health and care environment. You can sign up for the stakeholder newsletter here: https://www.northyorkshireccg.nhs.uk/sign-up-for-our-newsletters/

The Loop

The Loop is a virtual engagement network of patients, carers and the wider public with interests in health services funded by the CCG. It is free to join and Loop members get first-hand information about the work of the CCG and developments to health services across North Yorkshire. Members receive a monthly stakeholder newsletter (electronically) with the latest news and events and have the opportunity to contribute their views through topical surveys, focus groups, events and meetings. You can be in the Loop here: https://www.northyorkshireccg.nhs.uk/get-involved/the-loop/

THE LOOP

Patient Stories

We gather and share 'Patient Stories'[12], highlighting patient experiences of healthcare during the COVID-19 pandemic. This is part of the wider patient engagement work which also involves the Patient Partner Network in North Yorkshire. These personal and insightful stories provide the CCG with valuable information about the patient experience and also help demonstrate how care continued during the pandemic. They were part of work to help encourage everyone to access the care that they needed and not delay seeking guidance from a healthcare professional if they felt unwell.

[12] https://www.northyorkshireccg.nhs.uk/get-involved/patient-stories/

Social media

We have three active social media sites, on Twitter[13], Facebook[14] and Instagram[15]. These valued platforms help us share information and promote health and wellbeing campaigns. This year our social media presence has helped us share information about local access to COVID-19 vaccinations, promote safety as the COVID-19 pandemic continued, encourage the use of NHS111 and the NHS App, promote our winter wellness and flu vaccine programme, increase visibility of cancer services, 'Pharmacy First' and self-care and access to mental health services and crisis care.

Annual General Meeting

Approximately 36 members of the public joined us at our first virtual Annual General Meeting on 7 July 2021. There was positive feedback from the meeting, which attracted nearly twice as many participants as the meetings held last year for the three previous CCGs for North Yorkshire.

Broadening our reach

This year we have increased our expertise with digital engagement which is helping us reach audiences who may not have participated in the past, such as working age adults or young people. As we emerge from the pandemic, we will have the opportunity for blended engagement which will make use of our enhanced digital engagement approach coupled with face to face engagement. This will help us continue to reach communities across North Yorkshire.

[13] https://twitter.com/NorthYorks_CCG
[14] https://www.facebook.com/NorthYorksCCG/
[15] https://www.instagram.com/northyorks_ccg/

2.6 Financial Sustainability: We will work with partners to transform models of care to deliver affordable, quality and sustainable services

2.6.1 Managing the CCG Finances

The emergency financial measures introduced during 2020/21 to respond to the COVID-19 pandemic have continued into 2021/22, with the added focus on restoration and recovery of services.

NHS organisations have again received system allocations and have worked together to manage a breakeven position across the system and manage pressures collectively. The system funding covers all business-as-usual activities, COVID-19 spend and funding to improve elective recovery.

Our CCG forms part of the North Yorkshire and York System, which includes the following main NHS partner organisations:

- NHS North Yorkshire CCG
- NHS Vale of York CCG
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust

North Yorkshire CCG is the lead CCG for this system and as such receives system level allocations, and not just those relating to the population of North Yorkshire CCG.

For providers outside of our system (e.g., South Tees Hospitals NHS Foundation Trust, Humber Teaching NHS Foundation Trust, Tees Esk and Wear Valleys NHS Foundation Trust), COVID-19, winter monies and other system funding has been provided through their own local systems.

To aid with the recovery of services, additional funding has been made available in year, this has been in the form of Elective Recovery Funding (ERF) for acute services, Hospital Discharge Programme (HDP) Funding and Winter Access Funding (WAF) for primary care.

The 2022/23 Financial regime is effectively a roll forward of the 2021/22 financial allocation with a reduction for non-recurrent COVID-19 allocations, an increase for ERF and the end of funding for the HDP. North Yorkshire CCG will form part of the Humber and North Yorkshire Integrated Care Board (ICB), whilst the Health and Care Bill works its way into legislation, all CCGs have developed financial plans for the full 12 months of 2022/23 but within an overall ICB resource allocation limit. The 2022/23 resource allocation for Humber and North Yorkshire ICB is £3.3 billion, with North Yorkshire CCG's allocation being £851m. North

Yorkshire CCG has submitted a breakeven plan, achievement of this plan will require delivery of a £6m savings and efficiency requirement (4%).

The CCG had a cumulative deficit prior to the pandemic of £45m, this deficit will also transfer into the Humber and North Yorkshire ICB, this matter will be reviewed alongside the position of each constituent CCG in the ICB, current guidance states that if the ICB achieves break even for each of the following two years (2022/23 and 2023/24), the cumulative deficit will be written off.

2.6.2 Sustainable Services in Acute Commissioning

The focus of all acute providers over the last 12 months has been to ensure that those patients needing hospital care for both COVID-19 and non-COVID-19 related reasons could be treated optimally and safely in hospital. A number of priority initiatives that were being worked up pre-COVID-19 have been accelerated during the pandemic i.e., telephone triage (NHS111 First) and virtual consultations. These initiatives are now embedded and are routinely offered supporting optimal treatment and care ensuring that patients only attend hospital settings when necessary (see section 2.4).

2.6.3 Outpatient Transformation

During 2021/2022 the Humber and North Yorkshire (now Humber and North Yorkshire) Outpatient Transformation Board has been initiated, with three dedicated workstreams reporting into the board. North Yorkshire CCG has joined both the board and the workstreams that lead the programme of work and drive transformation across the ICS geography. This programme of work aims to support elective recovery by transforming outpatient services and adopting and embedding new ways of working and therefore creating capacity to support the wider system.

The acute hospitals continue to offer high quality, responsive advice and guidance and clinical triage services to improve access for primary care. This provides expert input at the point of referral, ensuring that patients receive their treatment and care in the most appropriate setting.

They also continue to offer and increase usage of video / telephone appointments where appropriate whilst maintaining equity of access for all patients. The teams are working with digital colleagues to explore, embrace and maximise digital opportunities which will give patients greater control and convenience for their NHS hospital or clinic appointments. This includes the Personalised Initiated Follow Ups initiative, which has been adopted in up to 5 specialities in each acute hospital. Patient initiated follow up allows the patient direct access to book their own appointment when needed and therefore reduces unnecessary follow up visits, reduces patient waiting times and releases clinical teams to see other patients in a timely manner.

They have also begun the gap analysis to understand and standardise as far as possible referral pathways, guidance and commissioning statements across the ICS footprint.

2.6.4 Alternative Care Models

The CCG continues to work with providers to deliver safe, efficient care which makes the best use of clinical and patient time.

The pandemic has increased the use of technology to deliver virtual consultations and the CCG will continue to support its continued use across all providers. New ways of providing virtual Multi-Disciplinary Team (MDT) clinics to enhance a shared care approach between primary and secondary care clinicians have been developed. This will enhance the management of long term conditions and avoid unnecessary outpatient clinic appointments.

2.6.5 Musculoskeletal First Contact Practitioners

During 2021/22 the CCG worked collaboratively with Primary Care Networks and hospital providers to implement Musculoskeletal First Contact Practitioners (FCPs) across North Yorkshire. This service enables patients with musculoskeletal conditions to access expert advice at the start of their care pathway from their local GP practice. The FCP role has had a positive response from service users and has developed excellent working relationships between primary and secondary care colleagues. It has demonstrated reduction in inappropriate referrals to secondary care services such as physiotherapy, orthopaedics and radiology and ensures that patients who do need ongoing treatment are seen by the right clinician, in the right place, first time.

2.6.6 Policy Harmonisation

During 2021/21, the commissioning policies of the three former CCGs which became North Yorkshire CCG on 1 April 2020 were harmonised and launched to ensure provision of equitable access to care across North Yorkshire.

2.6.7 Continuing Healthcare

During 2021/22 Continuing Healthcare (CHC) continued to play an important role in ensuring the healthcare system has been able to manage the discharge of patients from hospital settings safely and efficiently, prioritising safe discharge. The initial backlog in formal case assessments have now been completed on target.

An Actual Cost of Care review was undertaken jointly across services commissioned by North Yorkshire County Council, City of York Council, Vale of York CCG, The Independent Care Group and North Yorkshire CCG. This included reviewing services from health and social care and independent care providers to determine costs for different levels of funding needed from each service commissioner. This work formed the basis of weekly rates for residential/nursing and domiciliary care across North Yorkshire and York and revised market management plans during 2021/22.

The CHC team has implemented a policy in 2021/22 that enables families to 'top up' care costs to provide additional services over and above those identified as health costs.

2.6.8 Medicines and Prescribing

While there has been reduced attention on improving value for money in the use of medicines during the COVID-19 pandemic, significant progress has been made by active implementation during periods where resources allowed. The pursuit of rebates, active use of software to influence improvements in safety and value, as well as investment in practice level activity have all helped realise financial benefits. The CCG's Medicines Management Team invested considerable time to work with an independent sector provider prior to the surge in COVID-19 booster vaccination activity, which allowed external pharmacists to safely deliver carefully selected changes to medication with minimal intrusion on practice personnel (when booster vaccination did commence). The results of this project will be reported later in 2022 but collated feedback to date indicates that the savings programme was well received and financially beneficial for the years ahead. For more information on the work the Medicines Management Team has undertaken in 2021/22 please see section 6.18.

2.6.9 Reducing Antibiotic Resistance

The use of antimicrobials remains an area of focus, with overuse and drug selection being of great importance. Use of antimicrobials has remained low but the proportionate use of restricted antimicrobials had been growing since COVID-19 began to impact on health. This has been well managed by the Medicines Management Team and partners to keep prescribing below national rates through general and targeted education as well as audit and review of prescribing habits (see also section 4.3.3).

2.6.10 Palliative Care Prescribing

The Medicines Management Team reviewed and implemented the reestablishment of a service for 'Assured access to palliative care medicines', unifying variable arrangements across the CCG footprint with the valued and appreciated engagement of community pharmacy, prescribers and palliative care experts.

2.7 Integrated / Community Care: With our partners and people living in North Yorkshire we will enable healthy communities through integrated models of care

2.7.1 Integrated Operating Model: Place based innovations

During 2021/22, we have continued to work closely with each of our NHS community provider organisations: Humber Foundation Trust (HFT) for Scarborough, Ryedale and Whitby areas; Harrogate and Rural Alliance (HARA), a partnership between Harrogate District Foundation Trust (HDFT) and North Yorkshire County Council (NYCC); and South Tees Hospitals Foundation Trust

(STHFT) for Hambleton and Richmondshire. We have also worked closely with NYCC to increasingly develop and commission services in an integrated approach, as we build an integrated health and social care model across North Yorkshire.

The goal for all organisations is to develop integrated operating models that build care around the person, not the organisation, supported by effective multi-disciplinary team working. This journey has in many ways been accelerated during the pandemic, as organisations and teams have had to work together in innovative and different ways to respond to the challenges COVID-19 has created. Working with partners, we are in the process of consolidating what has been achieved from the last two years and taking the learning into designing and building the next stages of an optimised integrated model.

There are a number of examples of emerging good practice over the last 12 months:

- HARA, where health and social care services are brought together supported by underpinning section 75 agreements, has continued to develop increasingly integrated and innovative operating models. The major development has been the establishment of the ARCH (Acute Response and Rehabilitation in the Community, Hospital and Home) model to support discharge. This is a partnership between health and social care services in the community, in-reaching into Harrogate Hospital, to facilitate earlier discharge into 35 therapy-led virtual ward beds.
- In Hambleton and Richmondshire, STHFT has developed an integrated model of care that brings together community-based services such as crisis response and long-term conditions management, together with acute-based ambulatory care based at the Friarage hospital, supported by community geriatricians, aligned social workers and a new single point of referral.
- In Scarborough and Ryedale, frailty has been one of the main priorities established by the local Partnership Board, which has strengthened system working between HFT, York and Scarborough Hospitals NHS Foundation Trust (Y&SHFT), primary care, NYCC and voluntary and community-based services.

The principles of delivering integrated care as part of new operating models are further embedded throughout the more detailed sections on specific community developments (set out in the sections below).

2.7.2 Integrated Operating Model: Frailty

The development of services to support people with frailty continues to be a major priority for North Yorkshire place. This is particularly important given that the impact of the pandemic has been a greater level of deconditioning amongst some frail elderly people due to isolation.

In the Scarborough and Ryedale area, we have worked with HFT to redesign the local frailty service. A refreshed service model was relaunched to primary care in December 2022, with a greater focus on anticipatory care planning for people with moderate or

severe frailty, as assessed using the Rockwood Clinical Frailty Scale (CFS). The multi-disciplinary team will undertake a comprehensive geriatric assessment, identify proactive treatment and support, and develop a care plan. HFT have also continued the process of training their own staff on the CFS, as well as delivering educational sessions for partners. We have also worked with partners to look at the wider requirements of the frailty pathway in the area, in a project led by York and Scarborough Trust, sponsored by the Humber and North Yorkshire (HNY) Shared Care Record programme.

In Hambleton and Richmondshire, the focus has been on re-establishing the successful Local Enhanced Service in primary care to support people with moderate and severe frailty. GP practices resumed undertaking modified geriatric assessment and developing care plans. Individual practice sessions were held with the CCG's frailty lead GP to discuss progress and clarify objectives. The Richmondshire Primary Care Network also piloted a Care Home visiting model, again to help support the needs of frail elderly people. The local acute and community provider, STHFT, has continued to strengthen its integrated ambulatory and community care model that places responding to frail elderly people at its heart. Geriatricians based within the Friarage Hospital are now out-reaching into the community to support frail elderly people in their own homes during a crisis. STHFT is also leading the process of developing a group of professionals who are more expert in frailty using the Enhanced Competencies for Older People Framework.

In the Harrogate area, the Primary Care Networks (PCNs) led the process of creating a home-visiting occupational therapy team, which will support people identified as housebound or severely frail. This team will work closely with HARA to deliver seamless services. HARA have also worked with the NYCC Stronger Communities team and representatives of the Voluntary Sector to design a guide to what support should be available for frail people in the community aligned to the different levels under the Rockwood Clinical Frailty Scale. This will help to signpost people in the future to alternative sources of support.

Finally, as a system, together with the Vale of York CCG, we are participating in a national improvement programme for frailty led by NHS Elect. This brings together national examples of good practice and teams from around the country and supports them with quality improvement methodology and data capture and measurement to demonstrate progress. The programme runs from October 2022 to September 2023. The local ambition is to use the programme to help us complete the process of implementing the Rockwood Clinical Frailty Scale across the whole of North Yorkshire and York, across primary care and broader partners, supported by appropriate training and technology to share records and care plans.

Community Care to Avoid Unplanned Admissions

One of the major projects in 2021/22 has been to develop 2-hour Urgent Crisis Response Services across North Yorkshire. These services are an important part of the infrastructure that will help to support frail older people to remain at home in a crisis, rather than being admitted to hospital. Typically, they will see people with conditions like a urinary tract infection, mild delirium, an infection requiring IV antibiotics, or a recent fall.

While services were previously in place in parts of the county, coverage wasn't complete, and services didn't fully meet the requirements of the new national service specification or deliver the expected level of performance. Services will now all be listed on the 111 Directory of Service (DOS), track activity and performance using the Community Service Dataset, and be available from 8AM to 8PM, 7 days per week.

Using 'ageing well' funding, we agreed a development plan with each community provider so that a new or extended service would be in place by March 2022.

Harrogate was the one area that didn't previously have a service. We therefore agreed with HARA a new operational model. They have held a Rapid Improvement Workshop with partners, including the Yorkshire Ambulance Service, and recruited to a range of new roles. The service will go live in March 2022 and will gradually develop the skills of the new team and the volume of patients seen through the service during the next year.

HFT already provided a crisis response service, but it was limited in capacity and linked to broader intermediate care provision. Further investment has allowed a separate crisis response service to be established, which will be now operate 7 days per week in all areas.

STHFT also already provided a service across Hambleton and Richmondshire. This model was a fundamental part of STHFT's plans for an integrated frailty response. The service has therefore been strengthened with additional therapy capacity and also generic staff who can provide night sitting to enable more people to remain safely in their own homes. We have also worked with STHFT to start a pilot for admission avoidance beds in a suitable residential home in the community, to help people recover from a delirium in an alternative environment to hospital.

2.7.3 Integrated Operating Model: Improving Hospital Discharge Processes and Reducing Delayed Transfers of Care (DTOCs)

Supporting people to leave hospital has continued to be a priority during the last year, particularly as the NHS has started to return to business as usual and address the elective backlog created by the pandemic. The level of activity, combined with the continued volumes of people with COVID-19, has meant maintaining fast discharges has been challenging throughout the year. This has been exacerbated by a difficult care market for onward placements.

The CCG has worked closely with Vale of York CCG (VoY CCG), North Yorkshire County Council (NYCC) and City of York Council (CYC) to deliver support to local hospitals and meet the requirements of the National Discharge Policy. Leadership has been provided by two Discharge Co-ordinators across North Yorkshire and York, supported by two new system flow co-ordinators. A silver command structure has operated throughout the year to provide a weekly forum where all partners can come together to assess system performance, with Executive Level Senior Responsible Officer support from both NYCC and NYCCG.

Key elements of the discharge model that were established and developed include: a 7 day ‘discharge to assess’ approach based on trusted assessment, the operation of discharge hubs within each of the four main hospitals by NYCC supported by enhanced assessment and brokerage capacity, a lead commissioner role for onward care through NYCC, and joined-up assessment and support of CHC/Fast Track outside of the acute environment.

These systems were further strengthened through additional capacity in the community. Designated beds into which COVID-19 positive people can be safely discharged were established in line with Care Quality Commission (CQC) guidelines and authorisation. Additional care home capacity was block-booked to ensure a range of options in nursing and residential settings, particularly over the winter period. We worked with NYCC to establish Discharge Enabling Grants, to enable informal carers to step-in for a short period until an arranged domiciliary care package was able to commence.

NYCCG, VoYCCG and NYCC have worked with Medequip to strengthen the provision of community equipment in support of discharge, as well as to meet needs identified within the community. A rapid authorisation rota was in place throughout the pandemic, which enables non-stock and special items of equipment needed to on discharge to be arranged more quickly. We have also responded to stock shortages, continually sourcing and approving alternative items when the usual stock isn't available. We are currently in the process of working with Medequip to implement an improved community ordering system through a new community on-line module, supported by clearer roles and responsibilities for community provider organisations and their staff.

Looking ahead, we are ending the year by further revising the discharge model to prepare for the end of the National Discharge Fund. From 1st of April 2022, those who may contribute to their care on discharge will again do so. However, we are looking to provide greater support to help these people to arrange onward placements. We have also commenced a review of the future discharge arrangements over the next few years, including how we can strengthen reablement and rehabilitation capacity in the community.

Enhanced Health in Care Homes

Work to support care homes is undertaken in a range of ways, particularly through the CCG's nursing and quality team and also through NYCC. However, several initiatives have also been undertaken as part of the CCG's Ageing Well programme.

The Immedicare service is delivered in partnership with Airedale NHS Foundation Trust and technology experts Involve Visual Collaboration Ltd. The service offers video enabled clinical support for care homes, allowing care homes to connect directly with a clinical hub offering medical advice and guidance 24/7, 365 days/year. The service allows frail and elderly residents to be clinically assessed in their own surroundings, lessens their anxiety, and helps to prevent unnecessary visits to A&E Departments or admission to hospital. The service offers care homes an extra layer of resilience and increases staff confidence.

Immedicare was introduced to care homes in Hambleton, Richmondshire and Whitby Localities in 2016. In November 2021, Immedicare was extended into a further 20 residential homes across Scarborough, Ryedale and Harrogate. We are now further extending the service to 16 nursing homes across the same area. This will bring the total number of nursing, residential homes and extra care facilities with access to the system in North Yorkshire to 62.

We are also working with the NHS Improvement Academy to support 18 homes with a development programme. The work involves facilitated support to implement a process of safety huddles and how to recognise and respond to the deteriorating person. The first few homes are already participating in the programme and more will join in the following year.

Voluntary Sector / Stronger Communities

During the last year, the Voluntary, Community and Social Enterprise (VCSE) sector has continued to deliver an important role in supporting people through the pandemic and in helping people to achieve improved health, wellbeing and care outcomes.

A wide range of services are commissioned through North Yorkshire County Council (NYCC), including the Community Support Organisations (CSO), which have been vital to communities over the past two years. These 23 organisations have ensured everyone who needs help has someone they can call on, covering a range of things such as: shopping for food or other essentials, collecting and delivering prescriptions, caring for pets, using on-line technologies, and addressing loneliness. The NHS has provided additional resource this winter to strengthen the CSOs in the Scarborough area, in recognition of the particular pressures created there by the pandemic. We have similarly strengthened the VSCE-delivered Home from Hospital services in Harrogate and Scarborough to support discharges from hospital, again using NHS resource designed to address system pressures.

A range of services are jointly commissioned in the VSCE sector between NYCCG and NYCC as part of the Better Care Fund. These include services for Carers and Advocacy, both of which are currently being reprocured to secure longer-term services, led by NYCC.

The CCG continues to work collaboratively with Community First Yorkshire (CFY), the umbrella organisation providing practical support and advocacy to voluntary and community organisations, parish councils and social enterprises in North Yorkshire. This organisation has played an active role in whole system planning for the pandemic through the silver command structure and has been instrumental in co-ordinating the VSCE response to the additional pressures in the system this winter. CFY have also commenced working with the PCNs to develop more joined-up working and create opportunities for mutual support.

NYCCG sponsored a successful application led by CFY for Connecting Health Communities. As a result, a cross-sector group across North Yorkshire is bringing people with different perspectives together to explore the role of community transport as an enabler. The intention is to identify how we can address health inequalities by ensuring transport options across communities are

more widely available and hence help people to access services that help them stay well, healthy and happy. The project will learn about approaches which are working well and explore and recommend future ways of working across all parts of the health and social care system and wider wellbeing networks.

Finally, as mentioned in the frailty section above, we have also been working with both CFY and the NYCC Stronger Communities team as part of the work to identify how frail older people can be supported in their own community. This work was initiated in Harrogate and is now being extended to all parts of NYCCG, including Scarborough and Ryedale and Hambleton and Richmondshire. It has already proved useful in extending the language of the Rockwood Clinical Frailty Scale to VSCE and community partners. The work is helping partners to think differently about how we need to construct responses to frailty that better enable people to age in a healthy way.

2.7.4 Transformational Estates Programmes

Whitby Memorial Hospital Redevelopment

The £13.1 million project to renovate Whitby Community Hospital has been shortlisted for a Royal Institution of Chartered Surveyors (RICS) award. Work started in March 2020 to remodel and refurbish the Tower Block, which welcomed patients back into the refurbished part of the hospital in March 2022. This includes the new Urgent Treatment Centre, Podiatry Services, Physiotherapy and Audiology. The Tower Block is also home to the new Memorial Ward, where those who need to stay on the ward, and their families, will have access to accessible and comfortable spaces and facilities. The Café is also now open to the public, is based on the ground floor and can be accessed via the entrance near the vehicle turning circle. The Whitby Memorial Hospital will provide staff and patients with a modern, fit for purpose facility that is futureproof for many years to come.

Catterick Integrated Care Campus

During 2021/22, the CCG continued to work with programme partners to develop a brand-new joint Ministry of Defence and NHS hub delivering a range of health and social care services to improve the health and wellbeing of the people of Catterick Garrison, Richmondshire and beyond. Known as the 'Catterick Integrated Care Campus', this ambition would ensure local patient/service users, their carers and families have access to the right care, at the right time, in the right setting, delivered by the right professionals to enhance their wellbeing and independence, and improve their overall quality of life.

Initial design concepts have been shared by industry partners and a new programme of engagement with members of the local voluntary, community and enterprise sector and other stakeholders has begun. Planning discussions and site demolition is due to commence in Spring 2022. The CCG has continued discussions with NHS England/ Improvement, Humber and North Yorkshire

Health and Care Partnership and NHS Armed Forces colleagues to identify and confirm capital funding. The aim is to open the new facility in 2024, subject to formal business case approvals for partner organisations.

The Friary Hospital, Richmond

Work has continued throughout 2021/22 on the plans for a proposed redevelopment of the Friary Community Hospital.

The proposed redevelopment would secure the future of the hospital and the services provided. Our plan is that the renovated hospital should become an integrated primary care hub, working in close partnership with community services and continued provision of intermediate care facilities. We would also like to develop the facility into a 'frailty hub' which would enable greater capacity and capability to provide care for frail elderly patients, including those with dementia or delirium for whom the current inpatient ward is unsuitable.

The proposals for the Friary Hospital redevelopment complement the planned Catterick Integrated Care Campus (CICC).

Ripon

During 2021/22 a refreshed feasibility study was launched to consider solutions for the provision of primary care and community services.

Harrogate

Work continues to consider options for premises development for primary and community services in the Heart of Harrogate, while affordability remains a challenge, work continues to ensure service provision to the local population.

2.8 Vulnerable People: We will support everyone to thrive [in the community]

2.8.1 Mental Health, Learning Disabilities and Autism Services

Partnership working

The North Yorkshire Mental Health, Learning Disabilities and Autism Partnership (MH&LDA), which started in 2018, has continued to develop and lead the delivery against the NHS Long Term Plan (LTP) and other local priorities throughout the last year whilst continuing to manage the challenges from the COVID-19 pandemic.

The partnership is committed to investing in and improving services for local people through partnership working which is now well established. Through the robust planning process investment decisions were taken to ensure delivery against the Mental Health

Investment Standard (MHIS). The MHIS guarantees that investment into mental health services is at least in line with the growth in allocation received by the CCG.

The key principles of the partnership remain as:

- 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 Transforming Care Partnership (TCP).

As a strategic system across North Yorkshire our multi agency working and communication has been key in enabling us as a whole system to work collaboratively to ensure that our MH&LDA population remain a priority and remained safe whilst receiving person centred care through the pandemic.

Our Learning Disability and Autism programme, and in particular our multi-agency operational group 'the engine room' has developed processes and protocols collectively. This close working as a system has supported our health and social care providers to work together to ensure that our pathways and services have been accessible and that our support to our LD population did not stop.

The North Yorkshire Learning Disability and Autism Care Treatment Review (CTR), Care and Education Treatment Review (C(e)TR) and Dynamic Support Register (DSR) processes and protocols have been recognised nationally as best practice and are being adopted by other areas across the country.

Building on the work of 2020/21, the MH LD partnership board agreed a number of priorities for 2021/22 including the following:

- **Early intervention in Psychosis (EIP)**Following investment agreed through the MH&LDA partnership, plans were revisited to align with PCN footprints. The new model will deliver the national quality and access standards for which work will continue during 2022/23.
- **Individual Placement and Support (IPS) Services**: This initiative was to enable people with severe mental illnesses to find and retain employment and has proven highly successful during 2021/22. New relationships have been established with a wide

range of small employers such as local bookshops and smaller care homes to larger organisations such as councils. The first six months of 2021/22 saw 116 self-referrals, with 71 employment outcomes achieved and 48% of individuals who could have reached 26 weeks in employment achieved this milestone.

2.8.2 Crisis

The CCG has continued to invest and develop the crisis café model across North Yorkshire through partnership working with the voluntary sector. To support the Long-Term Plan ambition around mental health acute liaison the CCG was successful in the bid for transformation funds to support a 24/7 service at Scarborough Hospital from 1 April 2021.

A pilot scheme was developed over the winter by working with Scarborough Survivors to integrate mental health support workers into the A&E Department to support vulnerable patients and support A&E staff for those patients whilst in the department.

The CCG led the refresh of the 'Crisis Care Concordat' across North Yorkshire and York which led to an agreed vision and priorities across the system.

As a result of the COVID-19 pandemic, the Long-Term Plan ambition for a 24/7 all age crisis line was brought forward and mobilised at pace at the start of the pandemic and is being reviewed during 2022 to ensure that this is a sustainable service to support the wider system within the funding available.

2.8.3 Perinatal

Following on from the service that commenced in 2019, there continues to be further developments across North Yorkshire including the 'Dad Pad' app[16] which offers fathers access to specialist Perinatal Mental Health services.

Through the Humber and North Yorkshire Health and Care Partnership, we became a maternity mental health hub services fast follower to meet the psychological, emotional and mental health needs of women during their maternity journey. The development of the service within the North Yorkshire and York system continues to be progressed to support the local population.

2.8.4 ADHD/Autism service redesign

Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) continued to be a key priority for the MH&LDA partnership during 2021/22. In January 2021, the aim had been to reduce the waiting list by 31 March 2022. Unfortunately, the last six months has seen a 45% increase in referrals compared with the previous six months, which has had an impact on our ability to reduce the waiting list, however the longest waiting times have been reduced by 74%.

[16] https://www.northyorkshireccg.nhs.uk/on-the-go-wellbeing-support-for-dads-in-north-yorkshire/

Work continues with Vale of York CCG around the commissioning of a sustainable model from April 2022 onwards.

Other initiatives that are being piloted and explored to provide support include:

- A Neurodiverse Hub that is open to patients who have received a diagnosis
- A pre-diagnostic support tool to provide support to people throughout the pathway, which will provide practical strategies prior to assessment and assist people with making reasonable adjustments to help them manage.

2.8.5 'Transforming Mental Health Services'

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

By investing in community services, we aim to reduce the number of inpatient admissions as well as the length of time individuals need to spend in hospital (this is what people told us they wanted). When people need to spend time in hospital these services are provided in the purpose-built facility in York (Foss Park).

2.8.6 Living Well with Dementia

During 2021/22 the partnership funded a number of initiatives to improve the dementia diagnosis rate in line with the national trajectory of 66.7% including:

- Appointing Dementia Coordinators to work with GP practices and acute trusts to identify and support dementia patients.
- A significant care tool is being piloted with a care home in Harrogate which helps to identify early signs of dementia and deterioration. Findings from a pilot in London showed a significant reduction in admission rates and findings from the Harrogate pilot will be evaluated to help inform any potential proposals.
- A GP ward has opened in Bridlington to cater for patients awaiting a package of care a proportion of whom are likely to have dementia and may not have been diagnosed. A Dementia Coordinator will link in with this ward to ensure patients are receiving the right support and are on the appropriate pathway.

2.8.7 Promoting Access to IAPT (Improving Access to Psychological Therapies)

The ability for people to self-refer into IAPT services is now well established and has increased further during 2021/22. The service adapted during the pandemic with a move to delivering over a virtual platform but will continue to offer face to face treatment where required and clinically appropriate.

Under the partnership approach the ambitions within the NHS Long Term Plan remain a priority, with additional investment continuing during over the next two years.

As partners, we developed a three-year delivery plan based on a sustainable approach and which focussed on demand, workforce and funding, acknowledging the increase in the acuity on the types of referral over the last two years.

2.8.8 Community Transformation Programme

Significant work has been undertaken through 'Right Care, Right Place' across the whole system in North Yorkshire to develop integrated transformation plans for community mental health services. Initiatives have been co-produced with stakeholders and partners over the last three years and include place-based approaches; small scale testing and commissioning of initiatives such as primary care-based specialist mental health staff and the development of a new community mental health vision and values.

The Community Mental Health Framework (CMHF) is a focus for further planning, integration of service delivery, building on established partnership working across primary and secondary care, local authority and Voluntary, Community and Social Enterprise (VCSE) boundaries.

Transformation funding will be used to bring about whole system change across local partnerships, enabling people with moderate to severe mental health problems to live well in their communities. A fundamental principle underpinning our vision is that mental health and wellbeing is everybody's business. This includes:

- commitment to an all-age, whole life course approach; and,
- developing services based on a bio-psychosocial model – to focus on promoting wellbeing and prevention rather than diagnosing and treating illnesses.

Building on significant investment from our Commissioning Partnerships, we started the work to accelerate additional enablers for this transformation in 2021/22, to assess the impact of new capacity and to grow workforce capacity to deliver the longer-term plan for transformation in years two and three. This has built on new ways of working with Primary Care Networks embedding mental health workers into GP practices across North Yorkshire, and has further developed single access/assessment processes, integrated/non-stigmatising support, continued monitoring of four week waits, and supporting people with serious mental illness (SMI) to access physical health checks and interventions. Our new/emerging model of care will help us support those with complex and long term needs in addition to those with newly presenting (or re-presenting) SMI needs in the community, to ensure rapid access to appropriate, evidence-based interventions, including psychological therapies.

We recognise that the North Yorkshire geography is diverse, covering town and rural populations, therefore, one service model does not fit all. Furthermore, learning from the COVID-19 pandemic and consolidation of digital enablers will be integrated into the model and used to reach particularly vulnerable groups to tackle loneliness and isolation, ensuring services are wrapped around communities. Services will, in the coming years, move away from the traditional building focus to more place-based and located with community assets within the communities they serve. This model will work both physically and virtually ensuring that it can serve both the urban and rural areas of the locality.

2.8.9 Supporting people with severe mental illness

The CCG is working closely with primary care colleagues to improve the systems and processes to help with the uptake of the health checks for people with a severe mental illness. The CCG has seen improvement in uptake across the area during 2021/22 and achieved 39% at the end of Quarter 3 (ending 31 December 2021), which was above the national average of 34.9%, however further work is required to meet the national trajectory of 60%.

2.8.10 Care Homes

There are over 4,800 care home beds within the North Yorkshire area. Whilst the CCG does not commission services from care homes, we recognise the significant contribution made by our care home providers to improve the health and wellbeing of our local population and the importance of working together. There has been a significant effort made by our care home colleagues, the CCG and key partners from health and social care and other agencies in the response to the COVID-19 pandemic and these strong working relationships continue. For further information on the work carried out to support our care homes, please see section 6.13.

2.8.11 Support to Refugees and Asylum Seekers

Over the last 12 months we have seen some 300 refugees accommodated in bridging hotels in North Yorkshire. These are a mix of refuges, asylum seekers and Afghan nationals relocated to the UK as part of the national scheme. Two GP practices have registered them and completed health checks, started treatments, referred to secondary care services and supported patients to access other health and social services. This has been considerable additional work for the practices taken on willingly to assist this groups of patients.

Further the CCG is working with North Yorkshire County Council and other agencies to support the Homes for Ukrainian scheme. It is understood that approximately 150 hosts have volunteered to take Ukrainian families. As of 31 March 2022, no families had yet arrived in North Yorkshire as part of this scheme, but plans are in place to support both hosts and the Ukrainians.

2.9 Vulnerable People: We will promote the safety and welfare of vulnerable individuals

2.9.1 Safeguarding

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

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

- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements.
- An established Designated Professionals Team including a Designated Doctor and Nurse for Safeguarding Children and Children in Care, and a Designated Paediatrician for Child Deaths.
- Named GPs for Safeguarding Children and Adults and, as part of collaborative arrangements with Vale of York CCG, a Named Nurse and Specialist Nurse for Safeguarding in Primary Care (Children and Adults) .
- Regular reporting into the CCG Quality and Clinical Governance Committee from the Designated Professionals Team and the Primary Care Safeguarding Nurses.
- Appropriate arrangements in place to co-operate with local authorities and other partner agencies in the operation of North Yorkshire Safeguarding Children Partnership (NYSCP) and the North Yorkshire Safeguarding Adults Board (SAB). The CCG Executive Nurse and Designated Professionals for Safeguarding are members of both the Partnership and Board.
- A staff training strategy to support recognition and effective response to safeguarding issues in line with statutory guidance.
- Representation on regional and national safeguarding forums via the Designated Professionals Team.
- Through contractual arrangements the CCG ensures that it commissions safe services and continues to be an active partner working with agencies to keep adults and children safe from abuse, neglect and harm.

Work undertaken across the Designated Professionals Team during 2021/22 has included:

- The Designated Professionals Team have continued to work with safeguarding children, children in care and safeguarding adults' colleagues across the North Yorkshire and Humber footprint to develop a proposed model for safeguarding arrangements in the new Integrated Care System. This model will ensure that safeguarding remains integral to future

commissioning arrangements. This model was agreed by the Integrated Care Board and work is now ongoing to ensure that these arrangements are in place to support the new organisation in June 2022. An interim lead Designated Nurse has been appointed to lead on this work.

- Standard presentations have been developed to ensure that all Safeguarding Partnerships and Boards can receive assurance on the ICS arrangements and the primary of place-based safeguarding as we move to the new operating model.
- The number of cases which have reached a threshold for a statutory case review remains high. This represents a considerable amount of work for all safeguarding teams across the partnership but is essential if learning is to be extrapolated and integrated into practice.
- High levels of support are offered by the Designated Professionals team to safeguarding leads across NHS and private provider organisations. Regular online meetings, monthly safeguarding bulletins, advanced level training and reflective supervision support professional practice and help to build resilience in challenging times.
- A new Domestic Abuse policy specifically designed for use within primary care across North Yorkshire disseminated to all GP Practices. The policy aims to ensure that primary care staff are aware of their duty to be alert to signs of domestic abuse, to respond appropriately to disclosures of domestic abuse and to support victims and survivors.
- The Primary Care Safeguarding Training Guidance has been updated providing a valuable reference for Primary Care staff to identify what level of training they require to meet the safeguarding duties and responsibilities of their roles.
- All Primary Care Safeguarding Training has continued virtually in 2021/22 with 778 staff attending Level 3 Safeguarding training. In addition, 132 administration staff attended 'Managing Safeguarding Information' training in February 2022.

Safeguarding Adults

The huge challenges for health and social care teams have continued into a second year of pandemic, with the added impact of a tired and depleted workforce and a population with increasingly complex health and social care needs. These issues have been reflected in adult safeguarding with people presenting with multiple complex issues at later stages than may previously have occurred pre-pandemic, and issues surrounding vulnerable individuals who lack mental capacity. The Designated Professionals have worked with our partner organisations to develop guidance regarding the application of the Mental Capacity Act to emerging situations such as COVID-19 vaccination.

The Designated Professionals for Safeguarding Adults have continued to work closely with our partner organisations to reduce the risks of abuse and neglect, and chair key subgroups whilst addressing safeguarding concerns, supporting care homes and working strategically to learn lessons from emerging themes, trends, risks and safeguarding reviews.

Safeguarding Children

The Safeguarding Children Team have been closely involved with Partnership work and continue to chair key sub-groups. Multi-agency procedures and guidance have been reviewed and updated to ensure compliance with best practice and national guidance.

The Designated Nurses have led on a multi-agency response to learning from national report on Sudden Unexpected Death in Infancy. The work has focussed on supporting professionals to feel more competent and confident in their work with the most vulnerable families to reduce risk. A multiagency training programme has been commenced across North Yorkshire and York and is supported by local practice guidance and media campaign.

ICON (Babies Cry – You Can Cope) has now been formally launched across NHS England Northern Region and work is underway with the Tri-Service Safeguarding Partnership to deliver a global implementation campaign across defence.

The CCG has funded a new post to ensure appropriate health contribution towards information sharing and decision making at Initial Child Protection Conferences. Recruitment to this post has been successful and the new processes have been established.

The National Referral Mechanism (NRM) pilot across North Yorkshire and York has been extended until June 2022. The NRM is a framework for identifying and referring potential child victims of modern slavery. Primary care has contributed to the process by providing relevant and proportionate information to aid the panel's decision and the Named Nurse for Primary Care acts as the health representative on the local NRM panel.

Key Challenges and Opportunities for the future

Transition to an Integrated Care System (ICS) with a statutory footing is anticipated to be in place by July 2022 bringing opportunities to work collaboratively across new partnerships and pathways, whilst also maintaining assurance of the stability of safeguarding practice in place-based working. The combined growing network of expertise across the Humber and North Yorkshire systems will continue to support and embed safeguarding as new contracts develop and new teams are created.

Implementation of the Mental Capacity (Amendment) Act (MCA) 2019 Liberty Protection Safeguards (LPS) have again been delayed; we will continue preparation in safeguarding practice and as a system as we await from Government publication of the consultation on a new combined (MCA/LPS) Code of Practice and a revised timetable for implementation.

The Domestic Abuse Act (2021) has been added to the new 2022/23 NHS contract as a requirement for those delivering NHS services to take account of. The Act brings new duties and responsibilities for local authorities and other partners, including health. Statutory guidance is expected later in 2022.

Vulnerable groups and individuals will continue to be negatively impacted by COVID-19. We will continue to emphasise personal and team health and well-being, whilst also actively providing support to our colleagues and partners, as we manage the ever-increasing safeguarding agenda. The Safeguarding Children's Team will progress with a blended approach of face-to-face meetings and visits; and working virtually.

2.9.2 Crisis Support for Children

A dedicated Children and Young Peoples Crisis and Intensive Home Treatment service is available across North Yorkshire CCG provided by Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust. The crisis telephone service is available 24/7 and can be accessed by calling the freephone number 0800 0516171.

2.9.3 North Yorkshire School Mental Health Project

Following on from the successful establishment of Mental Health Support Teams in Schools in Scarborough and Selby in 2020, NY CCG successfully secured funding from NHS England in 2021 to expand this service to Hambleton and Richmondshire and Harrogate District localities. The teams are now established in all four sites and have three key functions:

1) Support education settings to develop and embed a whole school approach to wellbeing.
2) Provide timely advice, consultation and signposting to teaching staff.
3) Provide evidence-based psycho-social interventions to children and young people.

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

Integrating pathways for children and young people's mental health services remains a key priority across the North Yorkshire CCG.

The Go-To website (thegoto.org.uk) is a signposting website for children and young people's mental health, commissioned by the CCG in collaboration with North Yorkshire County Council. In 2021/22 work to improve the website has continued including focus groups with professionals and young people to improve the content, layout and usability of the website based on feedback.

Q3 2021/22 data is included below:

- 4,214 page views
- The most popular page was 'What's in North Yorkshire for me – 17 and under'.
- 1263 people visited the home page
- 1900 visits to the 'I'm a Young Persons' section
- 355 visits to the 'I'm a Parent or Carers' section
- 300 visits to the 'I'm a Professionals page'
- 147 visits to the 'Urgent Help' page
- An average of 1m 59s spent on the website
- 51% of people accessed through a PC
- 45% accessed through a mobile device
- 4% accessed through a tablet device

Joint commissioning

The North Yorkshire CCG and North Yorkshire County Council (NYCC) have worked together to establish joint commissioning intentions using a Section 75 arrangement for children and young people's early intervention mental health services (formerly Compass BUZZ and Compass REACH). This jointly commissioned service will be launched in April 2022.

Embedded digital offer

In 2020 a 2-year digital project was commissioned for young people aged 11-18 years across North Yorkshire. Kooth was introduced to provide additional remote support during the pandemic while existing children and young people's mental health services adapted to develop their own online options. Throughout 2021/22 young people have accessed online chat/text-based counselling, discussion forums and online self-care resources via Kooth.[17]

A consultation[18] is under way to inform future service developments to ensure both a face-to-face and digital offer is available to children and young people to support their emotional and mental health.

[17] https://www.kooth.com
[18] https://www.surveymonkey.co.uk/r/V85WGK5

2.9.5 Compass Phoenix (formerly Compass BUZZ)

In 2021/22 Compass Phoenix (formerly Compass BUZZ) continued to provide 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 also offers professional consultations for staff and direct interventions for children and young people.

Quarter 3 2021/22 data is included below:

- The number of referrals received by Compass Phoenix for direct intervention in Q3 was 423
- The number of new presentations for direct intervention in Q3 was 110
- The number of professional consultations undertaken in Q3 was 37
- The number of education staff who accessed webinar training in Q3 was 132 (315 year to date).

2.9.6 Buzz US

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

Quarter 3 2021/22 data is included below:

- The number of BUZZ US conversations opened in Q3 was 52 (181 year to date)
- The top reasons for texting in was for emotional wellbeing /worry (14), anxiety or panic attacks (13) and depression / low mood (12), which follows a similar trend to previous quarters.

2.9.7 Transforming Care for Children and Young People

The North Yorkshire and York Transforming Care Partnership (TCP) Children and Young People's (CYP) Dynamic Support Register (DSR) group is a multi-agency group that meet on a monthly basis, to review the DSR, which records details of children and young people with a Learning Disability and/or Autism who have been admitted to inpatient or residential settings (or those who are at risk of escalating into such settings within the next six months). The last two years have seen recognition from the group that the DSR requires refreshing.

The refresh of the Terms of Reference, Information Governance and Standard Operating Procedure will take place once resource to the CYP DSR has been allocated. The Senior MH&LD Manager and Head of Service are reviewing resource to the CYP DSR to enable this work to take place. The Designated Clinical Officer (DCO) for Special Educational Needs and Disability (SEND) chairs the monthly CYP DSR meetings.

2.9.8 Autism Pathway – Children and Young People

The new Children and Young People's Neurodevelopmental Transformation Project Manager started with the CCG in November 2021. This role will support the neurodevelopmental programme of work across North Yorkshire and York.

The provider for the Scarborough, Ryedale and Whitby Children's Autism assessment service is The Retreat. The provider for the service in Harrogate locality and the Hambleton/ Richmondshire locality is Harrogate and District NHS Foundation Trust (HDFT). The HDFT service is now operating as one team. NICE guidance recommends that the wait between referral and first appointment is no longer than 3 months. Both HDFT and The Retreat services have continued to receive increasing numbers of referrals throughout 2021/22. The number of accepted referrals for the combined HDFT service at YTD Q3 2021/22 was 456 (this is a 21% increase on the same period last year). The number of accepted referrals for the Retreat service at YTD Q3 2021/22 was 157 (this is an 18% increase on the same period last year). The increased referrals are impacting on waiting times, and the Providers' capacity to meet NICE guidance. The Retreat service has also been extended to March 2023.

Q3 2021/22 average wait from referral to 1st appointment:

- Scarborough, Ryedale and Whitby locality: at 41 weeks
- Combined Harrogate and Hambleton/Richmondshire localities: at 48 weeks

In the summer of 2021, we were successful in securing NHS England funding for the 'Better Pathways' pilot for Scarborough and Selby localities. The pilot project aims to test the effectiveness of developing the option of a referral service led by schools and reduce waiting times. After initial planning, the project went 'live' at the end February 2022. The Scarborough pilot provides that referrals are led by schools into The Retreat service, involving supervision from clinical staff at The Retreat. The Selby pilot involves the referral service led by Schools into Selby CAMHS, by embedding specialist advice and support from Selby CAMHS in schools to compile referral paperwork including, school and parent/carers' questionnaires and developing a multi-disciplinary team meeting involving Special Education Needs Co-ordinators to assess referrals. The aim is to reduce waiting times to initial appointment with CAMHS that will then further consider an Autism assessment and upskill school staff in their response to children who may have Autism.

Additionally, in summer 2021 we were also successful in securing NHS England funding for short breaks/respite young people. Organisations have been invited to expand their current offer of short breaks/respite for young people, with a confirmed Autism diagnosis, or who are on a waiting list. We have received three applications for this funding. The MDT panel met to review the applications and have requested further information for clarification. Once confirmed, we will be a position to award the funding. It is planned, that this will project launch in March 2022.

2.9.9 Special Educational Needs and Disabilities (SEND)

Health Providers have a statutory duty to respond to health information requests to inform of health barriers to education and the health interventions provided through NHS commissions for Education Health and Care Plans (EHCP) within six weeks. There is a national requirement that 100% of these requests should be returned within the six weeks. The COVID-19 pandemic has had an impact on the redeployment of some staff, and this caused a decline in timely responses, which was not reflected in the statutory guidance. In response to COVID-19, an easement was placed on the timely response up to 31st July 2020. Following this the easement was lifted and professionals were made aware of their continuing responsibility under the SEND Code of Practice (2015).

The EHCP 2021/22 year-end performance for health information requests returned on time is:

- Harrogate locality: YTD at 37%
- Hambleton/Richmondshire locality: YTD at 78%
- Scarborough and Ryedale: YTD at 44%

In Quarter 3 2020/21 the Designated Clinical Officer (DCO) carried out an audit of the timeliness of EHCP health advice returns for the six month period between Quarter 3 and Quarter 4 2019/20 to identify the number of late returns and understand the reasons for not meeting the target. The recommendations are as follows:

- The definition of ‘COVID-19’ was not deemed a sufficient reason for late returns
- DCO to request that Providers continue to provide valid reasons for late returns
- DCO to request that Providers continue to complete and return the Exceptions Form to identify non-exceptional reasons

The SEND administrator is developing an EHCP Quality Tool for Health to be administered prior to EHCP panel. This includes outcomes of Children's and Family Act 2014 – Interventions are SMART, commissioned and agreed with child, young person and family. In addition, the tool will identify exceptions, training needs of providers and allow for assurance that statutory return rates are maintained. The work will cover North Yorkshire as a whole.

In relation to the ongoing poor returns rate for Harrogate for the previous three years, this is documented on the CCG risk register, has been discussed at Board and is on the provider trust's risk register, and have an internal Business Case for an EHCP Nurse Specialist to undertake EHCP advice at the present time.

North Yorkshire and York have amalgamated the SEND structure together in streamlining pathways and policy for the ICS blueprint. The team now consists of a Designated Clinical Officer (DCO), two Associate Designated Clinical Officers (ADCO), and a SEND Administrator. This team works at place across North Yorkshire and York to ensure NHS providers are making reasonable adjustments, are fully trained for SEND and meet statutory requirements.

The team has formulated holistic SEND training packages for NHS providers across North Yorkshire and York in line with recommendations. This is to be rolled out regionally across the integrated care system in the North.

The DCO has led on communication and engagement strategies and agreements within North Yorkshire with the Local Authority, SENDIASS, Youth Watch and Parent Carer Voice to solidify joint working and co-production across the patch. This includes communication agreements between the bodies and front facing strategies for North Yorkshire.

2.9.10 Children's Continuing Care

The Children's Continuing Care Team works across the North Yorkshire and NHS Vale of York CCGs to provide continuing care packages of support, which are required when a child or young person has complex health needs, arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

Integrated working and jointly commissioned packages of support are essential to delivering a holistic care approach that supports the children and young people as part of their wider family. The team has built and continues to have professional and positive working relationships with local partners, including North Yorkshire County Council, City of York Council, the NHS and private providers.

The team has developed a training package which has been delivered to some provider services and the local authority with excellent feedback. The next stage will be to develop this into a more comprehensive training package to include transition pathways and differences between children's continuing care and adult continuing healthcare. The team are currently liaising with adult continuing healthcare colleagues to facilitate this as a joint piece of work.

The team have developed a caseload tracker to identify caseload capacity, dates for annual children's continuing care and for Education Health and Care Plan (EHCP) reviews. This process enables the team to be included in the EHCP process to ensure the best possible outcome for a child or young person.

2.9.11 Children's Sleep Clinic Pilot

We were proud that the Health Service Journal recognised the North Yorkshire CCG commissioned Children's Sleep Service pilot with a 'highly commended' award at the annual award ceremony held on 18th November 2021. The service has been re-commissioned across North Yorkshire for a further 12 months from 1st April 2022 to 31st March 2023.

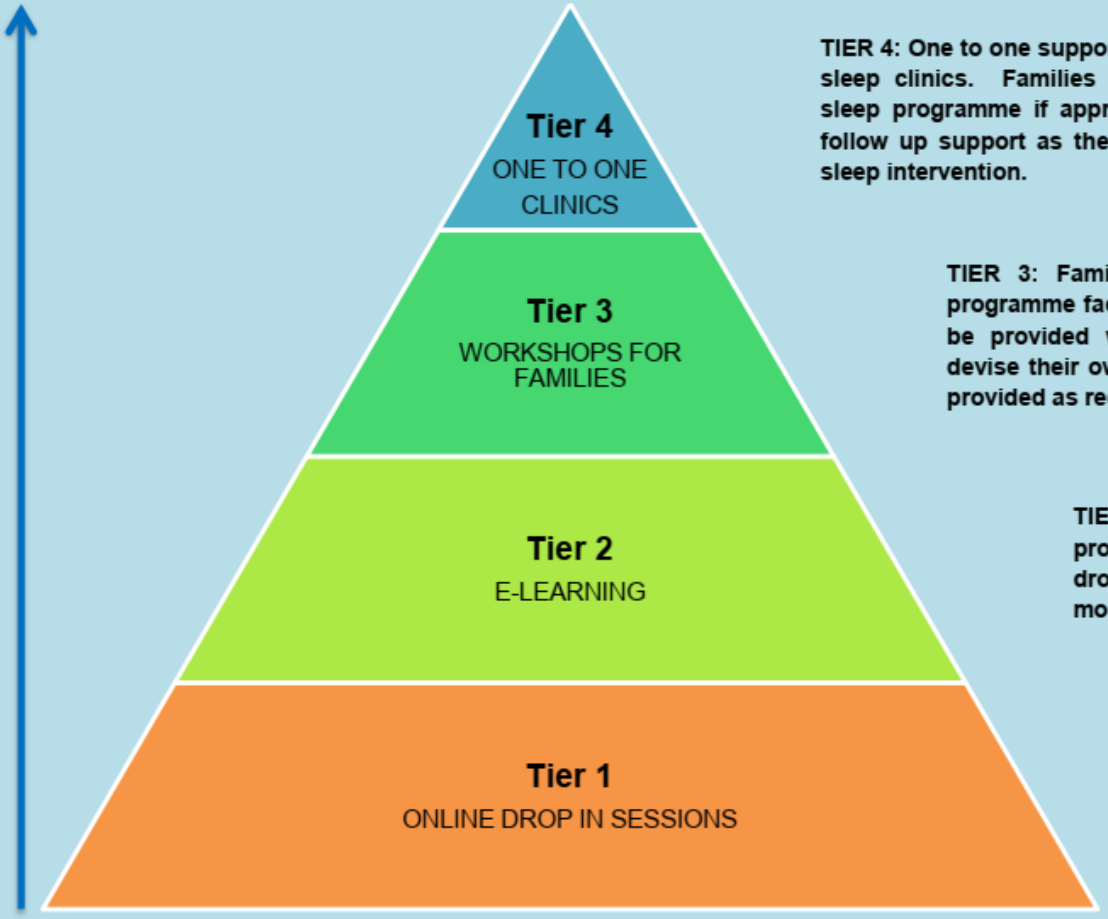
In February 2022, the CCG Children's Head of Service made a presentation to NHS England for the 'Better Start in Life' programme, highlighting the positive impact of the Children's Sleep service, which was well received by participants. Furthermore, the Head of Service has been working with the Local Authority to roll out sleep training across social care, which demonstrates effective joint working for children and young people's services.

The Q4 2021/22 performance is below:

- The e-learning Foundation Workshop has proved very successful for those that have wanted to take on the training, 134 parents/carers and 66 professionals have undertaken this workshop.
- Other training the Service offered has also been very well received, with 31 professionals undertaking the Sleep Tight training, 39 on the Sleep Champion and 5 attending the CPD training day on SEND. The highest level of training, the Sleep Practitioner training, was given to 10 Health care professionals.
- Sleep training has also been taken up outside of the commissioned service, with an additional 34 professionals taking the Sleep Tight and 39 professionals taking the Sleep Champion training.
- The service ran 17 online drop-in sessions for parent/carers online, these were not as well attended as hoped, but those that did attend found them useful.
- There have been 15 webinars attended by 117 professionals covering various topics, healthcare professionals, parents of teens, SEND professionals, primary age professionals, health and social care, and the voluntary sector.
- The Service has engaged with 675 direct contacts and supported 334 families using the provision of a tiered sleep intervention support programme and from April 2021 to March 2022, the service potentially reached over 1,620 people across North Yorkshire.

Details of the current tiered system are shown in the diagram below, however, this may be reviewed over the coming months.

THE SLEEP CHARITY
NORTH YORKSHIRE CHILDREN'S SLEEP CLINIC PILOT – TIERS OF INTERVENTION



TIER 4: One to one support provided through specialist sleep clinics. Families will receive an assessment, sleep programme if appropriate and up to 12 weeks follow up support as they implement the behavioural sleep intervention.

TIER 3: Families will access a two-week workshop programme facilitated by a Sleep Practitioner. They will be provided with sleep education and supported to devise their own intervention. Follow up support will be provided as required.

TIER 2: Access to an e-learning programme will be provided with the opportunity to attend an online drop-in session to ask further questions or gain more support from a Sleep Practitioner.

TIER 1: Online drop-in sessions provide evidence based information and support delivered by a Sleep Practitioner at early intervention level.

Cohort: Children and Young People aged 12 months up to 18 years of age at time of referral and who are registered with a North Yorkshire GP Practice affiliated to NHS North Yorkshire Clinical Commissioning Group (CCG), or not registered with any GP Practice and live within the North Yorkshire boundary and have NHS North Yorkshire CCG as their Responsible Commissioner.

North Yorkshire Children's Sleep Clinic pilot – Tiers of Intervention (dated 22nd March 2021 - FINAL)

2.10 Well Governed and Adaptable Organisation: In supporting our objectives we will be a well governed and transparent organisation that promotes a supportive learning environment

2.10.1 Adaptability to respond to COVID-19 pandemic

Throughout 2021/22 the CCG focussed on the pandemic and COVID-19 recovery. Details of our adaptability to the pandemic are referenced throughout the whole of the annual report.

2.10.2 Development and implementation of strategies and plans

As a newly established CCG in April 2020, several strategic documents were developed and implemented in order to support our objectives as a well governed and transparent organisation that promotes a supportive learning environment. Throughout 2021/22, we continued to use these documents, as detailed below:

Constitution and Standing Orders	Governance Handbook
Scheme of Reservation and Delegation	Operational Scheme of Delegation
Risk Management Strategy	Statutory and Non-Statutory Policies and Procedures
Business Cases	Committee Terms of Reference (including Joint Committees)
Communications and Engagement Strategy	Memoranda of Understanding
Annual Reports	Sustainable Development Management Plan
Emergency, Preparedness, Resilience and Response Policy Major Incident Plan and Business Continuity Policy	NY CCG Values
NY CCG Strategic Objectives	Governing Body Assurance Framework
Equality and Diversity Plan	Risk Registers
Internal Audit Reports	Internal Audit Recommendations
Effectiveness Reviews	HR and Organisational Development Plans

2.10.3 Our Financial Position

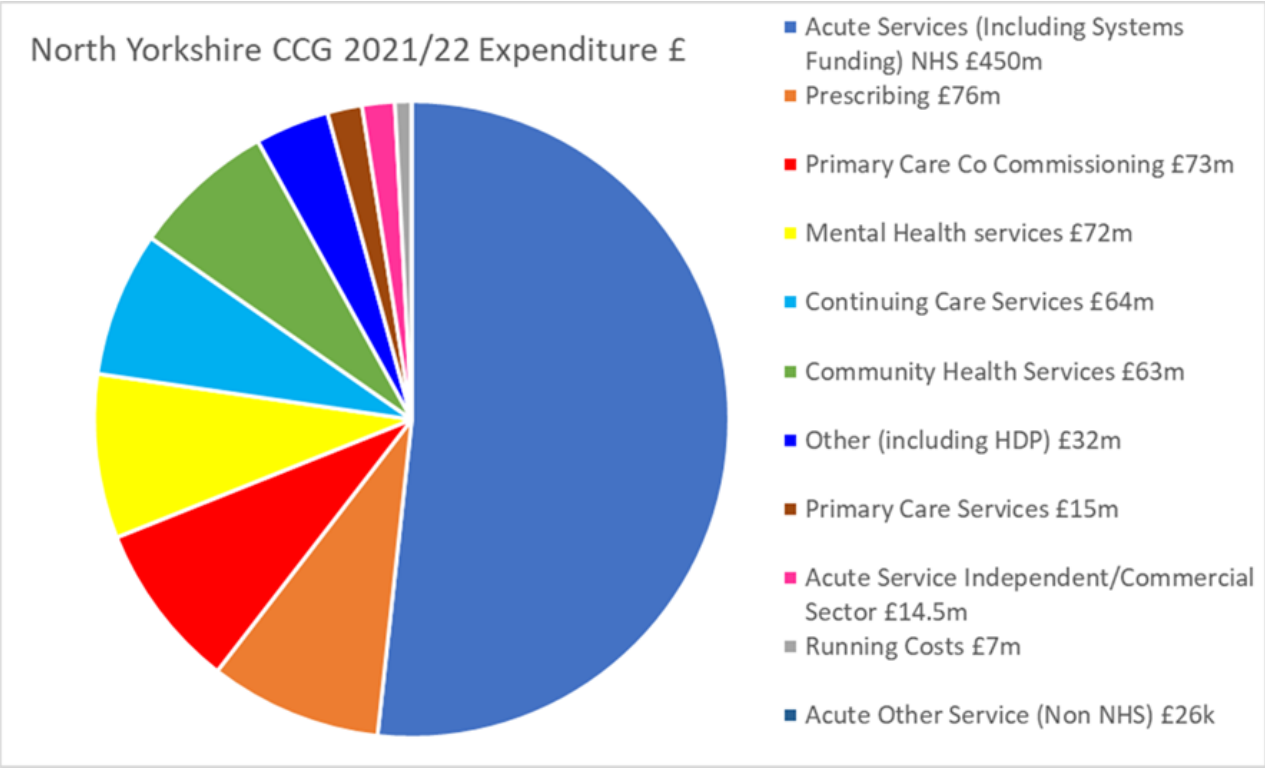
North Yorkshire CCG has delivered a surplus (£0.19m) during 2021/22. The CCG received a funding allocation of £870m in 2021/22, including £8.3m to fund its running costs. Within this allocation the CCG also received non recurrent funding for:

- £13.8m of Elective Recovery Funding (ERF) to increase elective activity and to start to tackle the post pandemic waiting lists in the NHS and Independent Sector.
- £11.2m to fund the Hospital Discharge Programme. This funding covers costs incurred by both North Yorkshire CCG and all North Yorkshire County Council residents (not just those who form part of the North Yorkshire CCG population).
- 2.4m Ageing Well monies to start implementing the NHS Long Term Plan commitment aimed at delivering a 2 hour urgent community response services for patients with an urgent need that can be managed in the community.
- £2.0m of Winter Access Funds and £0.8m of other primary care digital funds for investment in General Practice. This ensured patients continued to have access to services during the pandemic and over the winter period, additional appointments have been commissioned using online and virtual access to GPs and clinicians.
- £2.0m Mental Health Spending Review funding to accelerate delivery of key mental health commitments laid out in the NHS Long Term Plan in 2021/22. This funding has been invested across all sectors including health, local authority services and the voluntary sector to support key programmes of work, including where there is a pressure as a result of the COVID pandemic. The funding has been used to support children and young people through grants to the voluntary sector, joint working with secondary care and the local authority around discharge planning to reduce delayed transfers of care, additional capacity into a range of services such as IAPT, memory assessment, autism and ADHD, eating disorders to tackle backlogs and address waiting lists. The funding enabled other innovative schemes to continue and expand including peer support workers in Accident and Emergency Departments. The funding has also supported the recruitment of MH workers which are aligned to primary care in line with national guidance.
- £0.7m Post COVID-19 funding to help with some of the long-term effects of having contracted COVID-19, including investment in virtual wards, pulmonary rehabilitation services and FeNO (Fractional exhaled Nitric Oxide) testing to improve Asthma diagnosis and management.

Other areas of investment have included Additional Roles Investment to increase capacity in GP practices, this has been achieved through the recruitment of Social Prescribers, Clinical Pharmacists, First Contact Practitioners (FCPs), Mental Health Workers and

Physician's Associates, who are all working in GP practices. Investment has increased from £1.9m in 2020/21 to £3.5m in 2021/22, this investment is set to increase to £4.8m in 2022/23, with further funding available centrally if required.

The following pie chart provides a breakdown of where the funds were spent during 2022/23:



In line with national expectations, the CCG continued to invest in mental health services at a higher rate than its funding allocation increase. This requirement is mandated to CCGs through the Mental Health Five Year Forward View[19].

Sustainable financial recovery is still a high priority for the CCG, the significant investment we have seen throughout the COVID-19 response, has enabled us to transform services with the introduction of many digitally supported schemes such as digital front doors, appointments and triage, expansion in NHS111, and improved support in care homes by GP practices. The CCG continues to look for opportunities to work differently with partners, to transform services and deliver healthcare collaboratively, and meet the

[19] www.england.nhs.uk/mental-health/taskforce/

efficiencies still required to ensure the CCG can manage both the increase in patient numbers now waiting for treatment due to the pandemic and meet its statutory financial duties.

2.10.4 Risk Management

Our policy and approach to risk management is set out in detail in section 12.4 of the Annual Governance Statement and includes the management of COVID-19 related risks now incorporated as business as usual. 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.

2.10.5 Overview of Strategic Risks

In 2021/22, the Governing Body Assurance Framework (GBAF) for North Yorkshire CCG was reviewed twice in public and once at a development session by Governing Body Members. The Audit Committee received the GBAF prior to Governing Body approvals and was assured that processes are in place to manage all risks effectively.

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 CCG received an opinion of high assurance in the management of risk for 2021/22.

All significant risks that have an impact on the CCG's strategic objectives are detailed within the risk management section of the Annual Governance Statement, see section 12.4.

2.10.6 COVID-19 Reimbursements and Preventing Fraudulent Claims

During the pandemic, the CCG's biggest risk of fraudulent COVID-19 claims arose from primary care reimbursements and via the Hospital Discharge Programme. The approval mechanism for all such costs received scrutiny from both the Chief Finance Officer and the relevant budget holder Director for reimbursements up to £50,000, and additional scrutiny from the Finance, Performance, Contracting & Commissioning Committee for reimbursements over £50,000. A detailed list of these claims we reported in full to the Finance, Performance, Contracting & Commissioning Committee and to Governing Body.

In addition to the approval and reporting mechanism noted above, the CCG went further and commissioned the CCG's internal auditors, Audit Yorkshire, to undertake an independent review of both risk areas – primary care reimbursements and the Hospital

Discharge Programme. Both reviews were finalised in 2021/22 and the reports presented to the CCG's Audit Committee. Neither report highlighted any fraud arising in the samples they tested.

2.10.7 The CCGs Project Management Approach

The CCG's project management office (PMO) continues to work closely with project teams across North Yorkshire and Vale of York CCG to move to a standard approach across the geographical area. The CCG's project management handbook continues to provide a useful reference tool and standardised templates that CCG project managers use during the planning and delivery of key transformational projects and the Transformation and Financial Recovery programme.

3 Looking Ahead

The NHS has a lot to be proud of in how it has met people's needs during a time of national crisis. We were able to come together, quickly learn and adjust to new ways of working, and be agile in our decision making. We are now working actively to transform the way that health and care is planned and delivered. This will enable us to take a significant forward step in integrating services and improve people's experience at all stages of health and care. This work is part of a national transformation programme for healthcare to integrate decision making and align delivery. We have high hopes that this transformation will enable us to better ensure the needs of the most vulnerable are being fully met, embed a more responsive person-centred health and care service with a strong focus on prevention and staying well for longer, and improve care for all.

4 Performance Analysis

4.1 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.

4.2 NHS Constitution Requirements

In 2021/22, the continuing COVID-19 pandemic resulted in an increase in waiting times and a reduction in performance across all constitutional requirements nationwide. Pre-COVID-19 activity levels continue to be used by NHS England/Improvement to measure and monitor recovery. The CCG has continued with recovery plans with system partners across the Humber and North

Yorkshire health and care system using the NHS System Oversight Framework and has built on strong partnership working alongside NHS provider trusts and local authorities to improve performance.

The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document.

The NHS System Oversight Framework reflects an approach to oversight that reinforces system-led delivery of integrated care, in line with the vision set out in the NHS Long Term Plan, the White Paper – Integration and innovation: Working together to improve health and social care for all and aligns with the priorities set out in the 2021/22 Operational Planning Guidance.

This framework applies to all Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), NHS trusts and foundation trusts and gives a single set of oversight metrics, applicable to ICSs, CCGs and trusts, which is used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.

These metrics align to the five national themes of the System Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

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 2.10.3, 14 and 15 or for more detail our annual accounts from page 201.

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

NHS Constitution	**Target**	**Position 2021/22** (data as at 31 March 22)
Maximum 18 weeks from referral to treatment (RTT) < 18 weeks incompletes	92%	**66.6%**
Maximum 6 weeks diagnostic test waiting times	≤1%	**31.6%**
A&E waits – 4 hours to assessment, treatment and discharge	95%	**68.7%**
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	**84.5%**
Maximum one month (31-day) wait from decision to treat to treatment for all cancers.	96%	**95%**

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	85%	**72.1%**

4.2.1 18 Week RTT

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
Maximum 18 weeks from referral to treatment (RTT) < 18 weeks incompletes	92%	**66.6%**

Throughout 2021/22 the COVID-19 pandemic has continued to slow down efforts to reduce the number of patients waiting for treatment resulting in an increase in the overall waiting list during the year. Inevitably this has meant that patients are waiting longer for their treatment and the focus for recovery is therefore placed on reducing the number of patients waiting the longest. The target for the number of patients waiting over 52 weeks for treatment is zero and typically across North Yorkshire pre-COVID-19 there were very low numbers on a month-by-month basis. During 2021/22 we have seen an increase in patients waiting in excess of 104 weeks for their treatment rising to the peak in October 2021 and now steadily reducing month on month as a result of targeted recovery actions. Hospital capacity has been compromised throughout the year by infection, prevention and control measures, isolation and social distancing combined with increased referrals into secondary care and the return to pre-pandemic levels of urgent and emergency care demand.

Trusts continue to review their waiting lists in line with the clinical prioritisation framework from P2 to P6 below and employing Evidence Based Interventions (EBI) checks as part of that process:

Category	Definition
P1a	Emergency - operation needed within 24 hours
P1b	Urgent - operation needed with 72 hours
P2	Surgery that can be deferred for up to 4 weeks
P3	Surgery that can be delayed for up to 3 months
P4	Surgery that can be delayed for more than 3 months

Category	Definition
P5	Patient requested to remain on the Waiting List but defer treatment due to concerns regarding COVID-19
P6	Patient has been offered 2 dates for treatment and has declined to accept for non-COVID-19 reasons but still wishes to remain on the Waiting List.

This also includes a clinician conversation with any patient being removed from the waiting list and appropriate sign posting to ensure self-care, alternative care and re-presentation should the need arise. Any potential concerns identified during the clinical review are managed via the serious incident process and the CCG is monitoring this with hospital trusts. These actions are included within the national programme of 'Waiting Well' which aims to support the management of patients on current waiting lists and to mitigate the risks associated with extended waits.

Other methods of prioritisation continue to be used including Faecal Immunochemical Testing (FIT) as well as the commencement of pilot schemes in capsule endoscopy and cytosponge.

The majority of long waits fall into the P4 category and support offers are being developed across the Humber and North Yorkshire Health and Care Partnership (Integrated Care System (ICS)) to help these patients while they wait.

Acute providers across the ICS continue to work together to use the capacity available to treat the most clinically urgent patients by developing shared waiting lists and independent sector capacity is being maximised, particularly in relation to long waits.

4.2.2 Diagnostics

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
Maximum 6 weeks diagnostic test waiting times	≤1%	**31.6%**

The national target for the number of diagnostic tests within 6 weeks is 1%, historically North Yorkshire CCG had been over this target at between 3% and 6% throughout 2019/20, but due to the COVID-19 pandemic by April 2020 this number had increased to over 66% of tests having a wait of over 6 weeks. There had been continuous improvement until October 2021 with 26.4% of patients being seen at more than 6 weeks but due to the Omicron variant the position worsened with January figures showing 38.2% of patients being seen at more than 6 weeks, however by 31 March 2022 the year end position had improved to 31.6%. In 2022/23 we will see a new data collection set as part of the Faster Diagnostic Standard (FDS – see section 4.2.4) work that will help us to understand where diagnostic delays are impacting on cancer 2 week wait pathways and this will help target

interventions. Workforce pressure continues to be the main barrier to increasing capacity. There are plans to increase training places for radiography and increase international recruitment as part of the overall strategy within imaging networks, but it is recognised that there are no quick solutions. The establishment of Community Diagnostic Centres (CDCs) will provide space and equipment for additional activity and training but again, this will not be an overnight solution as centres will take time to develop and staff.

Direct access pathways for routine referrals to GPs are now open with some appointments requiring to be via planned attendance due to space and social distancing constraints in X-Ray departments due to COVID-19. Clinical pathways continue to be reviewed to improve appropriateness of imaging requests to ensure that capacity is optimised to those diagnostic investigations with highest clinical value and outcome. Non-obstetric ultrasound continues to be particularly pressured in York, with implementation of the Saving Babies Lives initiative impacting on non-obstetric ultrasound services across the region. Opportunities to review waiting lists and review criteria for access as well as identifying additional outsourcing will need to be discussed.

Significant effort is being made to ensure endoscopy lists continue to be optimised by offering mutual aid across providers in North Yorkshire and York and also using the independent sector for both insourced and outsourced capacity to maximise throughput and support recovery. Capital funding will be available from 2022/23 for three years and may help increase the number of endoscopy rooms in operation across the region, if bids are successful.

All trusts are reviewing and prioritising their diagnostic waiting lists and, as described in section 4.2.1 above, methods of prioritisation continue to be used in the lower and upper GI pathways including Faecal Immunochemical Testing (FIT) as well as the commencement of pilots of capsule endoscopy and cytosponge and other innovations. We have been working with York and Scarborough Teaching Hospitals NHS Foundation Trust and Pinpoint to develop a research proposal aimed at understanding the potential impact of using Pinpoint (a blood test that can be used to predict a person's risk of having cancer) on the serious non-site-specific pathway. The proposal is in the final stages of development and will complement the work in West Yorkshire that is looking at the use of this test for site specific pathways. If successful, the test could reduce the number of cancer 2 week wait and associated diagnostic tests by 20%.

Community Diagnostic Hubs are being scoped across North Yorkshire and York with early actions being implemented to support the clearance of backlogs created by the pandemic and informed by our work to understand health inequalities within our communities. Work continues across North Yorkshire and York to scope site options for CDCs with a view to establishing a full specification hub in York and two large diagnostic centres, potentially in Scarborough and Harrogate/Ripon as part of the programme. The model will include mobile provision and an increased offer across primary care networks.

4.2.3 A&E Waits

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
A&E waits – 4 hours to assessment, treatment and discharge	95%	**68.7%**

Each of the three main trusts serving the population of North Yorkshire reported a more stable position against the 4hour performance standard during December 2021 and January 2022 although well below the 95% national standard. A&E performance continues to be heavily compromised by high patient demand, high acuity of patient illness, infection prevention and control requirements in maintaining COVID-19 safe environments and increased admissions all contributing to North Yorkshire recording an overall performance of 68.7% for the year as at 31 March 2022 against the 4hr standard.

Significant and sustained increases in patient acuity (particularly for those arriving by ambulance) continue to be reported by Yorkshire Ambulance Service and all North Yorkshire A&E departments in 2021/22. A&E departments across the wider Humber and North Yorkshire (HNY) system reported a similar profile of acuity and demand. High and sustained staff absence rates across all providers, both COVID-19 and non-COVID-19 related as well as necessary COVID-19 testing of patients before admission, had a significant impact on hospital capacity, which in turn compromised flow and performance at each site. The North Yorkshire and York system continues to respond through the Bronze, Silver and Gold escalation routes supporting not only the acute hospitals but all other partner organisations on a daily basis. A&E Delivery Boards and Health Care Resilience Boards continue to function and provide an important North Yorkshire and York system oversight as well as sharing of new initiatives. North Yorkshire and York system Bronze escalation meetings have been held most days over the last 24 months in order to support and respond to the sustained levels of escalation and demand pressures across the North Yorkshire and York system.

The nationally driven NHS 111 First initiative commenced across the Humber and North Yorkshire area on 1 December 2020. Demand on the Yorkshire Ambulance Service (YAS) provided NHS 111 service has remained high during Quarters 3 and 4 of 2021/22. We continue to promote the appropriate use of the NHS 111 service across North Yorkshire using the national communication materials. These changes are aimed at increasing the number of NHS 111 calls that, having received an initial NHS 111 "A&E department" or a "speak to within 1 or 2 hours primary care" disposition, then receive a clinical review through the central or local Clinical Advisory Service (CAS) prior to their final disposition being confirmed.

This additional clinical review is provided through the existing central CAS based at YAS HQ in Wakefield and is supplemented through a locally based HNY commissioned CAS, provided by Vocare, commencing operation on the 5th December 2020. The positive impact has continued with consistently above 70% of patients every month, following clinical review, being safely

redirected to other pathways and away from A&E. The remaining 30% had their original NHS 111 A&E or speak to primary care dispositions confirmed. For more information see sections 2.4.1, 2.4.2, 2.4.3 and 2.4.4.

4.2.4 Cancer Waiting Times

The application of pre-COVID-19 activity levels continue to be used to as the baseline to measure and monitor recovery. Post-COVID-19 cancer services will look different to pre-COVID-19 services, for example, the development of new, shorter pathways towards diagnosis (Rapid Diagnostic Pathways) and the continued application of virtual interfaces with patients (where appropriate).

All Cancer Alliances, including the three which cover North Yorkshire, are currently working with key stakeholders to produce delivery plans for 2022/2023, which will be signed off with the National Cancer Team. These plans are required to address both recovery and performance metrics/outcomes.

A national consultation has just been launched regarding changes to the Cancer Standards and Operational Targets.

2WW Referrals and the Faster Diagnosis Standard

NHS Constitution	**Target**	**Position 2021/22** (data as at 31 March 22)
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	**84.5%**

Referral rates continue to be above the baseline as has been the case since April 2021. This means that the extent of the 'missing referral gap' continues to fall from 7,647 in April 2021 to 3,417 by the end of March 2022 across Humber and North Yorkshire. Increased 'front of the pathway' activity over and above the baseline inevitably has a detrimental impact on all subsequent performance targets and the size of the 62+ day backlog and referral increases in the Humber and North Yorkshire Cancer Alliance (HNY CA) reflect a similar pattern of increases both regionally and nationally.

However, not all cancer pathways are recovering at the same rate. For example, as a result of urological referrals being relatively slow to recover, and the consequent reduction in number of urological treatments, the National Cancer Team have identified and adopted prostate cancer as the subject of a national campaign.

The focus on the 28 Day Faster Diagnosis Standard (FDS) (28 days from receipt of referral to receipt of a diagnosis of cancer (or not)) continues. This standard will replace the 2WW wait cancer waiting time standard as per the national consultation referenced above. Whilst performance against this standard has been depressed throughout the pandemic, performance across the Alliance

continues to improve and performance for October and November 2021 have both been in excess of 70% across Humber and North Yorkshire, culminating in a March 2022 position of 73%.

It is important to remember that as the anticipated impact of the pandemic on cancer pathways reduces, in the pre-pandemic era capacity in cancer diagnosis, treatment and care was under pressure as a result of changing population demographics (cancer is predominantly a disease of old age). It is unlikely the pandemic will have significantly changed this situation.

31 Day Wait from decision to treatment for all cancers

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
Maximum one month (31-day) wait from decision to treat to treatment for all cancers.	96%	**95%**

Providers are adept at delivering treatments for patients once diagnosed. However, access to surgery has been the treatment option most impacted by the pandemic where capacity has been restricted to ensure 'COVID-19 secure' physical and working environments. In addition, there is a national shortage of oncologists, which has continued to resonate at regional, Humber and North Yorkshire levels.

62-day wait from urgent GP referral to first definitive treatment for cancer

NHS Constitution	Target	Position 2021/22 (data as at 31 March 22)
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	85%	**72.1%**

All Cancer Alliances continue to be challenged by the 62 day standard. Inevitably, as cancer pathways, which were already challenged pre-pandemic, are starting to manage the backlog on top of normal activity it means that this performance target will continue to be a challenge for some time. A common bottle neck across all Cancer Alliances both pre, during and post-pandemic will continue to be access to diagnostics, and all Cancer Alliances have significant work programmes and investments to tackle this issue.

In addition to providing short term increases in diagnostic capacity, the three Cancer Alliances serving North Yorkshire have acted as conduits for national transformation monies targeting medium to long term solutions to improve access to diagnostics. These initiatives include including networking of reporting systems, Artificial Intelligence and the development of Rapid Diagnostic Pathways. The HNY Cancer Alliance backlog position (15.7% of patients on the waiting list during the week ending 9 January

2022) places it as being one of the most challenged alliances in England, in this respect. However, it is also important to note that not all these patients will have a diagnosis of cancer and will also include patients whom for valid clinical reasons will have had their treatments delayed or postponed. See also sections 2.4.5 and 6.11.

4.3 Other performance measures

4.3.1 Hospital Infections

Indicator	Threshold	Position 2021/22 (data as at 31 March 22)
Clostridioides Difficile (Cumulative)	138	182
MRSA (Cumulative)	0	4
E.Coli (Cumulative	394	371

The Medicines Management team continue to have oversight of all cases reviewed and attend the relevant panels for each NHS trust. Community acquired cases are also reviewed through the Health Care Associated Infections (HCAI) panel processes. Where there are trust specific concerns regarding threshold breaches, the CCG continue to monitor and seek assurance in individual panels which are reported on up to the relevant governance structures.

The CCG is in regular discussions with York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) regarding wider infection prevention and control issues and following the revision of the post-infection review and reporting processes. Regular updates continue to be provided via the joint quality and patient safety meeting which the chief nurse attends. Of note for YSTHFT, the Trust requested a NHSE/I peer review across all aspects of Infection Prevention and Control at both York and Scarborough sites, which has assisted in providing the focus for actions required. Additional meetings are planned to look at further support and actions.

In relation to South Tees NHS Foundation Trust (STHFT), a meeting has been held between the CCG Chief Nurse and the Lead Nurse to offer support and review the processes. Currently weekly panels are being held to review all cases to ensure that any themes/lessons learned are identified and actioned. It is recognised that all acute providers are working under extreme pressures due to the impact of the Omicron variant.

The CCG remain assured by Harrogate and District Foundation Trust's reporting of HCAI and subsequent investigations where needed.

A hydration pilot across North Yorkshire and York care homes is due to commence with the aim to reduce urinary tract infections and E.coli bacteraemia. This has been supported through funds from NHSE/I and is being led by NHS Vale of York CCG.

All other HCAI data is monitored through the provider quality meetings and the CCG Nursing and Quality Team are represented. All community acquired HCAI's are reviewed through a panel process where themes and learning are shared.

As the COVID-19 pandemic continues, collaborative working continues with the CCG supporting both primary care and care homes. The CCG are appraised of any outbreaks of COVID-19 within acute and community provider organisations and attend relevant meetings where needed to support and for assurance.

The North Yorkshire CCG area is seeing an improved position of incidence of COVID-19 across North Yorkshire care homes settings. Full multi-agency partnership working continues to support care homes across the North Yorkshire System with focussed groups to monitor quality and safety of care home residents. A well-established local authority/public health led daily admissions panel continues in order to support care home admissions where they have experienced outbreaks.

4.3.2 GP Appointments

Indicator	Threshold	Position 2021/22 (data as at 31 March 22)
GP Appointments: Face-to-Face	n/a	**171,193**
GP Appointments: Non Face-to-Face	n/a	**67,051**
GP Appointments: Unknown	n/a	**9,811**
GP Appointments: All Appointments	n/a	**249,256**

GP appointments are now significantly above March 2020 levels by approximately 45,000. In December 2021 primary care also delivered the COVID-19 vaccination booster programme and dealt with an increase in demand and higher levels of COVID-19 in the community. Since January 2022 while overall levels of COVID-19 reduced, at this time there was a subsequent and significant increase in patient and staff COVID-19 infection in the period to Easter, 15th to 18th April 2022. This caused a sharp rise in primary care staff sickness absence and placed additional demand pressure on GP Practices. However, throughout this period no North Yorkshire GP Practices were closed. To support the winter and easter periods the CCG commissioned approximately 19,000 additional video and telephone appointments from third party providers through ringfenced Winter Access Funding to reduce the impact of staff sickness. In addition, local schemes have provided further extended access capacity to support patient demand.

4.3.3 Prescribing

Indicator	Threshold	Position 2021/22 (data as at 31 March 22)
Appropriate prescribing of antibiotics in primary care	0.871	**0.851**
Appropriate prescribing of broad spectrum antibiotics in primary care	10%	**7.2%**

In common with other CCGs in England, the overall rate of antibiotic prescribing within North Yorkshire CCG has been increasing since May 2021. This is following on from a significant reduction seen during early phases of the pandemic, when prescribing of antibiotics dropped by around 15% due to lower rates of respiratory tract infections. In a continued effort to consolidate the national improvements made in recent years on the prudent prescribing of antibiotics, NHS England/NHS Improvement have tightened the national target to 'at or below 0.871'. The March 2022 North Yorkshire CCG rate of 0.851 is below this new target and also slightly below the rate for England which is 0.853. Work continues in the effort to further reduce antimicrobial prescribing and the CCG issued the most recent antibiotic 'Prescribing Focus' to GP practices in May 2022.

The rate of prescribing of broad-spectrum antibiotics has been reducing steadily since May 2021. For North Yorkshire, this remains well below both the national target of 10% and the rate for England, which was 8.7% in March.

Of note is that North Yorkshire is one of only four CCGs in our NHSE region who are meeting both these prescribing targets. For more information on the work of the Medicines Management Team please see section 6.18.

4.3.4 Dementia

Indicator	Threshold	Position 2021/22 (data as at 31 March 22)
Estimate diagnosis rate	66.7%	**58.6%**

North Yorkshire dementia diagnosis rates remain fairly static at around 58%. This is above the Humber and North Yorkshire performance of 57.2% but falls under the national performance of 61.6% against a target of 66.7%. Resource and skill mix within teams continues to be a challenge, and there continues to be a growing waiting list due to increased demand. Processes have been streamlined where possible to make the patient journey and assessment less lengthy.

A paper has been submitted to the partnership to illustrate the gaps with proposals for additional posts, but it is acknowledged that consistency needs to be facilitated across North Yorkshire until next steps are reviewed. It was agreed at the last quality meeting

with Tees, Esk and Wear Valleys NHS FT (TEWV) to have a joint event with Vale of York CCG to agreed how to take this forward, which will involve TEWV and primary care colleagues.

A pilot is being explored in the Hambleton Richmondshire area to support the same day emergency care team and GPs to deliver diagnosis and treatment using the Diagnosing Advanced Dementia Mandate (DiADeM) tool for more advanced patients. This would improve the dementia diagnosis rate in the locality. Timely diagnosis and treatment could reduce admissions to acute hospitals, mental health hospitals and care homes. See also section 2.8.6.

4.3.5 Improving Access to Psychological Therapies (IAPT)

Indicator	Threshold	Position 2021/22 (data as at 31 January 22)
IAPT Roll-Out	4.8%	**4.1%**
IAP Recovery Rate	50%	**57.4%**

To meet the 20% commissioned access standard, 691 patients must enter treatment during a month. In January, the overall number of people entering treatment was 589 and the number of referrals received by the service was 743, with a significant number being inappropriate. The COVID-19 pandemic created disruption to the trainee programme and contributed to a high number of vacancies and high staff sickness levels but in spite of this 97.43% of people are seen within six weeks against a target of 75% and 100% are seen within 18 weeks against a target of 95%. See also section 2.8.7.

A gap analysis is being undertaken to assess the position compared to the long term plan ambition of 25% of people accessing treatment by March 2024. Next steps for consideration will include:

- Developing a local and mobile workforce
- Long term conditions pathways
- Enhanced training and support for people with a diagnosis of Autism Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD)
- Training places
- Referrals

4.3.6 Learning Disability Transforming Care Programme (TCP)

Indicator	Threshold	Position 2021/22 (data as at 31 March 22)
CCG Inpatient Beds	10	14
Specialised Commissioning Inpatient Beds	11	10
CAMH Beds	1	2

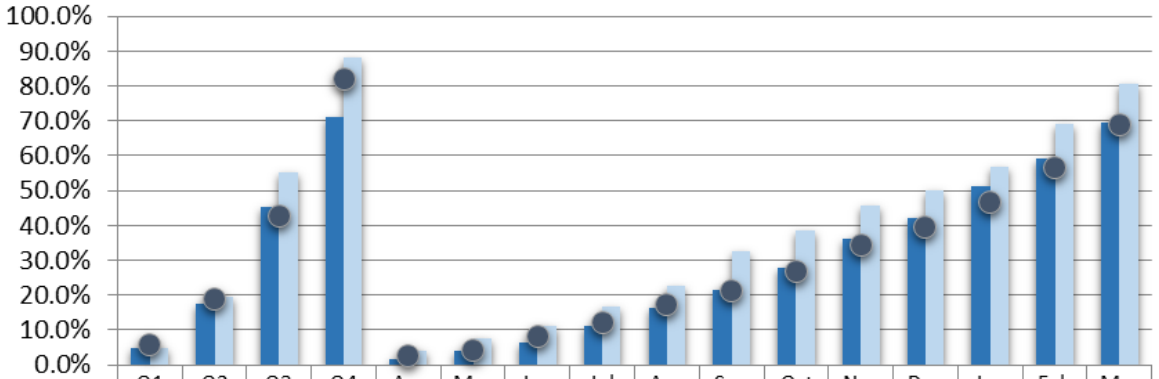
The inpatient North Yorkshire (NHS North Yorkshire CCG) and York (NHS Vale of York CCG) TCP trajectory for 2021/22 was set at 22 in total (including CAHMS) with a position of 26 at the end of the year comprising 14 CCG and 10 specialised commissioning beds respectively. The Children and Young People (CAHMS) trajectory was set at 1 with the actual position at 2.

Care and Treatment Reviews (CTRs) have been completed within expected timescales and all safe and wellbeing reviews have been undertaken with actions managed and monitored through the TCP governance processes. Monthly meetings are scheduled to link with the commissioning collaborative and the forensic outreach liaison service is fully engaged and embedded in discharge planning. However, crisis beds are under pressure with no beds available locally. See also section 2.8.1.

4.3.7 Annual Health Checks

The uptake of annual health checks for people with a learning disability continues to improve and delivered the 75% requirement across North Yorkshire and York for 2021/22. North Yorkshire CCG performance dropped below the target achieving 69.7% and plans are place to assist GP practices improve uptake of annual health checks for 2022/23.

Learning Disability Health Check Scheme

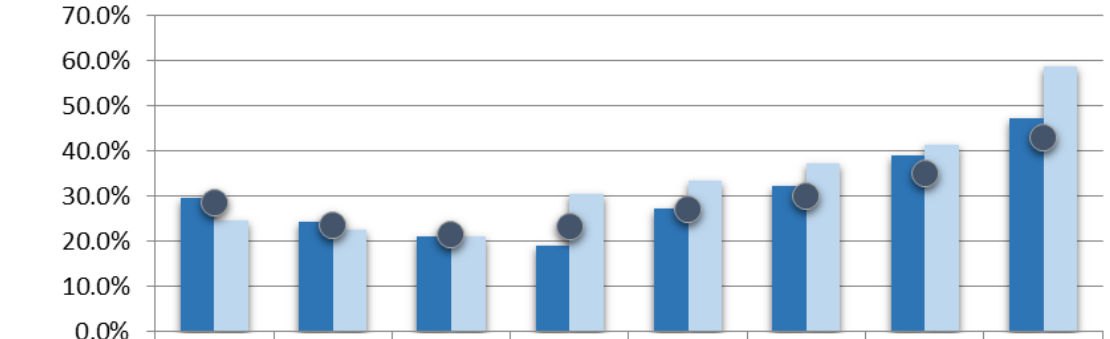


	Q1	Q2	Q3	Q4	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2020/21				2021/22											
NYCCG	4.9%	17.7%	45.4%	71.1%	1.6%	4.1%	6.5%	11.1%	16.3%	21.3%	27.7%	36.3%	42.3%	51.1%	59.4%	69.7%
VoYCCG	4.8%	19.7%	55.4%	88.1%	4.1%	7.6%	11.0%	16.9%	22.6%	32.7%	38.7%	45.7%	50.1%	57.0%	69.2%	80.5%
England	5.8%	18.9%	42.6%	81.9%	2.6%	4.3%	8.0%	12.2%	17.5%	21.4%	27.0%	34.3%	39.7%	46.6%	56.5%	69.0%

The uptake of annual health checks for people with a severe mental illness continues to improve but remains below the target of 60% across North Yorkshire and York for 2021/22.

NHS North Yorkshire CCG performance was 47.1% at 31st March 2022 and work is ongoing to assist GP practices to improve uptake of annual health checks for 2022/23.

Physical health checks for people with severe mental illness (SMI)



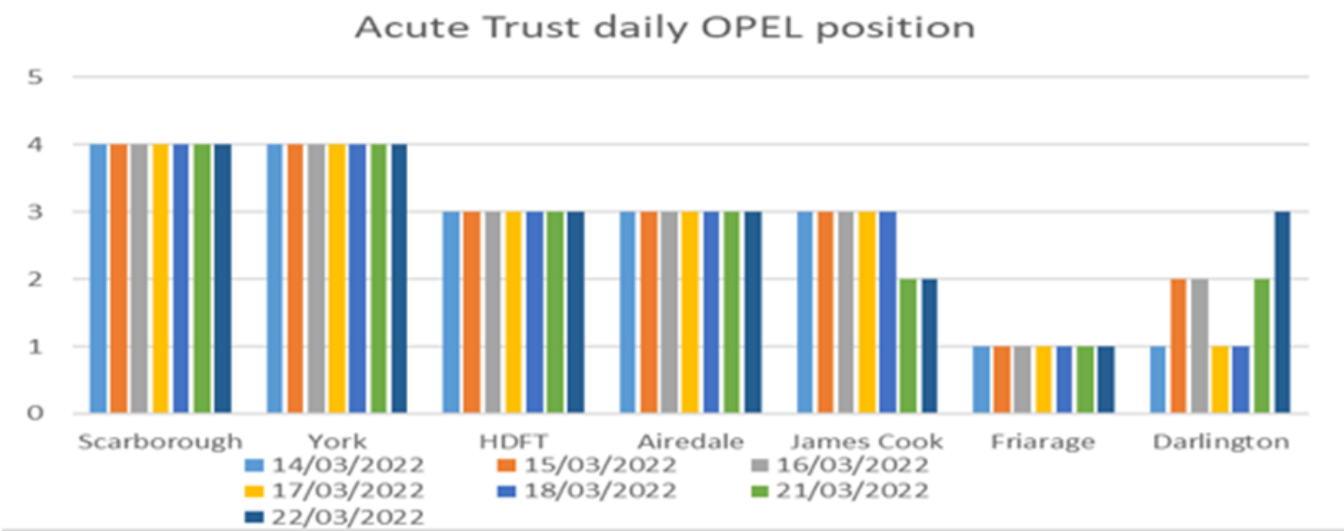
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	2020/21				2021/22			
NYCCG	29.5%	24.4%	21.2%	19.0%	27.2%	32.2%	38.9%	47.1%
VoYCCG	24.7%	22.6%	21.2%	30.5%	33.5%	37.2%	41.5%	58.8%
ENGLAND	28.6%	23.7%	21.6%	23.4%	27.1%	30.0%	34.9%	42.8%

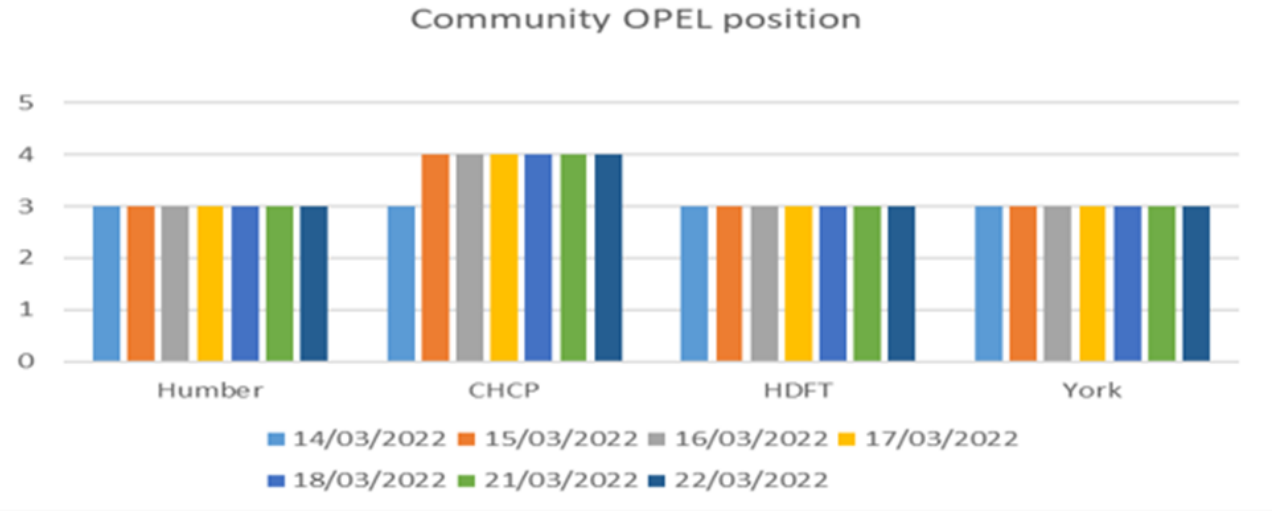
4.4 Managing System Pressures

4.4.1 OPEL Escalation Levels

As part of the ongoing COVID-19 pandemic response a programme of work was undertaken to promote the adoption of OPEL escalation levels, already used by many hospital providers, across primary care and the wider health and care system. A reporting process for primary care pressures was fully rolled out across all North Yorkshire GP Practices. This digital application enables practices to easily report current pressures and their level of operational escalation (1 – 4). These are monitored daily by the CCG and appropriate support is then provided to practices and also as part of the North Yorkshire and York System Overview Tactical Group.

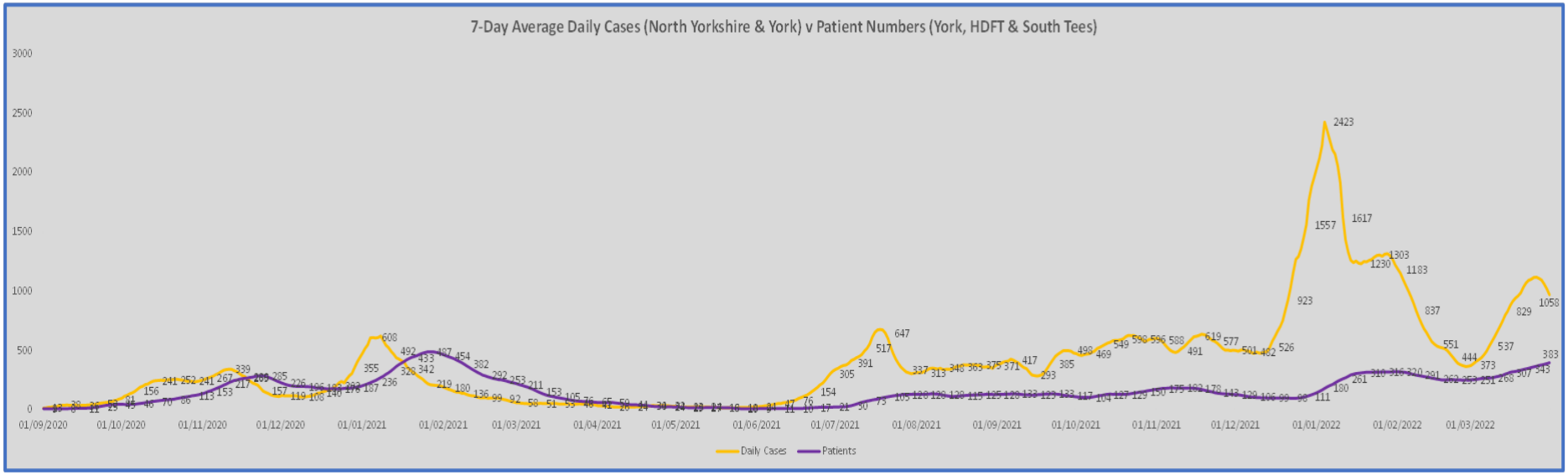
Local Authority	OPEL Position
North Yorkshire County Council	4
City of York Council	3
East Riding of Yorkshire Council	3





4.4.2 Managing COVID-19

In order to manage operational pressures, the North Yorkshire and York system tactical group and incident control hub has been monitoring the impact of COVID-19 on the system. Multiple activity data from different organisations have been tracked to inform our response. One example below looks at how rises in COVID-19 cases (yellow line) correlate to rises in hospitalisations (purple line). The graph below illustrates the position from September 2020 to March 2022.



Source: Rural Services Network, 2020

5 Sustainable Development

The NHS is the largest employer in Britain and is responsible for 4% of the nation's carbon emissions. In October 2020, NHS England & Improvement published it's Delivering a 'Net Zero' National Health Service report setting the ambitious targets to deliver a net zero NHS carbon footprint by 2040 and to achieve net zero on emissions we can influence (NHS Carbon Footprint Plus) by 2045.

The CCG recognises the role it plays in delivering these targets and how our activities and decisions have the 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, its 2040 net zero target and our legal duty to cut carbon emissions under the 2008 Climate Change Act.

The CCG has published the NHS North Yorkshire CCG Green Plan (2020 – 2022) on the CCG website[20], which was approved by the Governing Body. The Governing Body also appointed the Lay Member for Patient and Public Engagement as the Sustainability Lead for the CCG.

NHS North Yorkshire CCG is part of the Humber and North Yorkshire Sustainability and Climate Change Network Group which works in partnership with NHS and social enterprise organisations to lead and influence Humber and North Yorkshire's ambition to

[20] https://pdf.browsealoud.com/PDFViewer/_Desktop/viewer.aspx?file=https://pdf.browsealoud.com/StreamingProxy.ashx?url=https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/12/2020.12.10-FINAL-NHS-North-Yorkshire-CCG-Green-Plan-2020-22-V1.0.pdf&opts=www.northyorkshireccg.nhs.uk#langidsrc=en-gb&locale=en-gb&dom=www.northyorkshireccg.nhs.uk

meet the NHS carbon footprint targets, particularly as the CCG's progress to the long-term vision of integrated care systems. This group has also considered the transition of the sustainability workplan into the ICS.

The CCG is aware of the impact of the rurality of its localities and the challenges this creates in delivering equitable health services. Issues regarding health inequalities and how the CCG are addressing them are highlighted in Section 7. COVID-19 has exacerbated existing problems in rural areas and also highlighted new ones and these will be addressed during the recovery work over the coming year.

As a member of the Rural Services Network, the CCG also recognises the challenges faced by NHS organisations operating in rural areas, as highlighted in the diagram, and is working with its partners across the local health service to find ways to make improvements.

COVID-19 has had a substantial impact on the CCG's approach to working and has had a positive impact on sustainability in the organisation. The roll out across the organisation of smarter ways of working, such as mobile devices for all staff and the introduction of programmes such as Microsoft Teams and Jabber, has minimised the requirement for staff to travel. Staff have also had limited access to paper documents and as such there has been significant progress towards a paperless office.

The CCG has learned from the impact of COVID-19 on new ways of working and a Home First Working Policy has been developed offering staff the choice of working from home and as a result, reduces the level of staff commuting. The CCG estate was reviewed in 2021/22 which considered the impact the different working style had on the use and size of the existing office space. Changes to some of the office sites and introduction of hot desking systems has had a positive impact in terms of sustainability, such as energy efficiencies.

With regards to staff health and wellbeing during this period, a number of initiatives have been introduced to support staff working from home. These have included CCG wide and team 'coffee breaks', a Wednesday Un-winder Newsletter with suggestions for looking after physical and mental health, recommendations for books to read and TV and films to watch and mobile apps to support hobbies. The CCG has an active Staff Engagement Group which, among other things, has looked at ways to help staff maintain work life balance. Funding has also been received to promote the health and wellbeing of staff, see sections 8.1.4 and 15.8.3.

In addition to these changes to the way we work, the CCG has continued with positive work in the following areas throughout the year to increase its sustainability:

Emissions	What are we doing?
Pharmaceuticals	• We continue to reduce pharmaceutical waste.
Energy	• When staff return to the offices we will 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 will continue to encourage a paperless office.
Travel and Transport	• Staff are encouraged to work from home and hot desk where appropriate once working from offices resumes. • Teleconferencing facilities are available in the CCG office and all staff have access to Microsoft Teams reducing the need to travel to attend meetings. • Staff are encouraged to car share when attending meetings when it is safe to do so. • 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 motorcycle use. • The CCG offices have facilities available to encourage active travel such as cycle parking, showers that are accessible to staff and visitors alike.
Our People	• When staff return to the offices, they have access to facilities and support for their health and wellbeing including a staff room for rest and kitchen facilities. Our organisation and estates are 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.

5.1 Procurement

The NHS is a major employer and economic force both in North Yorkshire, 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 North Yorkshire and the surrounding area. We are committed to the

development of innovative local and regional solutions and in 2021/22 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 Improving Quality

The CCG complies with its responsibility to discharge its duty to improve quality under section 20 of the Health and Social Care Act 2008 (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.

To ensure effective governance, all potential new or changes to services have been subject to a Quality and Equality Impact Assessment (QEIA). This is completed as part of the commissioning cycle and are reviewed by the Quality and Clinical Governance Committee (QCGC) to ensure that all commissioning decisions are also considering the quality perspective in addition to the performance and financial objectives. 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 last year, in spite of the continued COVID-19 pandemic, work has continued with providers to seek assurance and have a productive dialogue regarding care provision, areas of improvement, lessons learned and new innovations.

6.1 Quality of Primary General Practice Services

The quality of General Practice primary care services has continued to be a key priority for the CCG and is overseen by the Primary Care Commissioning Committee, which in 2021/22 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 51 practices. Patient feedback from GP Practices continues to be good with Friends and Family performance above the national average.

The GP Survey (published 2021) shows favourable responses for North Yorkshire CCG compared with national figures. 89% of patients reported that their experience at their GP Practice was either Very Good or Fairly Good. This is compared with 83% nationally.

6.2 Care Quality Commission (CQC) Inspection of GP Practices

All 51 of our practices have been inspected by the Care Quality Commission (CQC). 98% of our practices had a CQC rating of 'Outstanding' or 'Good' compared to a national figure of 95%. One practice that had received a previous rating of 'Requires Improvement' was re-inspected during 2021/22 and received a rating of 'Good'. This was as a result of considerable work to

improve the services, leadership and governance of the practice and demonstrates the commitment and skills of the whole practice team.

6.3 NHS Continuing Healthcare Fast Track Pathway for End of Life 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 their 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 patient and family feedback, health care staff in hospitals and the 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 NHS North Yorkshire CCG, with the process managed through the Continuing Healthcare Team. In addition, the integrated end of life care pathway is now well established in the Hambleton and Richmondshire area. This service allows patients to die at home if it is their preferred place of care, knowing they are receiving the best possible care and support. Day time care is provided by Herriot Hospice Home Care, supported by the District Nurses, Community Nurses, Specialist Palliative Care and GPs. Marie Curie continue to provide an overnight nursing care service which is supported by Registered Nurses and Health Care Assistants. Following a successful pilot with Saint Michael's Hospice in Harrogate, a similar integrated pathway has been established for our end of life population in the Harrogate and Rural area supported by the District Nurses, Community Nurses, Specialist Palliative Care and GPs with Marie Curie also providing overnight care. To ensure equity of services across the North Yorkshire area and in response to continued challenges in securing timely care for people at the point of request, NHS North Yorkshire CCG is working with partners to commission a new service model for palliative and end of life care across the Scarborough, Ryedale and Whitby area. This integrated and locally responsive model of care intends to meet the needs of individuals whilst ensuring equity of access to palliative and end of life provision across the North Yorkshire area and aligns to that of other existing service models and pathways of care. Through this change we envisage improved outcomes for our end of life population and their families and for this area the overnight nursing service provided by Marie Curie partners will continue.

In September 2020, the Government updated the hospital discharge process providing funding via the NHS for up to six weeks for reablement and recovery on discharge from hospital, and in February 2021 this was extended until the end of June 2021. Four pathways were identified locally with Pathway 4 being those people at End of Life. The CCG has developed a Local Area Agreement with North Yorkshire County Council, with the CCG maintaining responsibility to review these individuals appropriately at four and eight weeks and either transfer to the Fast Track funded pathway or be assessed for Continuing Healthcare funding.

This was to minimise the need for people on this pathway to go through multiple assessments with potentially two agencies and to identify the most appropriate source of funding without delay, enabling choice including remaining at home and preventing unnecessary readmission to hospital. Access to Fast Track referral for those living in their own homes remains unchanged.

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

Supporting people to leave hospital has continued to be a priority during the last year, particularly as the NHS has started to return to business as usual and address the elective backlog created by the pandemic. The level of activity, combined with the continued volumes of people with COVID-19, has meant maintaining fast discharges has been challenging throughout the year. The CCG has worked closely with Vale of York CCG, North Yorkshire County Council (NYCC) and City of York Council (CYC) to deliver support to local hospitals and meet the requirements of the National Discharge Policy. For more information on the work carried out this year please see section 2.7.3.

6.5 Continuing Healthcare

Throughout 2021/22, with the easing of restrictions due to COVID-19, the Continuing Healthcare Team (CHC) has successfully adapted to working both virtually and returning to face-to-face appointments where necessary.

iQA is a software platform specifically designed for managing NHS-funded continuing healthcare and is used extensively by the CHC team for all aspects of CHC care management, finance and performance reporting and is being updated in line with NHS England reporting requirements. Dedicated staff time and resource continues to be employed to review standard processes for all areas of CHC activity allowing for consistent standards and practices

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. All PHBs are now managed ‘in house’ in conjunction with the North Yorkshire County Council Direct Payment Team. The CHC team is in the process of moving all packages of care at home on to a ‘Notional’ PHB in line with NHS England & Improvement targets and the ‘Right to Have’ guidance. The team is improving support planning and looking at ways of simplifying this for individuals and their families. In January 2022 a PHB Lead was employed to drive forward personalisation and improve the service offered, improving and developing links with the voluntary sector and third party sector. In January 2022 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 PHBs and received Significant Assurance on the effectiveness of the controls in place.

One of CHC's key objectives is to ensure that CHC assessments are undertaken in a timely way (within 28 days of referral). As at February 2022 the team has achieved over 80% of 28 day assessments meeting NHSE requirements.

During 2021/22 the Discharge to Assess funding period was reduced to 4 weeks from 6 weeks and a system is in place to manage the funding of those that extend beyond this time frame.

The Mental Health and Vulnerable Adults Team has continued to manage those individuals who require support under S117 Mental Health Act. This includes, but is not exclusive to, this group, legal support and challenges to Deprivation of Liberty restrictions and work is underway between the CHC S117 team and stakeholders to develop a pathway for children eligible to S117 funding.

6.6 Personalisation and Choice

The CCG has 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.

We are currently developing our improved PHB offer and are involved in a number of work streams and multi-agency planning reporting to market development board in nursing and residential strategy and also supported living and housing solutions.

We are involved in the Humber and North Yorkshire Personalisation Care Network Group and are in the process of developing a PHB Lead position within the team to lead and drive personalisation and choice.

6.7 Diabetes

Diabetes improvement workstreams have continued across all areas of North Yorkshire during 2021/22. We also continue to join the Humber Coast and Vale Elective Diabetes Steering Group which leads the programme of work and drives transformation across the ICS geography.

When people are newly diagnosed with diabetes, they should receive structured education to inform them about their condition and help them to self-manage. However, during much of the pandemic, providers in North Yorkshire were unable to offer face to face sessions. In response, virtual services for Structured Education were provided where possible. Patients on our Structured Education type 2 waiting list were referred to the Oviva Diabetes Support programme which was piloted as part of the wider ICS. The Oviva Diabetes Support programme is a remote, app-based programme over 12 weeks during which time patients have access to advice from a specialist coach to help them manage and improve their condition. Patients without a smartphone can

access the programme through regular phone calls with their coach. Once completed, patients have lifelong access to the app, resources and online materials. Positive outcomes have been reported and we continue to investigate the longevity of this pilot. We are now resuming face-to-face provision for people who prefer this method of support and addressing the waiting lists that have built up. We will continue to offer virtual support where this is appropriate.

The National Diabetes Prevention Programme (NDPP) is a nationally approach that supports people where they are identified as being at high risk of developing diabetes. Again, as a result of the pandemic, providers were unable to offer face to face sessions. Virtual services were delivered but utilisation of the programme has been much lower than would have been the case. The programme is restarting and has been actively repromoted with primary care, with a view to increasing the number of people benefitting in the future.

The Low Calorie Diet was introduced across North Yorkshire in February 2021. The fully remote programme, offering total diet replacement and accessed via GP referral is designed to help people with type 2 diabetes lose weight, achieve a healthy blood glucose level, and reduce their need for diabetes and blood pressure related medications. The programme is offered over a 12 month period and is led by a team of diabetes specialist dietitians who provide education and support. This continues to report strong weight losses, with an average loss of 15.6kg at the 6 month point.

In September 2021, albumin to creatine ratio (ACR) home testing for people with diabetes was introduced as a pilot across the Humber Coast and Vale area. This is a smartphone app and home test kit enabling people to complete their annual urinary ACR test from home using their mobile phone camera. The collaboration with health technology company Healthy.io, enables practices to engage with previously hard-to-reach patients and address any backlog in chronic disease management for people living with diabetes.

Primary care-based diabetes management is delivered by GP practices, as part of their general support for Long Term Conditions (LTC). The usual processes for managing LTC were obviously made more difficult as a result of the pandemic. Following a successful funding application through the Humber Coast and Vale ICS Diabetes Steering Group, we received primary care recovery funding to support diabetes care in our area. The aim was to increase the number of people with diabetes receiving all 8 treatment processes back towards the levels achieved before the pandemic. This funding also allowed the use of risk stratification tools to help target patients who may be at the most risk.

Effective footcare is a vital part of all diabetes services. Harrogate District Foundation Trust (HDFT) provides podiatry services across the whole of North Yorkshire and York. Supported by transformation funding, HDFT have continued to provide rapid response to active foot problems, including escalating to Multi-Disciplinary Foot Clinics. Education on the diabetic foot to primary

care and community professionals has now also resumed, with the aim of ensuring all staff who come into contact with a person with an active foot problem are able to escalate and manage this appropriately.

Finally, the role of Diabetes Inpatient Specialist Nurses has continued to develop in acute hospitals. In 21/22, the development focus has been on extending specialist nursing capacity in Scarborough hospital to cover the full 7-day period, supported with an additional post through transformational funding.

6.8 Respiratory Conditions

COVID-19 is a respiratory disease, so a series of innovations and developments have been put in place this year by respiratory teams in response.

HDFT, Y&SHFT and STHFT have all established Post-COVID-19 services for adults. These receive referrals from primary care, supported through a national enhanced service, and involve a multi-disciplinary assessment and treatment process for people still not recovering after 3 months. Additional investment has been agreed, supported by a national funding allocation, and these services have actively been recruiting additional physiotherapy, occupational therapy, psychology and nursing capacity. Support from Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) has also been provided to allow IAPT (Improving Access to Psychological Therapies) staff to participate in the MDT assessment process.

Services for children affected by Post COVID-19 syndromes are provided by the specialist centres: STHFT, Leeds Hospitals NHS Trust, and Hull University Teaching Hospitals NHS Trust. Pathways from HDFT and Y&SHFT paediatric departments have been established to these services.

Throughout the last year, STHFT, HDFT and Y&SHFT operated virtual wards for people who have COVID-19 so that they can be discharged home at an earlier stage. These services provide advice and reassurance over the phone, supported by tracking oxygen saturation levels using home-based oximeters to give confidence that levels are within safe and expected limits. These devices allow patients or nurses to identify if a deterioration is occurring and hence if a person may need further medical support. GP practices also continued to offer an Oximetry at Home service for people presenting with COVID-19 in primary care who at greater risk of asymptomatic hypoxia.

We started the process of developing and improving pulmonary rehabilitation services for people with Chronic Obstructive Pulmonary Disease. These are usually group-based classes which run for 6-8 weeks and comprise education and structured exercise to help people self-manage their condition. During the pandemic, these services largely had to be suspended, although providers were in some cases able to support people on-line. We have worked with providers (STHFT, Y&SHFT, and HDFT) to

recommence these services from Spring 2022. We have also been able to provide some non-recurrent investment to these services to start the process of working down the waiting lists and to begin the process of service expansion for the future. This included equipment needed to restart rehabilitation classes, IT to support virtual classes, and some temporary staffing.

North Yorkshire PCNs have also started participating in an ICS-wide project to implement FeNO (Fractional exhaled Nitric Oxide) diagnostic testing. This is part of a transformation programme sponsored by the Academic Health Sciences Network to improve asthma diagnosis and management (Path-to-FeNO). The programme involves working with PCNs to create PCN-level diagnostic services, supported by the provision of new FeNO testing machines.

6.9 Ophthalmology

NYCCG have joined the Humber Coast and Vale Eyecare Steering Group whose main focus is delivering the transformational priorities identified in the national eye care programme, locally we have also implemented three North Yorkshire and York task and finish groups to deliver these priorities on a local footprint.

The priorities include both the cataract and glaucoma integrated pathways and task and finish groups have been set up with key stakeholders to understand the integrated pathway definitions for cataract follow up pathways and glaucoma refinement referral and low risk patient monitoring pathways.

We are also part of the North East and Yorkshire Electronic Eyecare Referral system (EeRS) procurement. This is an electronic referral management, advice and guidance and image sharing system which will facilitate connectivity between primary care optometry/community optometrists and specialist/hospital eye care services. We are currently in Phase 2 for delivery of this system and therefore expecting implementation later in 2022, however the initial meeting of our North Yorkshire and York implementation group has taken place and scoping work continues.

The existing Minor Eye Conditions service has been reprocured to a Community Eye Care Service to ensure consistency of service and access across North Yorkshire and York. The new model commenced on 1 December 2021 in Vale of York and Ryedale areas and 1 February 2022 in Hambleton, Richmondshire, Whitby and Harrogate areas. This new model now includes a Glaucoma repeat readings service which rechecks the patients Intra Ocular pressure (IOP) on a separate occasion, therefore reducing the Glaucoma referrals into the hospital eye care services. The new model is accessible via community optometrists who provide the service on behalf of primary eye care services, and referral routes into the service include GPs, NHS 111, Urgent Treatment Centres, pharmacists and hospital A&E departments. This new model will avoid unnecessary hospital attendances, improve patient access to ophthalmology services closer to home and give early patient advice where self-management is appropriate.

6.10 Humber and North Yorkshire Integrated Stroke Delivery Network (HNY ISDN) Work Programme: Progress to Date

6.10.1 Review of Hyper Acute Stroke Units (HASU)

HASUs provide the initial investigation, treatment and care immediately following a stroke. An external clinical review (lead by the National Clinical Director for Stroke) of the hospitals providing hyper acute services across Humber and North Yorkshire has been completed.

The outcomes of these reviews have led to the development of action plans at provider level and the Integrated Stroke Delivery Network (ISDN) will work with providers over the next year to ensure these actions are progressed within the agreed timescales.

6.10.2 Thrombectomy

A region wide group of tertiary centres offering thrombectomy services has been established to implement the requirements of delivering 24/7 access to thrombectomy. An evident challenge to the provision of this service is the availability of trained workforce, including interventional radiologists (who use real-time imaging techniques, including X-rays and ultrasound, to guide surgical intervention).

A thorough review of the thrombectomy service on the HNY footprint has been undertaken in collaboration with stakeholders. It has identified some areas of good practice including timeliness of the delivery of the pathway at the thrombectomy centre (HUTH) as well as a number of issues that might be affecting current service delivery such as the limited hours of operation and availability of the artificial intelligence package, which helps identify suitable candidates for thrombectomy, at the other HASU sites. Plans to address these issues have been drawn up and will be actioned over the coming year through a newly established working group.

6.10.3 Artificial Intelligence (AI):

Stroke artificial intelligence (AI) techniques provides physicians and stroke teams with the ability to identify salvageable brain tissue within a matter of minutes, aiding rapid decision-making regarding suitability for intervention. RAPID is the AI tool, which will be utilised across North Yorkshire and Humber and North Yorkshire and will improve access to thrombectomy for stroke patients.

6.10.4 Use of data

The Sentinel Stroke National Audit Programme (SSNAP) measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners,

patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients

The ISDN use the data in SSNAP to support our work programme and help us understand why variation is occurring and work towards levelling up where required as well as to prioritise developments at every stage of the pathway and support workforce planning.

In 2021/22 we have developed workforce surveys for community and acute staff as part of our approach to developing an innovative and sustainable workforce model working alongside South Yorkshire and Bassetlaw and West Yorkshire and Harrogate integrated care systems.

6.10.5 Inequalities

All NHS organisations, systems and process are required to address inequalities in access to services. Stroke services are no exception to this requirement and HNY ISDN has started to make links with other programmes or work / initiatives to co-ordinate overlapping approaches (e.g., prevention and smoking control). This year we have started an awareness raising campaign in North Lincolnshire to help address concerns about late presentations across the footprint. This work will be extended to other areas across HNY in the coming year.

6.10.6 Patient and Public involvement

Following the success of our engagement events across Scarborough and Harrogate and with the appointment of our new project manager, we have worked with the Stroke Association and our stakeholders to consider the options for developing our approach to engagement. We have agreed on a combined approach of engagement events and the creation of a network of patient representatives across the region.

6.10.7 Rehabilitation

We are committed to levelling up our rehabilitation services and improving life after stroke. We have developed a community stroke forum which is focussed on issues relating to rehabilitation and post stroke support. We have restarted our gap analysis work to help us to understand the priority areas for levelling up across HNY.

6.11 Transformations of Cancer Services

Resources for funding the more substantive transformations have been directed via Cancer Alliances – three of which cover the North Yorkshire population (West Yorkshire and Harrogate; Humber and North Yorkshire and Northern Cancer Alliance). Examples of such transformations include:

- **Rapid Diagnostic Pathways**: aim to promote faster diagnosis by assessing patients' symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible. These initiatives include diagnostic pathways for serious non-specific symptoms and the design and implementation of optimal pathways for lung, prostate and lower gastro-intestinal cancers. All three trusts which provide a service for North Yorkshire patients have diagnostic pathways in place for patients who have serious non-specific symptoms. As these pathways have proved effective in providing timely diagnoses – trusts are considering which other cancer pathways could benefit from this approach. In addition, our trusts have/will be working towards implementation of the skin, head and neck and gynaecology optimal pathways. All optimal pathways are designed to provide a diagnosis by day 28 from referral.
- **Diagnostic Capacity/ Imaging**: Diagnostic services across the country are challenged by the demands associated with an increasing incidence of cancer (as a result of an ageing population) and the fluctuation in demand afforded by the pandemic. Provider trusts are working in partnership to develop 'network' services, enabling them to share images – providing a more resilient reporting service between them. Similar partnerships are developing regarding pathology and endoscopy services.
- **Introduction of new diagnostic technologies**: new diagnostic technologies which can be utilised alongside existing procedures e.g., capsule endoscopy which uses a small camera inside a pill-shaped capsule to take pictures of your gastro-intestinal tract. It is used to detect and diagnose conditions like gastro-intestinal bleeding, Crohn's disease, and coeliac disease. This initiative has been implemented at Harrogate, South Tees and York Hospital trusts.
- **Personal Stratified Follow Ups (PSFU)**: PSFU is an effective way of adapting care to the needs of patients after cancer treatment. The ambition for breast, colorectal and prostate cancer patients is that a significant proportion of patients have moved to supported self-management pathways with remote surveillance and guaranteed access back to their cancer team when needed. Work progresses across all three providers to secure PSFU pathways for breast, prostate and colorectal cancers with ambitions to include at least two other pathways (to include endometrial cancer). Providers are also considering digital solutions which can enhance follow up care for patients.

- **Teledermatology**: Teledermatology refers to the application of photographs of skin lesions taken in primary care settings which are then viewed by dermatologists in secondary and tertiary settings. Whilst these services are currently available in York and Scarborough and Cancer Alliances are supporting wider implementation of this initiative.

For more information on cancer services, please see section 2.4.5.

6.12 Voluntary, Community and Social Enterprise

The Voluntary, Community and Social Enterprise (VCSE) sector is an important partner for statutory health and social care agencies and during the last year, has continued to deliver an important role in supporting people through the pandemic and in helping people to achieve improved health, wellbeing and care outcomes. For further information on the work that has been done during 2021/22, please see section 2.7.3.

6.13 Care Homes

There are over 4,800 care home beds within the North Yorkshire CCG area. Whilst the CCG does not commission services from care homes we recognise the significant contribution made by our care home providers to improve the health and wellbeing of our local population and the importance of working together. Across 2021 and 2022 significant effort has continued to ensure the risks to our care home population are minimised as the COVID-19 pandemic has remained dominant. The CCG and key partners from health and social care and other agencies have worked consistently with care home managers and colleagues in the response to the challenges posed by the COVID-19 pandemic and these strong working relationships continue. The roll-out of a successful COVID-19 vaccination and booster programme supported by our Primary Care Network (PCN) partners has significantly contributed to this response.

Close partnership working continues with North Yorkshire County Council teams in the support of the quality and safety agenda which has imbedded processes in place in order to support our care home partners to improve the quality of care. Collaborative “virtual” care provider engagement events remain available to all care homes across North Yorkshire which is an opportunity for the provision of education, networking and key updates. The CCG nursing and quality team have supported with the development and rollout of several care home policy and guidance documents related to the pandemic response as well as responding to key initiatives from the national agenda. This includes the successful and widescale roll-out of electronic devices to aid video consultations with GP's and other healthcare professionals, and the provision of pulse oximeters to support the close monitoring of care home residents with COVID-19 or other health conditions.

Furthermore, the impact of the Omicron COVID-19 variant has placed extreme pressure on our health and social care system from early 2022 however the CCG has been grateful for the response from all partners particularly in terms of the need to secure extra community capacity and beds. Robust mechanisms are in place across our North Yorkshire system to ensure safe transfer of care from hospital to care homes with a daily panel process in place led by Public Health partners.

6.14 Learning Disability and Autism programme including Transforming Care – Mental Health, Learning Disability and Autism

We work closely with key partners including health providers, the local authority, NHS England, families, children and young people to establish a North Yorkshire and York Learning Disability and Autism programme including Transforming Care (NYY TCP) for children, young people and adults with a learning disability, autism or both. For further information please also see sections 2.9.7 and 2.9.8.

Through a retrospective review of admissions, we were able to identify that our key 'risk' is those people with a diagnosis of Autism Spectrum Disorder (ASD) only (non-Learning Disability). We also found that these were often people who were not previously known to any of our services, who presented at the point of crisis, and who despite a Local Area Emergency Protocol (LAEP)/Care and Education Treatment Review (CeTR) Multi-Disciplinary Team wrap around approach, required brief interventions and or alternative environments to provide meaningful assessment and treatment. This has evidenced our focus and commitment to develop safe spaces during 2021/22 and over the coming year to reduce the reliance on in-patient services.

Our local systems of monitoring and evaluating commissioner oversight visits is captured via our Dynamic Support Register (DSR) process to ensure that visits are timely and meaningful. We have named professionals involved in the process to ensure that the care people receive is appropriate and of a high standard, at the right time and in the right place. Our escalation process ensures a timely response to concerns, and it is envisaged that an ICS wide approach will extend capacity and intelligence. This year the DSR has demonstrated:

- An average of 100% compliance achieved with care and education treatment review (C(E)TR / care and treatment review (CTR) provision (all age post admission and pre-admission) through a dedicated C(E)TR/CTR resource across the TCP
- Timely access to Local Area Emergency Protocols (LAEP) for all ages
- A 42% reduction in use of (all age) in-patient beds
- Length of Stay for new admissions averages at around 28 days.

The dedicated TCP team currently monitors out of area community placements via the Adult Dynamic Support Register (DSR) so that there is a coordinated and timely response to reviews and crisis, which has enabled a greater level of admission prevention through a co-ordinated crisis response.

Via both the Adult and Children and Young People DSRs we have been able to identify trends and risks that have helped to shape and inform our three year commissioning plans going forward.

Indicator	Target 2021/22	Position 2021/22
Care and Treatment reviews compliance	90%	100%

6.14.1 Support and Housing

North Yorkshire and York is a large mainly rural county. The opportunities and difficulties this brings to service delivery and to people's ability to access universal services are understood. As is people's ability to develop and maintain social networks, particularly for those from a minority group. For commissioning and administrative purposes, health and adult services is divided into geographical areas of Harrogate; Craven; Scarborough; Whitby; Ryedale; Hambleton; Richmondshire, Selby and the City of York.

As a North Yorkshire and York system we offer support and a wide range of local social care services. We do this by either directly providing services or by offering information, advice and guidance about local services so people can arrange care and support themselves. We provide care and support to older people, people with learning disabilities, mental health conditions, physical disabilities, sensory impairment and other vulnerable groups. We also offer care and support to people's carers. We have continued to encourage people to think about their own health and wellbeing and have supported community groups around the county to promote community resilience.

Following the successful NHSE capital grant, we have been able to discharge one young woman to a bungalow that was near to her family with a support package that promoted independence in the least restrictive environment. This approach has led to further future developments that are due to be completed this year.

- Project Haxby is a conversion to two self-contained flats that are now complete
- Project Echo is a development of bungalows for people with complex needs and will be complete in November 2022 and the process of identifying the residents has started
- An expression of interest has been submitted and agreed to develop a North Yorkshire and York Safe Space as an alternative to hospital

- Via NHS England we have an allocation of funding to purchase a property for a young man.

6.15 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. All people who have a diagnosis of autism will now be included in the LeDeR programme from February 2022 and will receive a full focussed review of their care and treatment. For more information on this programme of work please see section 8.5.

6.16 Compass Phoenix (formerly Compass BUZZ)

In 2021/22 Compass Phoenix (formerly Compass BUZZ) continued to provide 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. For more information on Compass Phoenix and the related Buzz Us projects, see sections 2.9.5 and 2.9.6

6.17 EPRR Assurance

The CCG has a responsibility to ensure it is able to respond appropriately if there is an emergency that affects the North Yorkshire CCG and wider area such as pandemic flu, floods, cyber-attacks and terror threats.

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).

During 2021/22, the CCG has maintained its 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.

The CCG has an out of hours on call system, which is supported by senior members of staff and Executive Directors. All managers and Directors undertook training and an on-call induction.

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. The CCG submitted a Statement of Compliance to NHS England, rating itself as substantially compliant against the standards.

At the time of assessment, the areas in which the CCG assessed themselves as partially compliant were as follows:

- Whilst the CCG had an evacuation plan in place, there had been no opportunity to test its effectiveness due to the continued requirement for CCG staff to work from home
- An information sharing protocol was in development but had not been approved, this work has now been completed
- At the time of review, a desktop exercise had not been undertaken to test the CCG's Business Continuity Plans in the event of an incident. An exercise testing the response of CCG's business critical activities in the event of disruption to internet and mobile networks has since been undertaken.

The CCG has in place an EPRR exercising and testing programme from which lessons are identified and acted upon.

In response to the COVID-19 pandemic the CCG has continued to support local command and control processes enabling rapid decision making with briefings and national guidance circulated to GP practices and key staff.

The leadership of the CCG has continued to respond quickly to the evolving situation created by COVID-19. All staff continue to work, and the technology provider continues to support the organisation and GP practices to function and serve the population of the CCG.

Work has been ongoing in recent months reflecting on the transition to the ICB and the impact this may have on EPRR across the local system. Working groups have been established to develop the required systems to maintain assurance levels.

6.18 Medicines Management

2021/22 presented many unpredictable challenges to the Medicines Management Team, placing great demands on the workforce and necessitating frequent adjustments to the team's core aims in order to meet the immediate priorities for the health system and our population. The team has retained the highest level of professionalism throughout, has remained dedicated to supporting patients, colleagues and the NHS as a whole and the CCG is very grateful for their effort and commitment.

This year has seen further growth in collaborative working with colleagues in Vale of York CCG on a shared medicines and prescribing agenda. This has helped to consistently and efficiently address shared issues while there has been a reducing number of active personnel within the combined CCGs' Medicines Management workforce. Effective recruitment has become increasingly challenging, with increasing vacancies for pharmacists and pharmacy technicians due to the many new roles in practices and PCNs. As an alternative model, the team successfully trialled replacing one vacancy with a project delivery officer, without pharmaceutical qualifications. This beneficially expanded the skill mix, brought extra knowledge and experience to the team, and greatly aided the team's ability to manage workload. The team is working to retain and potentially expand on this development in 2022.

Requests for general pharmaceutical advice have continued throughout the year but with growing frequency and marked variance and expansion in the range of topics to which they relate. The team has worked very hard to sustain this core area of work to ensure patients and clinical partners are best advised to optimise the healthcare of our population.

6.18.1 Public Health

Since December 2020 the Medicines Management Team has experienced the greatest expansion in the role and demand to provide expert pharmaceutical advice and support to the COVID-19 and influenza vaccination programmes. There were many daily challenges from a brand-new national (COVID-19) vaccination programme, with details regularly adjusting and a limited but rapidly growing experience in highly specialised, unlicensed and sensitive pharmaceutical products. This necessitated the provision of assured advice and instruction, and structured inspection for the many sites across the county, plus a robust process to allow the legitimate movement of vaccines between sites to minimise waste. This placed great demands on all in the team and to ensure this was deliverable at the same time as meeting other (core) business, the team remodelled to identify individuals that would be dedicated to this area of work and allow others to continue with other business. The fluctuating demands of the programme necessitated team members assisting on and off to ensure this highest priority was appropriately supported.

2021 also saw an unprecedented series of outbreaks of avian flu in the county and a system was adapted to ensure contacts (most frequently farm workers) were able to access timely and appropriate anti-viral medication.

The use of antimicrobials remains an area of focus, with overuse and drug selection being of great importance. Use of antimicrobials has remained low but the proportionate use of restricted antimicrobials had been growing since COVID-19 began to impact on health. This has been well managed by the Medicines Management Team and partners to keep prescribing below national rates through general and targeted education as well as audit and review of prescribing habits.

6.18.2 Quality and Safety Programme

The pressures of COVID-19 on the health system saw a temporary pause to the pro-active medicines quality and safety programme. This has now been restarted and will be the priority area of focus for the Medicines Management Teams working in North Yorkshire and York. The Medicines Safety Group includes colleagues from CCG, primary and secondary care in a cross-system approach. This group remains responsible for local planning and promotion of national alerts as well as working to improve local systems to reduce risk associated with the use of medicines. The Primary Care Network (PCN) pharmacy workforce, as well as colleagues in community and hospital pharmacy, work closely with practice colleagues on historical risk areas as well as immediate safety alerts.

6.18.3 Access to Medication

The national supply chain has been subjected to greater challenges in recent times. The difficulties faced from the background of unpredictable manufacturing problems was compounded by distribution challenges on importation from or through Europe. These were greatly reduced by significant planning by the Department of Health and Social Care and NHS England Improvement, as well as manufacturers and wholesalers. Planning and adherence to instruction by local hospitals and dispensing contractors helped avoid many issues as well as ensuring they did not contribute to national pressures.

The Medicines Management Team reviewed and implemented the reestablishment of a service for 'Assured access to palliative care medicines', unifying variable arrangements across the CCG footprint with the valued and appreciated engagement of community pharmacy, prescribers and palliative care experts.

6.18.4 Social Care Support

Pharmaceutical expertise has been essential in resolving issues around the handling of medicines in local care establishments. Access by external personnel (including Medicines Management Team experts) to care home settings has been restricted unless necessary and this has presented great challenge to the effort to identify and correct anomalies in the medication related systems.

Despite this, our lead pharmacist in this field has been instrumental in assisting many care homes to resolve problems and to prepare for the transfer of residents when any home was closing. This has included working very closely with the local authority to develop protocols and policies to help set and achieve consistent standards for care providers in how medicines are managed.

6.18.5 Commissioning

The formation of NY CCG in April 2020 brought together different models on how decisions are made on commissioning positions in medicines, formulary choices, places in therapy and guidance. After considerable preparatory work, the North Yorkshire and York Area Prescribing Committee (APC) was launched in July 2021. This includes both CCGs, local acute trusts and mental health providers as well as local authorities, medical and pharmaceutical committee representatives. The APC has quickly established itself as the primary decision-making body for such business within the Strategic Partnership of North Yorkshire and York, fitting into existing CCG governance systems and preparing to operate during transition to and throughout the establishment of the Humber and North Yorkshire Integrated Care Board.

6.18.6 Value

While there has been reduced focus on improving value for money in the use of medicines during the COVID-19 pandemic, significant progress has been made by active implementation during periods where resources allowed. The pursuit of rebates, active use of software to influence improvements in safety and value, as well as investment in practice level activity have all helped realise financial benefits. The Medicines Management Team invested considerable time to work with an independent sector provider prior to the surge in COVID-19 booster vaccination activity, which allowed external pharmacists to safely deliver carefully selected changes to medication with minimal intrusion on practice personnel (when booster vaccination did commence). The results of this project will be reported later in 2022 but collated feedback to date indicates that the savings programme was well received and financially beneficial for the years ahead.

6.18.7 Workforce

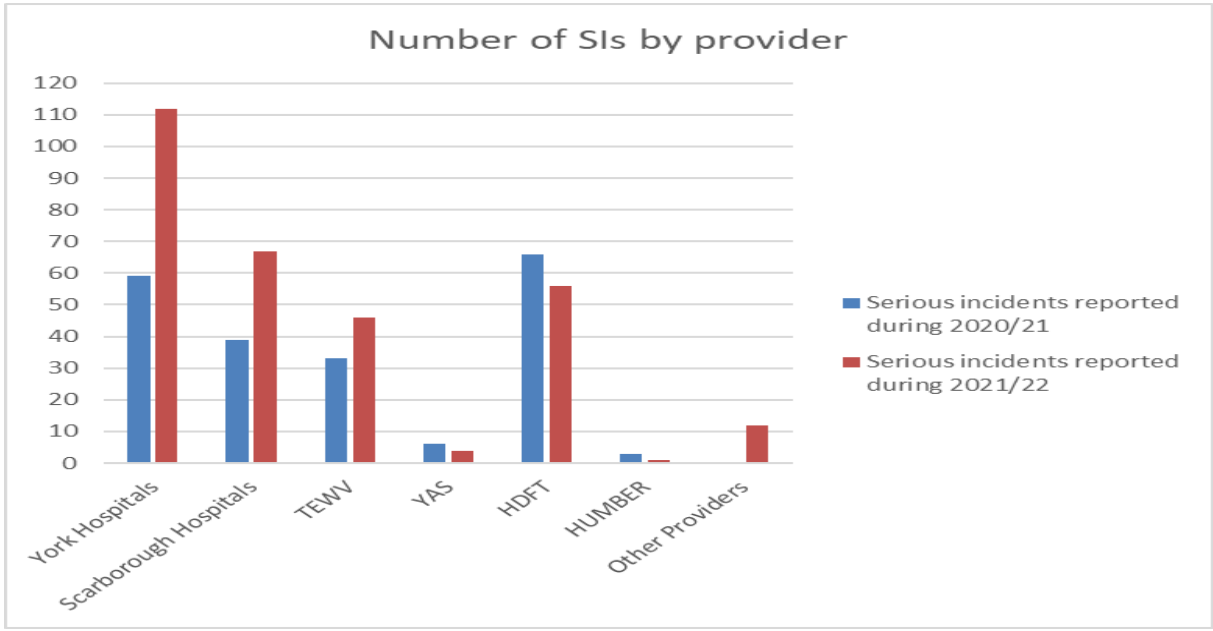
GP practices and Primary Care Networks continue to recruit to their pharmacy workforce, with additional national resources and recognition of the value and clinical benefits deliverable by pharmacists and technicians. This relatively new type of role has not been suited to all and while local pharmacy forums exist across North Yorkshire to support this workforce, their modelling and focus are currently inconsistent. Departure of some personnel has highlighted the need for the Medicines Management Team to establish a more supportive framework and programme. These aim to develop the skills, competencies and confidence of this workforce to ensure they are retained and the health system can optimise the benefits their professional training can offer.

6.19 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 CCG's Serious Incident Team for Harrogate, Scarborough, Ryedale and York providers, and the North of England Commissioning Support Unit for the Hambleton, Richmondshire and Whitby providers. The CCG receives all serious incident reports for review through the monthly Collaborative Serious Incident panel meetings, where each investigation report is peer reviewed, the robustness of the action plan assessed to ensure that lessons are learned and disseminated and fed back with any additional queries provided. Where urgent improvement actions are required a direct conversation with the provider Director of Nursing and CCG Director of Nursing is undertaken.

6.19.1 Scarborough, Ryedale and Harrogate Localities

Harrogate and District NHS Foundation Trust has reported 56 serious incidents during 2021/22, compared to 66 incidents reported during 2020/21. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations provide strong systemic protective barriers, are available at a national level. Four Never Events have been reported this year and the CCG and Harrogate and District Foundation Trust are working collaboratively to redesign their Serious Incident (SI) processes. This welcome involvement provides additional assurance and scrutiny of process and the opportunity to influence future processes and policies.



York and Scarborough Teaching Hospitals NHS Foundation Trust reported a total of 179 incidents during 2021/22 of which 67 occurred at the Scarborough and Bridlington Hospital sites. This is compared to a total of 98 incidents during 2020/21 of which 39 incidents occurred at the Scarborough and Bridlington Hospital sites. This increase can be an indicator of improved reporting systems and greater scrutiny of incidents however providers continue to report challenges from COVID-19, experiencing exceptional pressure on services, some of which can directly correlate to incidents. Three Never Events have been reported across the Trust with one incident at the York Hospital site and two incidents at the Scarborough Hospital site.

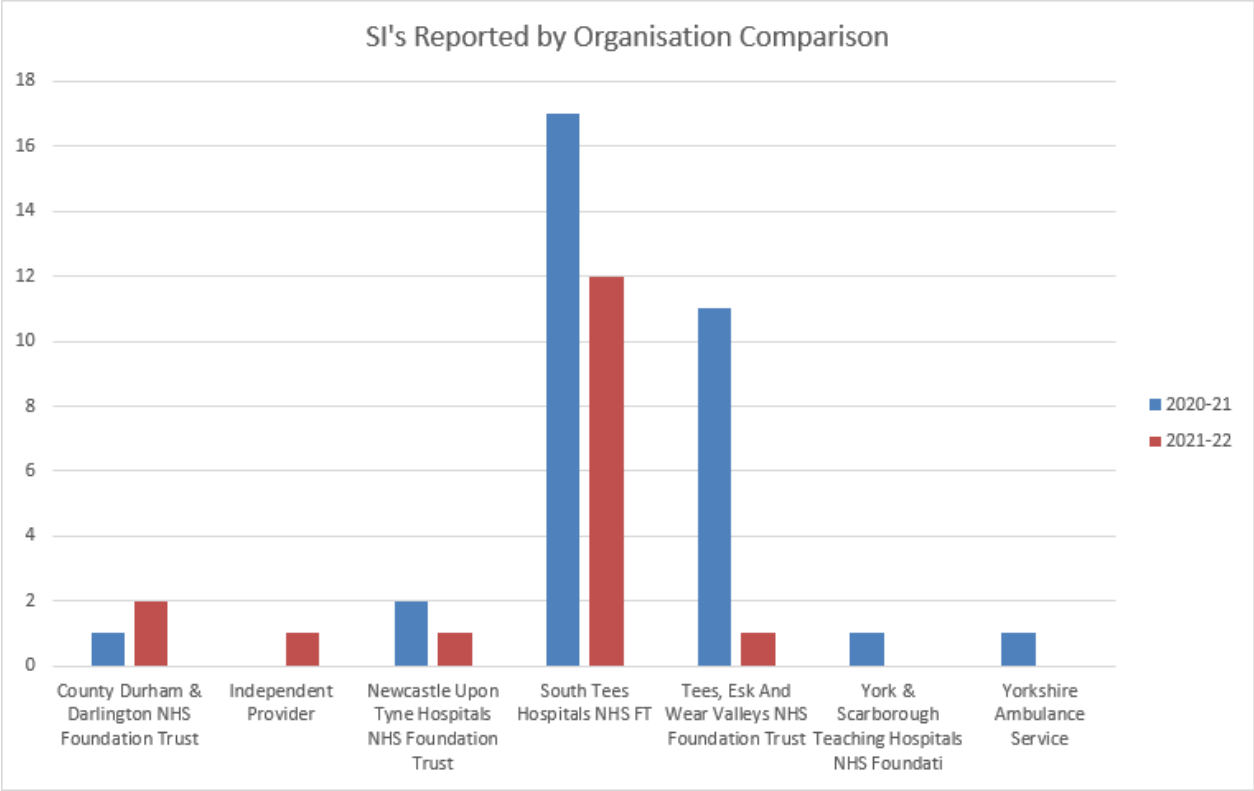
Tees Esk and Wear Valley NHS Foundation Trust (TEWV) has reported 46 incidents across North Yorkshire and York localities during 2021/22. Of these, 26 occurred within the Harrogate, Scarborough, Hambleton, Richmondshire and Whitby localities, with the remaining concerning York locality. In comparison, 33 incidents were recorded during 2020/21. The CCG are working collaboratively with TEWV to redesign their Serious Incident governance processes and this is being reported via the North Yorkshire and York Quality and Performance Committee.

6.19.2 Hambleton Richmondshire and Whitby localities

North East Commissioning services co-ordinate the Serious Incident process for the Hambleton, Richmondshire and Whitby localities. The chart opposite identifies the number of Serious Incidents reported by our main providers in 2021/22 (red) against those reported in 2020/21 (blue).

The table below identifies the number of SIs reported by our main providers in 2021/22 against those reported in 2020/21.

The number of serious incidents has decreased from the previous year, STHFT remains the highest reporter which is expected. Due to the low numbers, it is difficult to identify themes however



pressure ulcers (Q1) and falls (Q2) are the two main categories. The cases are discussed with our neighbouring CCG to ensure shared learning and collaborative working.

Organisation	2020/21	2021/22
County Durham and Darlington NHS Foundation Trust	1	2
GP Practice		
Independent Provider		1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	2	1
South Tees Hospitals NHS FT	11	12
Tees, Esk And Wear Valleys NHS Foundation Trust	10	1
York and Scarborough Teaching Hospitals NHS Foundation Trust	1	
Yorkshire Ambulance Service	1	
Grand Total	**26**	**17**

One Never event has been reported in quarter 3 concerning a misplaced Naso-Gastric tube. The provider has requested a down grade from a Never Event to a serious incident, this is currently under review and a thorough investigation is underway to identify key learning.

6.20 Health Care Associated Infections

The CCG and Acute Trusts continue to use the 2020/21 targets as the baseline for performance monitoring due to the Covid 19 pandemic. All providers have provided data to evidence their performance against these baselines. Clostridiodes Difficile (C Diff) cases have continued to rise and remains a concern for all, the CCG's Chief Nurse, Nursing/ Quality and Medicines Management teams continue to have oversight of all cases reviewed and attend the relevant panels for each NHS trust. This provides assurance that any themes/lessons learned are identified and actioned. Community acquired cases are also reviewed through the Health Care Associated Infections (HCAI) panel processes. It is recognised that all acute providers are working under extreme pressures due to the impact of the Covid 19 pandemic. All other HCAI data is monitored through the provider quality meetings and the CCG Nursing and Quality Team are represented. There has been an improvement regarding the number of E Coli infections, 371 reported cases against a target of 394.

As the COVID-19 pandemic continues, collaborative working continues with the CCG supporting both primary care and care homes. The CCG are appraised of any outbreaks of COVID-19 within acute and community provider organisations and attend relevant meetings where needed to support and for assurance. The North Yorkshire CCG area is seeing an improved position of incidence of COVID-19 across North Yorkshire care homes settings. Full multi-agency partnership working continues to support care homes across the North Yorkshire System with focussed groups to monitor quality and safety of care home residents. A well-

established Local Authority/Public Health led daily admissions panel continues to support care home admissions where they have experienced outbreaks. For more information see section 4.3.1

6.21 Vaccination Programmes

The flu vaccination programme across the CCG locality has proven to be a success with the national targets for vaccinating the over 65 age group exceeded. As the COVID-19 pandemic continues, there is increased pressure on all parties and collaborative working continues with the CCG supporting both primary care and care homes. The roll out of the national COVID-19 vaccination programme has been extremely successful in achieving the national targets, work is ongoing and to get to this point has taken significant co-ordination and collaboration with our Primary Care Networks being at the centre of the delivery model. For more information on vaccination uptake please see section 2.2.3.

6.22 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.

Due to the COVID-19 pandemic and the need to release capacity across the NHS to support the response, NHS England and NHS Improvement paused the collection and publication of the mixed sex accommodation breaches from April 2020, however this was reintroduced in October 2021 with updated guidance becoming available. Commissioner level data was published on 10 February 2022 with NHS North Yorkshire CCG data as below:

	NYCCG Breach Rate	England Average
October 2021	0.4	1.3
November 2021	0.3	1.4
December 2021	0.6	1.5
January 2022	0.5	1.5
February 2022	0.8	1.7
March 2022	0.9	1.9

(Breach rates per 1000 finished consultant episodes)

6.23 Safeguarding Adults and Children

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

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

- A clear line of accountability for safeguarding which is reflected in the CCG governance arrangements.
- An established Designated Professionals Team including a Designated Doctor and Nurse for Safeguarding Children and Children in Care, and a Designated Paediatrician for Child Deaths.
- Named GPs for Safeguarding Children and Adults and, as part of collaborative arrangements with Vale of York CCG, a Named Nurse and Specialist Nurse for Safeguarding in Primary Care (Children and Adults).
- Regular reporting into the CCG Quality and Clinical Governance Committee from the Designated Professionals Team and the Primary Care Safeguarding Nurses.
- Appropriate arrangements in place to co-operate with local authorities and other partner agencies in the operation of North Yorkshire Safeguarding Children Partnership (NYSCP) and the North Yorkshire Safeguarding Adults Board (SAB). The CCG Executive Nurse and Designated Professionals for Safeguarding are members of both the Partnership and Board.
- A staff training strategy to support recognition and effective response to safeguarding issues in line with statutory guidance.
- Representation on regional and national safeguarding forums via the Designated Professionals Team.
- Through contractual arrangements the CCG ensures that it commissions safe services and continues to be an active partner working with agencies to keep adults and children safe from abuse, neglect and harm.

Work undertaken across the Designated Professionals Team during 2021/22 has included:

- The Designated Professionals Team have continued to work with safeguarding children, children in care and safeguarding adults' colleagues across the North Yorkshire and Humber footprint to develop a proposed model for safeguarding arrangements in the new Integrated Care System. This model will ensure that safeguarding remains integral to future commissioning arrangements. This model was agreed by the Integrated Care Board and work is now ongoing to ensure that

these arrangements are in place to support the new organisation in June 2022. An interim lead Designated Nurse has been appointed to lead on this work.

- Standard presentations have been developed to ensure that all Safeguarding Partnerships and Boards can receive assurance on the ICS arrangements and the primary of place-based safeguarding as we move to the new operating model.
- The number of cases which have reached a threshold for a statutory case review remains high. This represents a considerable amount of work for all safeguarding teams across the partnership but is essential if learning is to be extrapolated and integrated into practice.
- High levels of support are offered by the Designated Professionals team to safeguarding leads across NHS and private provider organisations. Regular online meetings, monthly safeguarding bulletins, advanced level training and reflective supervision support professional practice and help to build resilience in challenging times.
- A new Domestic Abuse policy specifically designed for use within primary care across North Yorkshire disseminated to all GP Practices. The policy aims to ensure that primary care staff are aware of their duty to be alert to signs of domestic abuse, to respond appropriately to disclosures of domestic abuse and to support victims and survivors.
- The Primary Care Safeguarding Training Guidance has been updated providing a valuable reference for primary care staff to identify what level of training they require to meet the safeguarding duties and responsibilities of their roles.
- All Primary Care Safeguarding Training has continued virtually in 2021/22 with 778 staff attending Level 3 Safeguarding training. In addition, 132 administration staff attended 'Managing Safeguarding Information' training in February 2022.

For more information on the work the Safeguarding Teams have undertaken in 2021/22, please see section 2.9.1.

6.24 Maternity

Since the publication of Better Births in 2016 and of the report of the Morecambe Bay Investigation in 2015, the NHS and its partners have come together through the national Maternity Transformation Programme to implement its vision for safer and more personalised care across England and deliver the national ambition to halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025.

The Humber and North Yorkshire Health and Care Partnership (Integrated Care System) Local Maternity System (LMS), of which the CCG contributes, plans the design and delivery of services following the ten national programme work streams which are

supporting the implementation of Better Births locally. The Senior Responsible Officer (SRO) for the LMS is the CCG Chief Nurse supported by the LMS Programme Lead.

The LMS has concentrated on:

- Procurement of a Maternity Information Technology Solution which is due to roll out from 28 March 2022, with digital Midwives in post in all providers
- Maternal Medicine pathways being developed, with a plan for communication and engagement including service user website. Additional funding confirmed for 22/23 to continue to support implementation of pathways.
- Smoking Prevention Lead has commenced in post
- Diversity Champion commenced in post
- Continued growth and development of Continuity of Carer
- Perinatal Mental Health Lead commenced in post
- Safety including the review and support of Serious Incident investigations and implementation of learning across the LMS
- Ask a Midwife online programme
- Ockenden Audit Plan and preparation for visits in 2022/23.

7 Engaging People and Communities

7.1 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.

The NHS Constitution (2010) also places duties on us and sets out rights for patients to be involved in the planning of healthcare services, the development of proposals for changes in the way services are provided and decisions made affecting the operation of services.

7.2 Our Communications and Engagement Strategy

The CCG has a five-year Communications and Engagement Strategy which was adopted by the Governing Body in July 2020. This is the first North Yorkshire communications and engagement strategy and embeds best practice building on past experiences. Everyone has a stake in the health of their community. Health matters to people and we want effective communication and engagement to be at the heart of what we do. The strategy was developed at a time when the world was responding to the COVID-19 pandemic. We took lessons learned to embed inclusiveness and resilience for the future to inform our approach.

You can find our Communications and Engagement Strategy on our website[21].

7.3 Our Engagement Aims and Objectives

We want to listen to the public our patients, their carers and representatives to make sure we secure the best quality services we can with the resources we have available. We want to ensure we:

- Uphold our commitment to “no decision about me, without me”
- Listen and take patient experiences into account when we are developing local healthcare services
- Communicate to ensure our staff, partners and patients are kept informed, with access to information people need, when they need it
- Recognise potential barriers to communication and engagement and be open and accessible to all of our community

[21] https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/08/NYCCG-communications-and-engagement-strategy-FINAL.pdf

- Use patient and community perspectives and experiences to improve the quality of our commissioning and improve health outcomes
- Build confidence in the organisations and raise awareness and understanding of the CCG, its role and the challenges
- Build excellent relationships with patients and our partners.

7.4 Engagement Through the Pandemic

Like much else across the NHS, we have had to adapt the way we have engaged over the last year in response to the COVID-19 pandemic. Working with the public and our partners we have found ways to keep people connected and continue our invaluable conversations with those who use our services through the last year. Often this has required adapting to virtual engagement together, but this is something that we have done successfully. You can learn a bit more about some of our engagement activities this year below:

7.4.1 Primary Care

Our Patient Partner Network (PPN) has been a cornerstone of engagement on primary care services this year (you can read more about the PPN in section 2.5.1 and learn about their activities on our website[22]). Through the year we have been able to have a two-way conversation with our PPN partners about GP adaptations to COVID-19, continuity of services, digital connectivity and service development.

We have also supported primary care through public engagement to help ensure that the public knew the best routes to the care that they needed in the pandemic environment and had the information they needed to keep themselves and others safe when accessing services. It has been important throughout the year to help people have the confidence to visit their GPs and seek non-COVID-19 health care advice. We sustained communications and engagement activity throughout the year to help assure people that 'primary care is open' and to highlight the ways in which primary care have been working differently to keep people safe.

We have produced a number of targetted communications toolkits for primary care to help.

[22] https://www.northyorkshireccg.nhs.uk/get-involved/patient-partner-networks-ppns/

7.4.2 Access to GP practice services during the pandemic

In June/July 2021 we sought feedback from patients on their experiences accessing GP practice services during the COVID-19 pandemic. We received 127 responses to this survey which explored the level of satisfaction with virtual appointments. Of these 48% of appointments were face-to-face and 52% via telephone. Nearly 80% rated their appointment and how it took place as good or very good (62% said very good); 9% bad or very bad experience and about 13% average. While some people thought face-to-face is a must, there is strong support for telephone appointments and the ease and speed which often come with them. This intelligence helped us shift the narrative so that face-to-face appointments were not the first choice for all patients.

7.4.3 COVID-19 and the Vaccination Programme

Throughout much of the year there has been a strong focus on engagement around COVID-19 and the COVID-19 vaccination programme.

In addition to regular news releases[23], and information shared through social media we have had regular conversations with our Patient Partner Network members. We have sought to give people assurance and ensure transparency through a weekly media press conference hosted by the North Yorkshire Local Resilience Forum. We also shared a platform with local authority and North Yorkshire Police partners in a virtual public meeting in January to answer questions about COVID-19 and the COVID-19 vaccination programme[24].

The COVID-19 vaccination programme was a national priority from December 2020, and we used the digital tools available to us, as well as media partners, to ensure that people had easy access to the information they needed. As part of the vaccination roll-out there has also been focused work to ensure that we effectively engaged with populations when vaccination confidence may be lower to encourage take up. This included work with Eastern European communities to encourage GP

[23] You can see all of our news releases on our website at https://www.northyorkshireccg.nhs.uk/category/news/
[24] You can see a recording of the meeting here: https://www.northyorks.gov.uk/covid-19-your-questions-answered

registration and access to vaccinations, and partnership working with local authority partners to facilitate access for homeless populations and rough sleepers.

7.4.4 Mental Health

There has rightly been a focus on mental health over the past year.

We have actively engaged with service users, parents and carers, and professionals on various aspects of children and young people's mental health. This has included focus groups to develop The Go-To mental health hub (you can read more about The Go-To in sections 2.9.5 and 2.9.6) and recruiting and developing young people as The Go-To Champions to encourage mental health outreach. We are working with young people to develop a video to help people get the most out of The Go To website for mental health and wellbeing in North Yorkshire. We expect the video to be completed before the end of the year.

Our North Yorkshire, a sleep referral service for children and young people suffering sleep disorders received a highly commended award at the prestigious annual HSJ awards.[25] These services use behavioural therapy, sleep clinics and workshops – rather than medication – to improve a child's sleep health (see section 2.9.11).

We have participated in North Yorkshire and York workshops alongside health and social care partners, the voluntary sector and experts by experience to lay the foundations for co-production. We are involved in the evolving communications and engagement strategy to unify partners and set out a North Yorkshire and York plan.

This year we have seen the start of an active campaign to address mental health and wellbeing in men, with specialised support. We have also this year ensured a focus on mental health and wellbeing across NHS staff, including our own, with access to appropriate resources and a dedicated health and wellbeing hub.

[25] https://northyorkshireccg.nhs.uk/health-initiative-to-help-children-overcome-sleeping-difficulties-scoops-national-hsj-accolade/?highlight=hsj

7.4.5 Scarborough Acute Services Review

The Scarborough Acute Services Review commenced in 2018 and was set up to ensure the sustainability of services provided at Scarborough Hospital. The review took as its starting point that there would always be an Emergency Department and associated services available on the Scarborough Hospital site but that some services may be delivered differently in future. This might be because of staffing challenges or national drivers for some specialist services to be provided at larger Centres of Clinical Excellence to improve service quality and outcomes.

During the review some services were reconfigured to provide sustainability such as General Surgery and Oncology and some to follow national clinical best practice such as stroke services. We are nearing the end of this review and expect it to conclude in the next business year.

In addition, £47m funding has now been secured for a new build state of the art Emergency Department and Critical Care facility with the building work about to commence on site. This will offer much improved facilities and will sustain Scarborough Hospital at the centre of the local community for the future.

7.4.6 North Yorkshire Hyper Acute Stroke services

We undertook substantial work this year to gather evidence on patient experience of hyper acute stroke services across North Yorkshire. This included a survey of patients who had experienced the service, patient stories and two events – one for services on the East Coast and the other for those in and around Harrogate. Nearly 50 people attended the November 2021 events, delivered in partnership with HealthWatch North Yorkshire, one focusing on services in Harrogate district and the second on services on the East Coast. The events followed the stroke journey from onset of stroke symptoms through to community rehabilitation and life after stroke and was largely delivered by clinical experts from across our NHS partners and from Stroke UK.

To complement the events, we ran a survey in November and December to capture the experiences of people who have experienced hyper acute stroke services delivered by our acute trusts. Our trust partners have shared the survey with over 350 patients who have experienced the hyperacute stroke pathway in the region. We have received over 100 responses to the survey from across the area.

You can read more about this work on our website.[26]

[26] https://northyorkshireccg.nhs.uk/get-involved/patient-engagement/previous-engagement/

7.4.7 Autism and ADHD assessment services

In April and May 2021, we led work across North Yorkshire and York to gather input from patients and the community into adult autism and ADHD assessment services to help us identify opportunities for improvement.

We are now working with colleagues in the North Yorkshire and York Children and Young People's teams to design engagement to help inform a re-procurement of autism and ADHD services for children and young people which will take place early next business year.

7.5 Patient Advice and Liaison Service and Complaints

NHS North Yorkshire CCG is committed to dealing with complaints about the services provided by the CCG and the services we commission. We manage complaints in line with National Guidance to ensure we learn from the experiences of the patient, their carers and families to improve the services we commission. We ensure that complaints, concerns and issues raised are properly investigated in an unbiased, non-judgemental, transparent and timely, and appropriate manner.

During 2021/22, the CCG has responded to 324 contacts and this has been categorised as follows:

Complaints	Concerns	Queries / Other	Compliments	MPs	Total
51	195	36	6	36	324

Two complaints were transferred to the Parliamentary and Health Service Ombudsman (PHSO) and the CCG's response was upheld in both cases.

During 2021/22, the PHSO has continued working with the NHS and other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling called the Complaint Standards. The standards, model procedure and guidance are being tested in pilot sites during 2021. They PHSO plans to refine these and introduce them across the NHS in 2022.

The CCG is working with partners across the system to develop systems and processes to be integrated into the ICS and these will be based on the PHSO Complaint Standards and based on:

- Promoting a learning and improvement culture
- Positively seeking feedback
- Being thorough and fair
- Giving fair and accountable decisions.

The CCG welcomes feedback, both positive and negative, about experiences of local NHS services as this helps us to improve services for all patients. The Patient Relations Service can be contacted by phone, letter or email:

Email: NYCCG.PatientRelations@nhs.net
Phone: 01609 767607
Address: Patient Relations, NHS North Yorkshire Clinical Commissioning Group, 1 Grimbald Crag Court, St. James Business Park, Knaresborough, HG5 8QB

8 Reducing Health Inequalities – making sure we consider everyone's needs

Health inequalities are the unfair differences in health outcomes that are caused by the difference in where people live or their social and economic circumstances. We have a legal duty to ensure that patient access to health services and the outcomes achieved is not affected as a result of inequality of access. We want to ensure there is equality of access and treatment for all the services we commission both as a matter of fairness and as part of our commitment to reduce health inequalities and improve health and wellbeing. We ensure our staff receive training to understand equality and diversity in commissioning service provision and we consider equality and diversity in all our commissioning. We do this by carrying out a quality and equality impact assessment for all the services we commission or where a service change is being considered. We consider the needs of particular communities when making decisions about local health services. Whilst we have a statutory duty to do this, we also know that it's the right thing to do. Whenever we consider a change to an existing NHS service we look at the impact this may have on particular groups in the North Yorkshire area. We are committed to ensuring that all patients are able to access the services they need, when they need them, and for them to be provided in the most suitable way. This means that everyone in North Yorkshire should have equal access to NHS information and services. We want to remove any barriers to this, particularly those that may be due to factors such as age, race, disability, or gender. We know people may access services in different ways and we take steps to help support those who may have difficulties. We are committed to ensuring that health services in North Yorkshire are culturally sensitive, inclusive, accessible, and appropriate for our residents.

8.1 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 equality and diversity using the Equality Delivery System (EDS2/3) framework to support the promotion of equality of opportunity in the way we commission healthcare services, eliminating unlawful discrimination 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.

8.1.1 Equality Objectives and Equality and Diversity Plan

The CCG has published the NHS North Yorkshire CCG Equality and Diversity Plan on the CCG website[27]. The plan captured the work which had already been achieved by the previous CCGs prior to their disestablishment and identified where progress was still to be made.

The plan includes the following Equality Objectives:

- To ensure that all our communication activity is accessible, taking into account a wide range of communications needs, and seek assurance that our providers do the same
- To ensure and provide evidence that equality is consciously considered in all commissioning activities
- To embed equality and diversity principles in the work of the CCG through the support to all staff and Governing Body members
- To continue to demonstrate strong leadership on equality so that it remains firmly on the agenda throughout any organisational change.

The objectives support the establishment of sound systems and data relevant to the local area, population and service users regardless of future changes.

8.1.2 Quality and Equality Impact Assessments

Quality and Equality Impact Analysis is a way of estimating the likely equality implications of either:

- The introduction of a new policy, project, or function, or
- The implementation of an existing policy, project, or function within the organisation.

The CCG has developed and implemented a tool and guidance for use by staff to help identify the any potential impact and take action to remove possible discrimination. Specific training is offered to CCG staff and the relevant Committees will consider the results of this analysis during the decision-making process.

[27] https://pdf.browsealoud.com/PDFViewer/_Desktop/viewer.aspx?file=https://pdf.browsealoud.com/StreamingProxy.ashx?url=https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/12/2020.12.10-FINAL-NHS-North-Yorkshire-CCG-Green-Plan-2020-22-V1.0.pdf&opts=www.northyorkshireccg.nhs.uk#langidsrc=en-gb&locale=en-gb&dom=www.northyorkshireccg.nhs.uk

The Quality and Clinical Governance Committee considers the results of all Quality and Equality Impact Assessments to monitor any cumulative impact of decisions made by the CCG.

8.1.3 Understanding our Population

The CCG uses the North Yorkshire Joint Strategic Needs Assessment[28] and other demographic data to make sure that we know our population and we also feature this information on our website.

8.1.4 Work Supporting Equality and Diversity during 2021/22

The CCG ensured that equality and diversity is an integral part of our Communications and Engagement Strategy[29].

During 2021/22 the CCG continued its work in relation to equality and diversity:

- Continuing to use consultation and engagement with all customer groups to identify service needs and how customers would like services to be delivered
- Continuing 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:

- Completion of Equality Impact Assessments on all new policies and projects and Quality and Equality Impact Assessments whilst aligning the CCG's Commissioning Policies
- Continue to keep the local community updated on local developments, via Twitter, Facebook, radio campaigns and media releases
- The Staff Engagement Group which can offer support to the CCG in relation to engagement with staff with regards to Equality and Diversity
- Establishment of a process to meet any needs for translation and interpretation for CCG service users

[28] https://www.nypartnerships.org.uk/jsna
[29] https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/08/NYCCG-communications-and-engagement-strategy-FINAL.pdf

- Staff wellbeing has been supported, particularly throughout the impact of COVID-19 through initiatives such as coffee break, online staff events and wellbeing awareness sessions aimed at helping staff look after their own mental health
- The CCG rolled out the national programme 'REACT Mental Health' Conversation training for all line managers during the summer and autumn of 2021 to support their ability to pick up individual conversations with their colleagues where identified
- Staff undertake mandatory equality and diversity training.

8.1.5 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/.

Accessibility of information is incorporated into our Communication and Engagement Strategy[30]. The strategy highlights the CCG's 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 ads and other distracting content for easier reading
- Allowing users to customise settings that are built in to suit individual user needs and preferences.

[30] https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2020/08/NYCCG-communications-and-engagement-strategy-FINAL.pdf

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

- Retirement and Flexible Retirement
- Secondment Policy
- Standards of Business Conduct Policy
- Starting Salaries Policy
- Statutory and Mandatory Training Policy
- Substance Misuse Policy
- Temporary Promotion Policy
- Travel and Expenses Policy
- Working Time Regulations Policy
- Whistleblowing Policy

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.

8.1.7 WRES Information

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnics (BME) board representation. We recognise our role in asking providers to report on their performance against the WRES framework from 1 July 2015, as well as paying due regard to the standard in its own workforce practices.

Workforce Race Equality Standard reporting during 2021 was completed on behalf of North Yorkshire CCG. The submission for 2021/22 is due for completion in August 2022[31].

8.2 Health profile

There is a high proportion of people aged over 65 (32%) in the North Yorkshire area compared with the national average (23%) ('national average' for this section refers to England). In contrast, the proportion of people aged 20 to 40 (25%) is lower than the national average (32%). The age profile shows a lower proportion of the population in age groups 0 to 4 and 20 to 39 years compared with both England and the North East and Yorkshire region and a higher percentage (3%) of men and women in the 85+ age group than the national average (2.3%).

[31] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

There are areas of deprivation within the CCG with 8 out of the 51 practices having a higher deprivation score than the national average. The most recent GP Patient Survey, published in 2021, was redesigned to reflect the changes to primary care services as a result of the COVID-19 pandemic with questions around the overall experience of GP practices as well as access to services and appointments via the telephone, on-line and face-to-face. In the NHS North Yorkshire CCG area practices performed well compared to the national average.

Survey Question	NHS North Yorkshire CCG	National Average
Overall, how would you describe your experience of your GP practice?	89% Good	83% Good
Generally, how easy is it to get through to someone at your GP practice on the phone?	80% Easy	68% Easy
How easy it is to use your GP practice's website to look for information or access services?	82% Easy	75% Easy
Overall, how would you describe your experience of making an appointment?	78% Good	71% Good
In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)?	80% Yes	74% Yes

8.2.1 Disease Prevalence

In North Yorkshire CCG, hypertension, depression, diabetes and asthma are the most common health problems with risk factors for most diseases higher in North Yorkshire CCG than for England.

8.2.2 Lifestyle and Behaviour

In terms of lifestyle choices that can have an impact on current and future health of the population, there are 6 GP practices that have a higher rate of smoking prevalence compared to the national average and there is a higher rate of adult obesity with 38,144 people on the obesity register and 26 practices that have a rate that is higher than the national average.

8.2.3 COVID-19, Cancer and Inequalities

As key stakeholders engaged in the commissioning and provision of cancer services, the CCG has a duty to support and ensure equity of access to services and there is focussed attention at national and local level to detect and address inequalities which may have been exacerbated by the pandemic. Cancer Alliances are working with North Yorkshire CCG to identify and design services which address any identified inequalities. For more information on cancer services please see sections 2.4.5, 4.2.4 and 6.11.

8.2.4 Tackling Inequalities in Stroke Services

All NHS organisations, systems and process are required to address inequalities in access to services. Stroke services are no exception to this requirement and HNY Integrated Stroke Delivery Networks (ISDN) has started to make links with other programmes or work/ initiatives to co-ordinate overlapping approaches (e.g., prevention and smoking control). For more information on stroke services, please see sections 2.4.6 and 6.10.

8.3 Homelessness Services

We continue to provide this service and it performs well in delivering essential services to this disadvantaged population and have been working with the local authority to facilitate access to the COVID-19 vaccine for homeless populations see section 7.4.3.

8.4 Learning Disability Annual Health Checks

In previous years, we have fallen short of national targets for the provision of Annual Health Checks, however in reality it is a dataset that we have carried and been monitored by, but with limited ability as a CCG to actually affect productivity. We recognise that in order to make improvements, we needed to understand the barriers, and develop plans to overcome this. The CCG has established a Mental Health/Learning Disability Primary Care operational group to take forward the action plans derived from the recent findings from a series of engagement and feedback mechanisms across primary care, self-advocates and parent/carers led by the exemplar site investment. We are dedicated to improving the quality and quantity of health checks for our learning disabled population with plans and priorities that include improved data collection and health promotion, raising awareness for young people aged 14 to 18 years, and seeking alternative models of delivering Annual Health Checks that are timely, person-centred and contribute to a 'live longer live well' approach.

8.5 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. All people who have a diagnosis of autism will now be included in the LeDeR programme from February 2022 and will receive a full focussed review of their care and treatment.

The CCG has a strong review process in place to identify key themes of learning and areas to reduce health inequalities. Some key themes include assessment of pain in non-verbal patients, role of the carer when supporting in hospital, effective use of the

hospital passport and ongoing work to improve access and uptake of the annual health check. The CCG is up to date with the LeDeR reviews and has no backlog.

The North Yorkshire and York steering group shares the themes and learning across a range of health and social care services and includes an expert by experience in the panel. The inclusion of autism in LeDeR reviews has been communicated to key partner agencies and providers. Training for GP practice staff is provided to ensure updates, themes and learning is shared and staff are confident in the reporting process.

8.6 Special Educational Needs and Disabilities (SEND)

North Yorkshire and York have amalgamated the SEND structure together in streamlining pathways and policy for the integrated care system blueprint. The team now consists of a Designated Clinical Officer (DCO), two Associate Designated Clinical Officers (ADCO), and a SEND Administrator. This team works at place across North Yorkshire and York to ensure NHS providers are making reasonable adjustments, are fully trained for SEND and meet statutory requirements.

The team has formulated holistic SEND training packages for NHS providers across North Yorkshire and York in line with recommendations. This is to be rolled out regionally across the integrated care system in the North. For more information on the SEND programme, please see section 2.9.9.

9 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 North Yorkshire.

The Accountable Officer of the CCG is the Vice-Chair of the HWB and works with the Board to ensure that joint priorities are delivered across the North Yorkshire footprint.

This year, the HWB has met twice. Given the COVID-19 Pandemic, the Chair and Vice-Chair recognised that the priority of colleagues on HWB was managing the day-to-day response to the pandemic and preparing for recovery.

At the formal meetings held, the CCG has played a key role in appraising the Board of progress with the move towards an Integrated Care System (ICS) for Humber and North Yorkshire and its implications. It also contributed to a COVID-19 System Review – outlining the position in primary care and acute care.

The CCG has continued to contribute to HWB's objectives to improve the health and wellbeing of the local population in a number of ways outside of the formal HWB environment. For instance, it has:

- been a key player in the Mental Health and Learning Disabilities Partnership, which also comprises, Tees, Esk and Wear Valleys NHS Foundation Trust, and North Yorkshire County Council
- contributed to the Joint Health and Wellbeing Strategy. Further to this, the service commissioning plans produced by clinical commissioning groups, local authorities and NHS England must be informed by the joint health and wellbeing strategy.
- contributed to the on-going development of the Joint Strategic Needs Assessment including developmental work on data profiles for primary care
- been a key element of the Learning Disabilities Autism Group and its area groups, which have been the engine room for transforming care work that has resulted in good progress on discharges from Hospital
- played a leading role in the Harrogate and Rural Alliance – a partnership involving the NHS, North Yorkshire County Council and GPs, designed to deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Priorities have been adjusted to reflect the response required within each locality based on the actions required to deal with the pandemic, and
- pro-actively contributed to initiatives on Delayed Transfers of Care, reflecting the requirements of the Right to Reside Discharge Policy.

Whilst it has not met regularly as an entity throughout the pandemic, the HWB has been kept appraised of developments and key partners briefed.

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

- The Accountable Officer has continued to lead on the vaccination programme for the Humber and North Yorkshire Health and Care Partnership (Integrated Care System), which includes the North Yorkshire and York health partnership. See section 2.2.3 for more information on the vaccination programme and the number of vaccinations given.
- Liaison with partners on the North Yorkshire County Council Weekly COVID-19 Gold Sessions, which focus on a review of the data and a number of priority areas including Testing and Tracing Strategy, Enforcement and Compliance.

- As part of the Health Protection Coronavirus Regulations, the CCG has continued to play a fundamental role in the Strategic Co-ordinating Group of the North Yorkshire Local Resilience Forum (NYLRF). The Forum is a partnership of local agencies working together to manage emergencies. The CCG is part of the risk conversations, identifying where it can support organisations with their regulatory requirements. The Accountable Officer attends NYLRF Press Conferences and the CCG supports multi-agency communications and those specifically relating to the vaccine rollout, including countering mis-information
- The Chief Nurse leads on the vaccine roll out for the North Yorkshire and York system.

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

NHS North Yorkshire
Clinical Commissioning Group

Accountability Report - Corporate Governance

10 Members Report

10.1 The Governing Body

Governing Body Members

Dr Charles Parker
Clinical Chair – April 2020 to Present

Charles has lived and worked in the Hambleton area for over 30 years. Having trained in London, Charles moved up to work in Northallerton and stayed. Charles trained to be a GP in Northallerton working at the Friarage Hospital, where his two sons were born. Charles joined Topcliffe Surgery as a partner in 1992 and worked there until September 2020. The priority for the practice has been accessible, evidence-based care. For 16 years, Charles has also worked as a civilian medical practitioner for the local barracks at Topcliffe. Charles joined NHS Hambleton, Richmondshire and Whitby CCG as a Lead GP Governing Body Member when it was first established and was later appointed as Clinical Chair from December 2015 to March 2020. Charles was appointed as Clinical Chair of NHS North Yorkshire CCG in April 2020.

Amanda Bloor
Accountable Officer – April 2020 to Present

Amanda was appointed as the Accountable Officer for NHS North Yorkshire CCG on 1 April 2020. Prior to this, Amanda served as Accountable Officer for the three North Yorkshire CCGs (Hambleton, Richmondshire and Whitby, Harrogate and Rural District and Scarborough and Ryedale) from December 2018 and 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.

Dr Bruce Willoughby
GP Governing Body Member – April 2020 to Present
Lead for Integrated / Community Care

Bruce qualified from Newcastle University in 1993 and went on to become a GP in Northumberland. After several years of working with the Primary Care Group on stroke improvement, Bruce left General Practice and trained as a specialist in public health across the North East including working in a variety of primary care trusts, a care trust, government office for the North East and a hospital trust. In 2008, Bruce moved to his native Yorkshire and took up a consultant post in Public Health Medicine in North Yorkshire and York PCT. In 2012, after feeling he was in need of getting back to the coal face and missing patient contact, Bruce returned to General Practice. He has worked since then as a GP at a number of practices within Harrogate and the surrounding

area and now is part of Sterling Medical Chambers which provides GP locum services to local practices. Prior to the establishment of NHS North Yorkshire CCG, Bruce served as a GP Governing Body Member for NHS Harrogate and Rural District CCG from September 2014 to March 2020.

Dr Christopher Ives
GP Governing Body Member – April 2020 to Present
Lead for Hospital Based Care

Chris graduated from Hull York Medical School (HYMS) and has remained mainly in the area working in various specialties. Chris has spent time as a tutor at HYMS before then becoming a local GP in Ryedale. Chris 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. Chris has interests in many aspects of medicine including both respiratory medicine and palliative care. Prior to the establishment of NHS North Yorkshire CCG, Chris served as a GP Governing Body Member for NHS Scarborough and Ryedale CCG from April 2017 to March 2020.

Dr Mark Hodgson
GP Governing Body Member – April 2020 to Present
Lead for Integrated/Community Care

Mark qualified at Manchester University in 1982 and has worked as a GP in Aldbrough St John since 1988. The practice is small and rural serving 3,250 patients over a wide area. Prior to the establishment of NHS North Yorkshire CCG, Mark served as a GP Governing Body Member for NHS Hambleton, Richmondshire and Whitby CCG from April 2012 to March 2020. Mark's portfolio of responsibility included being Clinical Lead for Transformation of Community Services, end of life care and innovation and technology and Caldicott Guardian.

Dr Peter Billingsley
GP Governing Body Member – April 2020 to Present
Lead for Hospital Based Care and Vulnerable People

Peter has lived in Scarborough for over 20 years and believes that working in his hometown he is a stakeholder in its future. Peter has an in-depth knowledge of local care provision, where it excels and where it falls short. Prior to the establishment of NHS North Yorkshire CCG, Peter served as a GP Governing Body Member for NHS Scarborough and Ryedale CCG from April 2017 to March 2020.

Dr Ian Woods
Secondary Care Doctor – April 2020 to Present
Chair of the Finance, Performance, Contracting and Commissioning Committee

Ian qualified in Medicine in 1979 and after specialist training became a Consultant Anaesthetist in 1988. Ian's special interests included Intensive Care and also Patient Safety. Ian 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.

Prior to the establishment of NHS North Yorkshire CCG, Ian served as a Governing Body Member at both NHS Harrogate and Rural District CCG from January 2018 to March 2020 and NHS Scarborough and Ryedale CCG from April 2016 to March 2020. Ian lives with his family in North Yorkshire and enjoys walking and photography.

Kenneth Readshaw
Lay Member for Audit and Governance – April 2020 to Present
Chair of the Audit Committee

Ken is a chartered accountant who trained with KPMG and 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 Wensleydale School and Sixth Form Governing Body 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.

Prior to the establishment of NHS North Yorkshire CCG, Ken served as a Governing Body Lay Member at both NHS Hambleton, Richmondshire and Whitby CCG from September 2013 to March 2020 and NHS Scarborough and Ryedale CCG from October 2016 to March 2020.

Sheenagh Powell
Lay Member for Finance – April 2020 to Present
Deputy Chair of the Governing Body
Chair of the Primary Care Commissioning Committee

Sheenagh has many years' experience of working in the NHS including roles as a board member, finance director and chief executive. Sheenagh's career crosses NHS organisations including primary care trusts, an NHS foundation trust and NHS England. Prior to the establishment of NHS North Yorkshire CCG, Sheenagh served as a Governing Body Lay Member and Chair of the Audit Committee at NHS Harrogate and Rural District CCG from January 2018 to March 2020.

Kate Kennady
Lay Member for Patient and Public Engagement – April 2020 to Present
Chair of the Quality and Clinical Governance Committee
Chair of the Remuneration Committee

Kate Kennady is the Lay Member with responsibility for patient and public engagement. Kate is retired having spent her working life in the NHS latterly as a senior nurse and has worked in a number of acute hospital trusts. Kate's last post was as Director of Quality at the Mid Yorkshire Hospitals Trust. Kate then worked for the Royal College of Nursing as a Professional Learning and Development Facilitator for the Yorkshire and Humber and Northern regions. Kate is a registered nurse and undertook her training in Liverpool. Kate also has a master's degree from the University of Leeds in Health Service Studies. Prior to the establishment of NHS North Yorkshire CCG, Kate served as a Governing Body Lay member for patient and public involvement at NHS Harrogate and Rural district CCG from February 2018 to March 2020.

Wendy Balmain
Director of Strategy and Integration – April 2020 to Present

Prior to the establishment of NHS North Yorkshire CCG Wendy was appointed Director of Strategy and Integration for the three North Yorkshire clinical commissioning groups in June 2019 and prior to that served as Director of Transformation and Delivery for NHS Harrogate and Rural District CCG from November 2016 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 – April 2020 to Present

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 December 2018. From June 2019 to March 2020, he operated as Director of Acute Commissioning for the three North Yorkshire CCGs and then from 1 April 2020 for NHS North Yorkshire CCG until October 2020 when he was appointed to a joint role for NHS North Yorkshire CCG and York and Scarborough Teaching Hospitals NHS Foundation Trust on secondment as Executive Programme Director for the East Coast Acute Services Review transformation programme.

Jane Hawkard
Chief Finance Officer – April 2020 to Present

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. Jane is the SIRO for the North Yorkshire CCG.

Sue Peckitt
Chief Nurse, North Yorkshire CCG – April 2020 to Present

Prior to the establishment of NHS North Yorkshire CCG, Sue was appointed Chief Nurse for the three North Yorkshire clinical commissioning groups in June 2019. Sue 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 at Deputy Chief Nurse level for six years prior to her current appointment and holds a Masters 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. Sue is the Caldicott Guardian for the North Yorkshire CCG.

Julie Warren
Director of Corporate Services, Governance and Performance – April 2020 to Present

Prior to the establishment of NHS North Yorkshire CCG, Julie was appointed Director of Corporate Services, Governance and Performance for the three North Yorkshire CCGs in June 2019. Julie 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.

GP Clinical Leads (Non Members)

Dr Sarah Hay
GP Clinical Lead for Quality – April 2020 to Present

Sarah qualified in 1995 from St Mary's Hospital, Paddington. She moved to Yorkshire in 1999 to train as a GP. As a GP Registrar she was the Yorkshire representative at the BMA. Sarah is a part-time partner in a small practice in Harrogate, her interests include Information Technology, GP Appraisal and her clinical interest is palliative care, having worked in three hospices over the years. Prior to joining her practice, Sarah worked as both a locum and salaried GP in Leeds and Harrogate and also spent a year working as a GP in New Zealand. In addition to being a partner, Sarah does regular sessions at the out-of-hours service in Harrogate and also works as a GP Appraiser.

Prior to the establishment of NHS North Yorkshire CCG, Sarah was a GP Governing Body Member for NHS Harrogate and Rural District CCG and GP Lead for Quality, Governance, Urgent and Emergency Care, Cancer and End of Life from April 2013 to March 2020.

Dr Omnia Hefni
GP Clinical Lead for Workforce Development – April 2020 to Present

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

Prior to the establishment of NHS North Yorkshire CCG, Omnia was a GP Governing Body Member for NHS Scarborough and Ryedale CCG and GP Lead for Secondary Care from April 2013 to March 2020.

Dr Tim Rider
GP Clinical Lead – Medicines Management – April 2020 to Present

Tim is a qualified pharmacist and GP and is currently a GP Principal at the Leeds Road Practice, where he has been for nearly 13 years. Tim trained in pharmacy at Kings College London and did his pre-registration pharmacy training at St James' Hospital, Leeds. He attended Leeds School of Medicine and qualified in 2004 and completed his GP training in 2008. Tim currently spends time each week working with the Medicines Management Team. This is a dedicated and experienced team of pharmacists and pharmacy technicians who design and implement medicines management strategy. The group focus on providing high quality evidence based guidance to our local population of patients and clinicians, to ensure all patients receive the highest quality, and most cost effective pharmaceutical care, with the least unnecessary waste.

10.2 Council of Members

Chaired by the Clinical Chair of the Governing Body, the Council of Members is made up of the Lead Commissioning GPs from each of the 51 GP Practices who each agreed who would be attending from within their Practice. Each Practice is responsible for working with the Governing Body and GP Commissioning Leads to engage in the commissioning, monitoring and improvement of service in the area. Members of the Executive Team 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 Executive Team also provides the Council of Members with updates of ongoing work within the CCG and gives members the opportunity to ask questions directly to the Executive Team. It also provides an opportunity to keep the Practices informed of the financial position.

The composition of the Council of Members throughout 2021/22 and up to the signing of the Annual Report and Accounts is as follows:

GP Practice	Representative Member	GP Practice	Representative Member
Aldbrough St John – Doctors Lane Surgery	Dr Michael Keavney	Ampleforth and Hovingham Surgeries	Dr Greg Black
Ayton and Snainton Medical Practice	Dr Felicity Day	Beech House Surgery	Dr Claire Keenleside
Brook Square Surgery	Dr Sarah Livesey	Castle Health Centre	Dr Ivan Aixala-Marcos
Catterick and Colburn Surgery	Dr Rebecca Crowther	Central Dales Surgery	Dr Jonathan Pain
Central Healthcare	Dr Deepankar Datt	Church Avenue Medical Group	Dr Fiona Buckley
Church Lane Surgery	Dr John Crompton	Derwent Practice	Dr Julian Wadsworth
Dr Akester & Partners	Dr Gareth Roberts	Dr Ingram & Partners	Dr Alistair Ingram
Dr Moss & Partners	Dr Ben Millar	Eastgate Medical Group	Dr Chris Walsh
East Parade Surgery	Dr Ian Dilley	Eastfield Medical Centre	Dr Asif Firfirey
Egton Surgery	Dr Giles Horner	Filey Surgery	Dr Anna Black
Glebe House Surgery	Dr Alex Hetmanski, Dr Rhiannon Bigham, Dr Kizzy Dyas, Dr Laura Mezas, Dr Rachael Emison		
Great Ayton Health Centre	Dr Peter Green	Hackness Road Surgery	Dr Philip Jones

GP Practice	Representative Member	GP Practice	Representative Member
Harewood Medical Practice	Dr Debbie Ashcroft, Dr Julia Brown	Hunmanby Surgery	Dr Sree Jaidev
Kingswood Surgery	Dr Ruth Kirby	Lambert Medical Centre	Dr Sally Tyrer
Leyburn Medical Practice	Dr Julia Brown, Dr Debbie Ashcroft	Mayford House Surgery	Dr Georgina Jackson
Mowbray House Surgery	Dr Duncan Rogers	Nidderdale Group Practice	Dr John Hain
North House Surgery	Dr Peter Johnson	Park Parade Surgery	Dr Victoria Finan
Quakers Lane Surgery	Dr Jacquie Moon	Reeth Surgery	Dr Michael Brookes
Ripon Spa Surgery	Dr Charles McEvoy	Scarborough Medical Group	Dr Nicola Cole
Scorton Medical Centre	Dr Richard James	Sherburn and Rillington Practice	Dr Jacqui Caine
Sleights and Sandsend Medical Practice	Dr Simon Stockill	Springbank Surgery	Dr Angela O'Donoghue
Staithes Surgery	Dr Richard Rigby	Stockwell Road Surgery	Dr Matthew Travis
Stokesley Health Centre	Dr Mark Duggleby	The Danby Practice	Dr Marcus Van Dam
The Friary Surgery	Dr Todd Green	The Leeds Road Practice	Dr Peter Banks
The Spa Surgery	Dr Mark Hammatt	Thirsk Health Centre	Dr Andrew Trzeciak
Topcliffe Surgery	Dr Caspar Wood	Whitby Group Practice	Dr Napa Gopikrishnan

10.3 Member Practices of the CCG

The CCG is a membership organisation. All practices who provide primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract in our area are eligible for membership of this CCG. The practices which make up the membership of the CCG are listed above.

11 Clinical Commissioning Group Committees

11.1 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.[32]

11.2 Personal Data Related Incidents

I can confirm that NHS North Yorkshire CCG have not reported any personal data related incidents to the Information Commissioners Office in 2021/22.

11.3 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.

11.4 Modern Slavery Act

NHS North Yorkshire 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 2022 is published on our website.[33]

[32] https://www.northyorkshireccg.nhs.uk/about/conflicts-of-interest/
[33] https://www.northyorkshireccg.nhs.uk/about/publications/

11.5 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 Accountable Officer to be the Accountable Officer of NHS North Yorkshire CCG.

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

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

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

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

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

- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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.

Amanda Bloor
Accountable Officer

12 Annual Governance Statement 2021/22 by the Accountable Officer of the NHS North Yorkshire Clinical Commissioning Group (42D)

12.1 Introduction and context

NHS North Yorkshire Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2020 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 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

12.2 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.

12.3 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.

12.3.1 Constitution

The CCG maintains a Constitution and associated Standing Orders, Prime Financial Policies and a Scheme of Reservation & Delegation, all of which has been approved by the CCG's Membership and Governing Body and has 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 51 Member Practices across North Yorkshire (at 1 April 2021). 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.

As a newly established CCG in 2020 there was no requirement to update the Constitution, Standing Orders or Scheme of Reservation or Delegation in 2021/22.

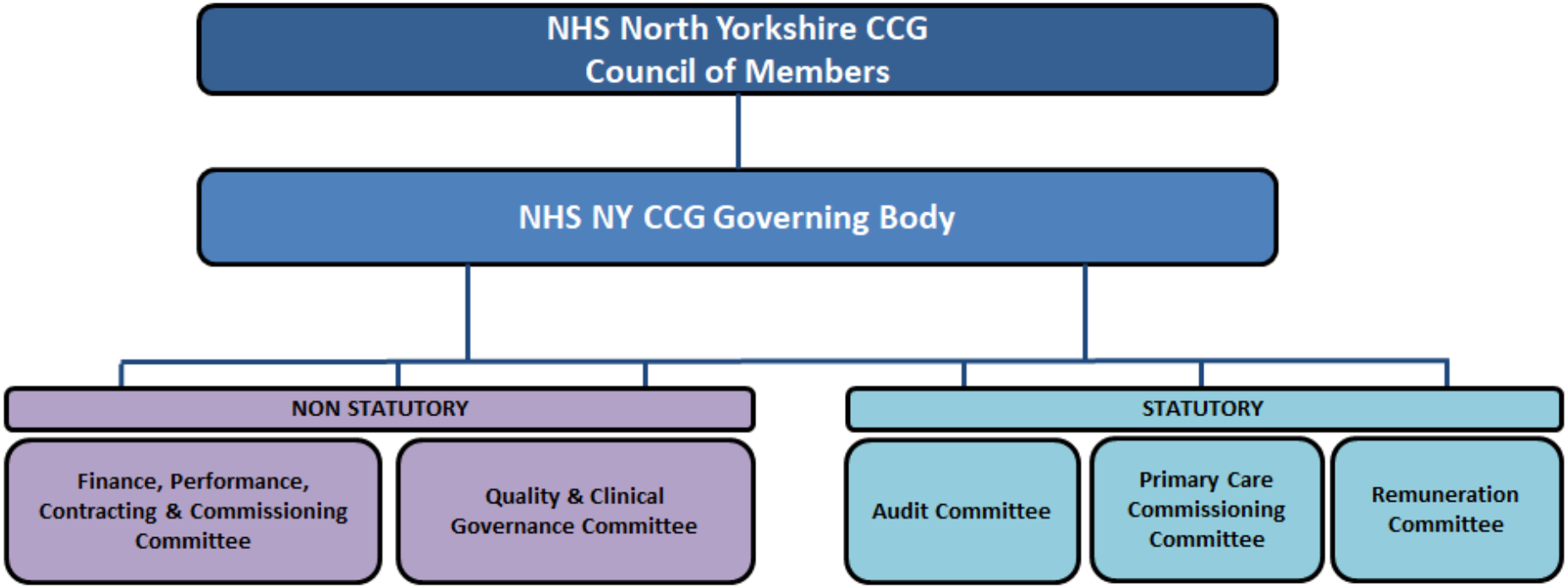
12.3.2 Governing Body and Committee Structure

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 individuals 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.



Committee / Meeting	Role
Council of Members	The Council of Members 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 attend to support the work of the group, and bring items to the meeting for discussion and approval if necessary, e.g., 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.
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 group's 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 regulation • Leading the setting of vision and strategy • Approving commissioning plans • Monitoring performance against plans • Providing assurance of strategic risk.

Committees Published report *NY CCG Governing Body Committees Annual Report 2021/22*, provides a detailed evidence on matters relating to the year 2021/22 and includes attendance records: https://www.northyorkshireccg.nhs.uk/about/	
Audit Committee	Chaired by the Lay Member for Audit and 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	Chaired by the Lay Member for Patient and Public Engagement, the Remuneration Committee has delegated responsibility for advising the Governing Body on all aspects of salary not covered by Agenda for Change, arrangements for termination of employment, monitoring and evaluating the performance of individual Governing Body Members and approving human resources policies and procedures.
Quality and Clinical Governance Committee (QCGC)	Chaired by the Lay Member for Patient and Public Engagement, QCGC 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. In 2021/22 this committee was also responsible for reviewing COVID-19 related risks at the start of the pandemic.
Finance, Performance, Contracting & Commissioning Committee FPCCC	Chaired by the Secondary Care Doctor, the FPCCC monitors and reviews the overall financial position of the CCG's, activity information, provider contract positions and issues, deliverability of the Quality, Innovation, Productivity and Prevention (QIPP) programme, 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 Body on the CCG's financial position, flagging concerns and issues for further discussion. In 2021/22 this committee was also responsible for reviewing COVID-19 spend.
Primary Care Commissioning Committee	Chaired by the Lay Member for Finance, the PCCC provides assurance on the delegated arrangements from NHS England to NYCCG for primary care commissioning. The Committee members make collective decisions on the review, planning and procurement of primary care services under delegated authority from NHS

	England. The Committee focuses on quality, efficiency, sustainability, productivity and new models of primary care.
Joint Committees	NHS North Yorkshire CCG is part of the NHS Humber and North Yorkshire Health and Care Partnership (Integrated Care System). https://humbercoastandvale.org.uk/ In 2021/22, the CCG also held the following collaborative working arrangements: • West Yorkshire and Harrogate Joint Committee (Associate Member) https://www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs • Northern CCG Joint Committee (Associate Member) https://northcumbriaccg.nhs.uk/events/northern-ccg-joint-committee • Southern Collaborative of CCGs Joint Committee (Member) https://teesvalleyccg.nhs.uk/events/joint-committee-of-the-southern-collaborative-of-ccgs/

12.3.3 Council of Members Effectiveness

The responsibilities of the Member Practices are:

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

Due to COVID-19 priorities, the Council of Members only met twice in 2021/22, however engagement did take place virtually as appropriate and the Clinical Chair met with all Practice virtually to discuss wider strategic issues affecting all practices.

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

The Council of Members is committed to reviewing its own performance, however due to COVID-19 priorities this will not take place until early spring 2021.

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

12.3.4 Governing Body Effectiveness

The CCG 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 has undertaken two assessments. The first assessment examines how the CCG compares with the UK Corporate Governance Code, from the Financial Reporting Council. The code is part of a framework of legislation, regulation and best practice standards which aims to deliver high quality corporate governance. The second assessment utilises Healthcare Financial Management Association (HFMA) Audit Committee Handbook guidance and helps to determine if the Governing Body has carried out its duties effectively. The Governing Body reviewed the outcome of both assessments which determined that the Governing Body has carried out its duties effectively in 2021/22.

The Governing Body met throughout 2021/22 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 2021/22.

The Governing Body and Committees 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 Quality and Clinical Governance Committee.

There have been a number of development sessions held for the Governing Body in 2021/22 and the areas covered at these sessions is shown below.

Governing Body Workshop	Governing Body Workshop Topic
April 2021	• Finance and Planning • ICS Governance • Risk Management Planning for 2021/22 • Development of Vision, Values and Behaviours • Development of Strategic Objectives • COVID-19
June 2021	• Finance and Planning including COVID-19 spend • COVID-19
July 2021	• Joint Governance Arrangements - Review of Joint Committee terms of reference and work plans • COVID-19
August 2021	• CGHQ Certified Cyber Security training for Boards • ICS Governance • COVID-19
October 2021	• Joint Governance Arrangements - Review of Joint Committee terms of reference and work plans • Risk Management, Risk Appetite and Governing Body Assurance Framework review and approval
December 2021	• Risk Management • COVID-19
March 2022	• Governing Body and Committees Effectiveness Reviews • Safeguarding training for Boards • COVID-19

12.3.5 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 2021, 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 into 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 CCG's 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 CCG has a Risk Management Strategy that has been approved by the Governing Body. The Governing Body also reviewed its risk appetite six months into the year. In April 2020, Internal Audit completed an audit of the CCG's risk management and governance arrangements and provided an opinion of high 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 2021/22 and has been supported by the Board Secretary / Senior Governance Manager in the day to day management of managing conflicts of interest throughout 2021/22.

In February 2021, Internal Audit completed an audit of how the CCG manages conflicts of interest and provided an opinion of high assurance.

The CCG's 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 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 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 also publishes key messages of the Governing Body and PCCC from its meeting with 24hours of the meetings taking place.

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.

12.3.6 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.

12.4 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 2021/22, 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 2020, the North Yorkshire CCG developed COVID-19 risk registers, managed by the Quality and Clinical Governance Committee. These risks became part of the 'business as usual' as time progressed. The CCG manages risks through a North Yorkshire Corporate Risk Review Group, led by the Director of Corporate Services, Governance and Performance. 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.

The Board Secretary has responsibility for developing the GBAF. In 2021/22, the GBAF was developed with Executive Directors and approved by the Governing Body. The Audit Committee reviewed the GBAF prior to Governing Body approval and gave assurance that processes are in place to effectively manage risk across the organisation.

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

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

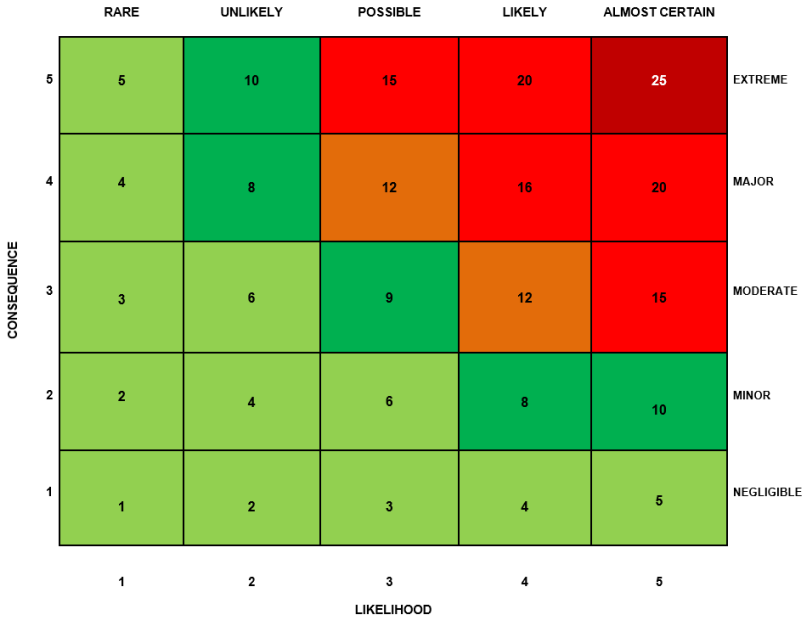
All committee and Governing Body papers carry a specific section within the executive summary page to identify high level risks arising from the area under discussion.

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

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.



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:

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

12.4.1 Capacity to Handle Risk

The Governing Body, Committees and Executive Directors have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2021/22 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, twice at meetings in public and once at a development session
- 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 updates from the Director of Corporate Services, Governance and Performance, 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.

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 12.3.4).

Audit Committee

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.

As a newly established CCG in 2020, the Audit Committee has received the GBAF, Risk Registers and risk management updates at each of the meetings and is assured that processes are in place to manage risk effectively throughout this time of transition to a North Yorkshire CCG.

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.

Following approval of the Risk Management Strategy, the Quality and Clinical Governance Committee receive quarterly reports which details any significant risks aligned to it.

In 2020, at the beginning of the pandemic, the Committee managed COVID-19 risks until they became part of business as usual.

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.

Following approval of the Risk Management Strategy, the Finance, Performance and Commissioning Committee receive 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.

Following approval of the Risk Management Strategy, the Primary Care Commissioning Committee receives reports which detailed any significant risks aligned to it.

Corporate Risk Review Group

The Corporate Risk Review Group (CRRG) 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. On those months that the group has been unable to meet due to COVID-19 priorities, risk leads have reviewed and update their risks on the registers and have provided assurance that they are satisfied within their directorate that risks are being managed effectively. The Director of Corporate Services, Governance and Performance has been notified by the Board Secretary/Senior Governance Manager if any risks have significantly changed and required to be reviewed at Committee level.

Accountable Officer

The Accountable Officer has overall accountability for the management of risk and is responsible for continually promoting risk management and demonstrating leadership, involvement and support. They, along with the Governing Body, have overall responsibility for the maintenance of financial and organisational controls and to ensure that effective risk management arrangements are in place. The Accountable Officer takes executive responsibility for ensuring that there are effective systems and processes in place and is responsible for ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG.

Chief Finance Officer

As Senior Responsible Officer for NHS finances across the North Yorkshire CCG, 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.

Director of Corporate Services, Governance and Performance

The Director of Corporate Services, Governance and Performance is responsible for:

- Ensuring risk management systems are in place throughout the CCG and that risk management principles are embedded in organisational culture
- Ensuring the GBAF is regularly reviewed and updated

- Ensuring there is appropriate external review of the CCG's risk management systems, and that these are reported to the Governing Body
- Overseeing the management of risks as determined by the Corporate Risk Review Group (CRRG)
- Ensuring risk action plans are put in place, regularly monitored and implemented.

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 Chief Nurse is the Caldicott Guardian for the organisation.

Senior Governance Manager / Board Secretary

The Senior Governance Manager has responsibility for:

- Ensuring that the Governing Body Assurance Framework and Corporate Risk Register are developed, maintained and reviewed by the Executive Directors, the Corporate Risk Review Group, and Committees as appropriate
- Providing advice on the risk management process
- Ensuring that the CCG's Governing Body Assurance Framework and Corporate Risk Register are up to date
- Working collaboratively with Internal Audit.

Other Directors / 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.

All Staff

All staff have a duty to comply with the organisation's policies and procedures. Staff that require registration with a professional body must act at all times in accordance with that body's code of conduct and rules.

All staff working for the CCG are responsible for:

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

12.4.2 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 on the CCG's strategic objectives are managed through the Governing Body Assurance Framework and for 2021/22 are detailed below:

Strategic Objective	Principle Risk	Positive Assurance and Controls in Place
Strategic Commissioning	The COVID-19 pandemic and further risk of a second wave of occurring could seriously impact on the delivery of health services for the NY population.	• Robust infection prevention and control measures in place across all health settings. • System Silver Command membership widened to provide increased focus on managing winter pressures and impacts from a second surge. Membership includes representatives from all care sectors and providers. • Comprehensive daily information and reporting on system activity. • Winter plans from health providers completed and operational from 2 November 2020. • Surge plans for 2021/22 prepared and enacted by acute providers, aligned with winter plans. • Surge plans finalised for mental health, primary care and community care. • Primary care OPEL system agreed • Confirmed discharge pathways and operational models/ co-ordinators all agreed • Lessons learned (clinical and operational) • Recovery reporting to Governing Body, including Quality & Performance Dashboard to QCGC. • EPRR, Business Continuity Plan and Major Incident Plan approved by Governing Body.

Strategic Objective	Principle Risk	Positive Assurance and Controls in Place
Acute Commissioning	Sustainability and transformation of services to meet capacity and in acute settings across NY does not keep pace required leading to compromised quality of services and issues with capacity and demand.	• Transformation of planned care delivery including diagnostics and outpatient services across HNY footprint. Aligning work streams with national Adopt and Adapt initiatives as well as exploring prime provider and re-structuring of services at scale. Acute provider working groups feed into HNY Transformation Board. • Acute trusts using clinical prioritisation of elective waiting list in line with national guidance. ICSs looking at clinical risk review so that common guidance is used. Maximise capacity through elective and cancer care hubs and virtual hubs. • Working with both acute and Independent Sector Providers (ISP) to clearly understand amount of activity and clinical threshold required to maximise capacity now Increasing Capacity Framework published. • The NY & Y Cancer Recovery Plan and assurance report includes services at HDFT, YTHT and STHT. Reported through Governing Body Performance Report and monthly to SLE via Clinical Network Lead.
Engagement with Patients and Stakeholders	Insufficient system wide engagement and decision making of partner organisations could impact on the CCGs ability to work effectively to transform the way services are commissioned for the local population.	• Regular meetings with system partners at all levels, led by VSMs • Cooperative working though ICS structures • Strong professional relationships and interorganisation intelligence sharing in place • MoUs and ToR for Joint Committees and joint commissioning arrangements. • Council of Members / Member Practice meetings • Trust workplace plans in place • Regular contract monitoring • Regular reporting of any developments through formal committees and to the Governing Body
Vulnerable People	Limited external oversight of care and treatment for people who are most at risk i.e., those at home alone; and in care facilities with compromised staffing and with an increase in restrictive practices, will lead to an increased risk of abuse and neglect to vulnerable groups.	• SI reports / never event reports to the Chief Nurse and QCGC. • Ongoing contact with partners including NYC Quality and Assurance Team and CQC to pick up any early indicators of concerns and to provide support • Advice and guidance to providers when needed; telephone support; webinars; email contact; training; links to guidance and support with supplies. • Regular virtual meetings with NYS Quality Assurance Team, CQC and CCG to discuss intelligence pertaining to care providers. • Domestic Abuse support services have altered support arrangements to continue to provide a service to victims of Domestic Abuse. • Daily multi provider command calls provides assurance regarding issues with care homes / domiciliary care. • Acute provider trust and TEWV meetings in place • Contract meetings: TEWV Clinical quality meeting and Harrogate quality meeting • Links with safeguarding teams • CRRG monthly monitoring of risks
Vulnerable People	Due to the government advice re social distancing/isolation	• 'The Designated Nurses have worked with the LA and other partner agencies to agree temporary arrangements whereby key meetings regarding children subject to child protection plans and children in need take place virtually. This will provide the opportunity to review existing multi-agency plans and agree

Strategic Objective	Principle Risk	Positive Assurance and Controls in Place
	there are reduced opportunities for health providers and other partner agencies to have face to face contact with vulnerable children and their families, therefore there is a greater risk that safeguarding children's issues will not be identified and addressed.	future actions. The Designated Nurses have also liaised with the 0-19 Healthy Child Service across North Yorkshire with regard to arrangements for ongoing support and contact with vulnerable children and families. • Close monitoring in partnership with Police and Social Care and other partner agencies such as IDAS (Independent Domestic Abuse Service). • Continuation of domestic abuse notifications from police to midwives and 0-19 practitioners to support targeted interventions. Also working with relevant agencies to ensure that staff working in swabbing stations are provided with information in relation to domestic abuse services so that they can support any members of the public who approach them with disclosures. Parents encouraged to continue to access health care for children as needed - RCPCH 'Traffic Light' guidance distributed to all parents via text messaging from 0-19 service. • Working with Primary Care (finding/contacting vulnerable families). • Consider additional work using COVID-19 money. • Vulnerable families RAG rated by Social Care to target support.
Well Governed and Adaptable Organisation	Insufficient workforce, talent management and succession planning system wide could lead to inability to deliver statutory duties and organisational objectives and priorities.	• Publication of The People's Plan – aims to tackle the range of workforce challenges in the NHS, recognising that this is one of the strategic risks for the NHS. • Appraisal process in place with a focus on talent management and succession planning • CCG's working together on a wider footprint to align resources and functions where possible. • Establishment of the Communication and Engagement Group which includes elements of staff engagement. • Establishment of Primary Care Networks building on resilience within PC services.

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.

During 2021/22 the CCG has maintained sound risk management and internal control systems as described in the risk management section of this statement.

In March 2021, Internal Audit completed an audit of the CCG's risk management and governance arrangements and provided an opinion of high assurance.

12.5 Other Sources of Assurance

12.5.1 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 principal risks identified.

The governance structure within the CCG provides the control mechanism through which the 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.

12.5.2 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.

12.5.3 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.

12.5.4 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 will complete and submit its 2021/22 Information Governance Toolkit ahead of the national deadline on 30 June 2022. In seeking further assurance of the quality of evidence provided, Internal Audit will carry out an assessment of the evidence supporting the Information Governance Toolkit 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.

NECS was the CCG's main business intelligence provider in 2021/22.

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

12.5.5 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 2021/22 it has not developed any analytical models which have informed government policy.

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

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

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

12.6 Control Issues

In the Month 9 Governance Statement return, the CCG reported that for 2021/22 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.

12.7 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 2021/22 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 2021/22 at its meeting in June 2022, together with the report from external audit, before these are presented to Governing Body. The CCG has received an internal audit report giving high assurance on the controls in place for ensuring good governance of its financial systems.

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

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

The NHS System Oversight Framework 2021/22 provides the basis for the ongoing review and oversight of NHS organisations, including CCGs. NHS England has a statutory duty to review the progress and performance of CCGs, and this has been applied proportionately through the past few years given the covid pandemic response.

12.7.1 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
- Reports to Council of Members
- Consistent and regular reporting through Committees of the Governing Body
- Consistent and regular reporting through management board arrangements

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

12.7.2 Counter Fraud Arrangements

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

In January 2020 the NHS Counter Fraud Authority (NHSCFA) 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. In May 2020 the LCFS produced an annual counter fraud plan aligned to the standards.

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

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

The CCG's counter fraud arrangements are currently in compliance with NHSCFA's Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the appointment of the LCFSs, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud. However, it should be noted that these standards have subsequently been superseded by the Government Functional Standard GovS 013: Counter Fraud (Functional Standard), which was formally introduced in February 2021.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's standards, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA. The 2019/20 assessments for the three North Yorkshire CCGs were completed with reference to the NHSCFA "Standards for Commissioners". The assessments were submitted in May 2020 with an overall assessment of green. In 2021 the NHSCFA released their interpretation of how the Government Functional Standard GovS 013: Counter Fraud should be applied within NHS organisations and published a set of "NHS Requirements" which replaced the "Standards for Commissioners". The LCFS has completed a self-assessment for 2021/22 based on the new NHS Requirements. This self-assessment has been reviewed by the CFO and Audit Committee Chair and was submitted prior to the NHSCFA deadline of the 31 of May. The overall grading was amber and a summary of the return is included within the Annual Counter Fraud Report 2021/22.

12.8 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 NORTH YORKSHIRE CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 2022

12.8.1 Introduction

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

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

12.8.2 Executive Summary

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

Key Area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2021 to 31st March 2022 provides High Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are being applied consistently. In the Head of Internal Audit Opinion for 2020/21 we reported the Internal Audit Standards Advisory Board (IASAB) had issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020).

Key Area	Summary
	The pandemic has continued to have an impact on the progression of the audit programme during 2021/22 but not to the same level as in 2020/21. We have delivered the planned audit work, subject to agreed changes, and have continued to follow the advice provided in the above guidance to ensure we remain compliant with the PSIAS. Where there has been an impact on the audit programme this has been communicated to and agreed with the Audit Committee and clear records of any changes have been maintained via our progress reports. The audit programme at the CCG has also been undertaken in the context of the imminent transition to Integrated Care Boards (ICBs). An element of our audit work during 2021/22 has been to support and provide assurance on this transition process.
Planned Audit Coverage and Outputs	The 2021/22 Internal Audit Plan has been substantially delivered as planned. This position has been reported within the progress reports across the financial year and any changes to the audit programme have been captured in these. Audit coverage in 2021/22 has been focussed on: • The organisation's Risk Management and Assurance Framework • Core and mandated reviews, including follow up • A range of individual risk-based assurance reviews • Management and oversight of transition to the Integrated Care Board. The following changes were made to the planned coverage: • Cancellation of the Data Security and Protection Toolkit due to NHSD confirmation that this is not a required audit for CCG's in 2021/22. Due to the imminent introduction of the ICB however, a decision has been taken to undertake assurance work on the IT Risk Registers instead, in order that the ICB can be assured at the outset that good IT/IG controls are in place and operating as expected, or that appropriate action plans are in place to mitigate any risks. A significant proportion of the audit plan was given to the review of the arrangements relating to the closedown of NHS North Yorkshire Clinical Commissioning Group and the setting up of the Humber and North Yorkshire Integrated Care Board (HNYICB). As required by the Due Diligence Checklist, Audit Yorkshire and Senior

Key Area	Summary
	Officers from the CCG have been active members of numerous programme boards. In particular, those tasked with the closing down of Governance, Information Governance and Financial Arrangements. Audit work is ongoing to consider the design and operation of shadow governance arrangements, place readiness and progress against the Due Diligence Checklist. Further work is planned in this area in the first quarter of 2022/23 as a result of the delayed transition to ICBs.
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

12.8.3 Roles and responsibilities

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

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

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

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

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

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

12.8.4 The Opinion

My opinion is set out as follows:

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

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

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

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

Overall Opinion

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

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

Opinion Definitions

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

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

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

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 Governance Framework, operation of the Assurance Framework and associated Risk Management processes has been undertaken in 2021/22. The audit has confirmed that the Assurance Framework is fit for purpose and is designed to provide the Governing Body with sufficient and timely assurances on its system of internal controls to manage its strategic risks. Arrangements are in place to provide sufficient oversight of the Assurance Framework. The Assurance Framework is designed in accordance with NHS requirements and meets all the elements required. The Assurance Framework covers the organisation's key risks.

The Assurance Framework is a live Governing Body tool and is reported to it in line with an agreed timetable, with any escalation process being driven via the Audit Committee. Regular oversight of the Assurance Framework is also undertaken by the Governing Body sub-committees, to ensure they have received sufficient assurances on the strategic risks allocated to them. The Assurance Framework clearly reflects the impact of COVID-19 on the organisation.

Our audit work also confirmed that NHS North Yorkshire Clinical Commissioning Group has appropriate and effective controls in place to ensure that risks are identified, assessed, recorded, reviewed, updated and reported on, with escalation where appropriate, and has established clear processes for reviewing risk registers and for tracking progress on addressing risks. Risk Management procedures in place align to the CCG's Risk Management Strategy, which documents the organisational risk tolerance levels when managing individual risks.

A key element on the 2021/22 Audit Plan has been to review the transitional arrangements relating to the closing down of NHS North Yorkshire CCG and the setting up of the Integrated Care Board (ICB). As required by the Due Diligence Checklist created by NHS England, Audit Yorkshire and senior officers from NHS North Yorkshire CCG have been active members of numerous programme boards, in particular, those tasked with the closing down of governance, Information Governance and Financial arrangements, as well as attending the overarching Transition Board.

During the last few weeks of 2021/22, Audit Yorkshire will be undertaking our own deep dive review on the Due Diligence Checklist to ensure that the closedown of NHS North Yorkshire CCG is being conducted in a safe and legal way, with sound risk management arrangements being in place. In addition, we will also be completing a Readiness to Operate review as well as a review of the Maturity Matrix that will feed into the setting up of the Integrated Care Board.

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

Core & Risk Based Reviews Issued

We issued to date:

4 **high** assurance opinions:	• Risk Management and Governance Arrangements • Patient Experience • Conflicts of Interest • Budgetary Controls and Reporting & Key Financial Controls
6 **significant** assurance opinion:	• Personal Health Budgets • Primary Care Commissioning – Commissioning and Procurement • Hospital Discharge Scheme • QIPP • CHC – Funded Nursing Care • CHC – Reporting*
0 **limited** assurance opinions:	
0 **low** assurance opinions:	
2 reviews without an assurance rating	• Mental Capacity Act – Benchmarking exercise on readiness • Recommendation Tracking – Benchmarking exercise

**Draft report*

Follow Up

A total of 45 Internal Audit recommendations have been live during 2021/22 (this includes recommendations from previous years' reports that were still live in April 2021).

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

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
0	4	4	37	45	9%

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

Consideration for your Annual Governance Statement

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

A high overall opinion has been provided. Attention is drawn to the fact that to date no final reports have been issued in 2021/22 with a "limited assurance" opinion. In addition, no "limited assurance" reports were issued in 2020/21.

Looking Ahead

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

During the COVID-19 response, there has been increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This has continued during 2021/22 and subject to the passing of legislation collaboration will be placed on a statutory footing from 1 July 2022. At this point

the Clinical Commissioning Group will transition to the Humber and North Yorkshire Integrated Care Board and will no longer be a statutory body in its own right. The Integrated Care Board will become the statutory body, supported by six places. North Yorkshire will form one of these places and continues to plan for this transition and further develop its existing place-based partnership arrangements. The formal move to system working at Humber and North Yorkshire and place level will require robust accountability and assurance arrangements to ensure statutory functions and the system wide financial envelope are delivered.

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

13 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 and I have provided detail on areas of internal control to consider:

Service Auditor Reports

North Yorkshire CCG, like all CCGs, relies on national systems to undertake some of its day-to-day activities. The CCG receives Service Auditor Reports (SARs) from the external auditors of these systems to give it the assurance that they are being properly governed and appropriate policies and procedures are in place and being adhered to. Four of the SARs that North Yorkshire CCG place reliance on have been issued for 2021/22 but have been qualified. North Yorkshire CCG has reviewed these qualifications and has assured itself that it has its own procedures in place which mitigate any concerns.

Payroll and HR System

The national system holds HR data and undertakes payroll functions. Our CCG sets pay budgets on an individual level using national information such as pay-scales, employer national insurance rates, and employer NHS pension rates. Each month both the CCG finance team and the relevant budget holders scrutinise individual pay to ensure it is consistent and within budgets. Any anomalies are immediately investigated with relevant line managers and the Human Resources team.

Finance Ledgers System

Issues raised with regards to the sales ledger element. Our CCG has its own Income Register to monitor and control the raising of sales invoices. The CCG also reviews the debtors list on a fortnightly basis and undertakes any relevant actions to understand debt and collect outstanding debt. These internal controls give the CCG confidence that this SBS control issue would not impact at all on the CCG's financial position.

GP Payments System

GP contract details and parameters is dealt with nationally. Our CCG works very closely with specialist primary care finance staff at NHS England through its co-commissioning of primary care services arrangements. This dedicated finance team assist the CCG in setting budgets using national guidance/polices and through their in-depth understanding of the make-up of local GP practices.

Variance against these budgets is monitored on a monthly basis by this team with a detailed monthly report submitted to the CCG. The CCG also has good working relationships with its local GP practices whereby verification of anomalies can be made directly.

Prescribing Costs

Prescribing costs are dealt with nationally and recharged accordingly to CCGs. Our CCG employs a dedicated medicines management team which includes qualified pharmacists. One of their functions is to review prescribed medication at an individual patient level. Checks undertaken include the appropriateness of the medications prescribed. The team also constantly review the prescribing authority's information to check its accuracy. Errors, such as costs arising from a prescribing GP no longer employed by a local practice, are corrected on the system and recharged accordingly.

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
- Quality and Clinical Governance Committee
- 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 2021/22.
- Due to the establishment of the CCG in April 2020, the terms of reference for each Committee were new for 2021/22.

- Due to the establishment of the CCG in April 2020, the Constitution and statutory appendices were new for 2021/22 and ensure governance arrangements are both compliant with the latest recommendations and are effective.
- The Governing Body has attended development sessions throughout the year and has completed a review of its own effectiveness for 2021/22.
- All Committees have carried out self-assessments of their effectiveness. The outcome of the self-assessments have been reviewed by the Governing Body.
- All Committees produced an annual report for 2021/22. The annual reports were 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 2021/22 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 2022

NHS North Yorkshire Clinical Commissioning Group

Remuneration and Staff Report

14 Remuneration and Staff Report

14.1 Remuneration Committee

Details of the Remuneration Committee and activity is available in section 12.3.2.

14.2 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.

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

No performance related pay was paid to any senior manager of the CCG in 2021/22.

14.2.2 Senior Managers Service Contracts (not subject to audit)

No senior managers for the CCG have been engaged under service contracts in 2021/22.

14.3 Policy on the Remuneration of Very Senior Managers 2021/22

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.

14.4 2021/22 Senior Manager Remuneration (subject to audit)

2021-22 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Dr C Parker Clinical Chair/GP	90-95	-	-	-	35.0-37.5	125-130
Mrs A Bloor Accountable Officer	150-155	-	-	-	50.0-52.5	200-205
Mrs J Hawkard Chief Finance Officer	130-135	-	-	-	42.5-45.0	175-180
Mrs W Balmain Director of Strategy and Integration	120-125	-	-	-	30.0-32.5	150-155
Mr S Cox (note a) Director of Acute Commissioning	120-125	-	-	-	40.0-42.5	160-165
Mrs S Peckitt Chief Nurse	105-110	-	-	-	45.0-47.5	155-160
Mrs J Warren Director of Corporate Services, Governance and Performance	115-120	-	-	-	37.5-40.0	155-160
Dr P Billingsley GP	100-105	-	-	-	50.0-52.5	150-155
Dr M Hodgson GP	55-60	-	-	-	-	55-60
Dr C Ives GP	35-40	-	-	-	-	35-40
Dr B Willoughby GP	85-90	-	-	-	30.0-32.5	120-125
Mrs K Kennady Lay Member	10-15	-	-	-	-	10-15

2021-22 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mrs S Powell Lay Member	10-15	-	-	-	-	10-15
Mr K Readshaw Lay Member	10-15	-	-	-	-	10-15
Dr I Woods Secondary Care Doctor	30-35	-	-	-	-	30-35

Notes

a) Mr S Cox was Director of Acute Services until the 31st March 2022.

14.5 2020/21 Senior Manager Remuneration (subject to audit)

2020-21 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Dr C Parker Clinical Chair/GP	80-85	-	-	-	17.5-20.0	95-100
Dr A Ingram Vice-Clinical Chair/GP (note a)	35-40	-	-	-	-	35-40
Mrs A Bloor Accountable Officer	145-150	-	-	-	40.0-42.5	185-190
Mrs J Hawkard Chief Finance Officer	130-135	-	-	-	37.5-40.0	165-170

2020-21 Salaries and Allowances						
Name and Title	**(a) Salary (bands of £5,000) £000**	**(b) Expense payments (taxable) to nearest £100 £00**	**(c) Performance pay and bonuses (bands of £5,000) £000**	**(d) Long-term performance pay and bonuses (bands of £5,000) £000**	**(e) All pension related benefits (bands of £2,500) £000**	**(f) Total (bands of £5,000) £000**
Mrs W Balmain Director of Strategy and Integration	115-120	-	-	-	37.5-40.0	155-160
Mr S Cox Director of Acute Commissioning	115-120	-	-	-	32.5-35.0	150-155
Mrs S Peckitt Chief Nurse	105-110	-	-	-	127.5-130.0	230-235
Mrs J Warren Director of Corporate Services, Governance and Performance	115-120	-	-	-	35.0-37.5	150-155
Dr P Billingsley GP	100-105	-	-	-	-	100-105
Dr M Hodgson GP	55-60	-	-	-	-	55-60
Dr C Ives GP	50-55	-	-	-		50-55
Dr B Willoughby GP	90-95	-	-	-	37.5-40.0	130-135
Mrs K Kennady Lay Member	10-15	-	-	-	-	10-15
Mrs S Powell Lay Member	10-15	-	-	-	-	10-15
Mr K Readshaw Lay Member	10-15	-	-	-	-	10-15
Dr I Woods Secondary Care Doctor	30-35	-	-	-	-	30-35

Notes

a) – Dr A Ingram was vice clinical chair until the 31st December 2020.

14.6 2021/22 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 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2022	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr C Parker Clinical Chair/GP	0.0-2.5	0.0-2.5	20-25	55-60	473	35	523	-
Mrs A Bloor Accountable Officer	2.5-5.0	0.0-2.5	60-65	135-140	1,165	51	1,243	-
Mrs J Hawkard Chief Finance Officer	2.5-5.0	0.0-2.5	50-55	95-100	906	42	971	-
Mrs W Balmain Director of Strategy and Integration	2.5-5.0	(0.0-2.5)	20-25	35-40	444	32	496	-
Mr S Cox Director of Acute Commissioning	2.5-5.0	0.0-2.5	50-55	60-65	791	38	850	-
Mrs S Peckitt Chief Nurse (note d)	0.0-2.5	5.0-7.5	45-50	135-140	982	65	1,066	--
Mrs J Warren Director of Corporate Services, Governance and Performance	2.5-5.0	0.0-2.5	40-45	80-85	747	34	802	-
Dr P Billingsley GP	2.5-5.0	(0.0-2.5)	15-20	25-30	280	34	330	-
Dr B Willoughby GP	0.0-2.5	0.0-2.5	45-50	100-105	792	35	844	-

Further Pension Declaration Notes

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

b) Dr M Hodgson does not contribute towards the NHS Pension Scheme as part of his employment at North Yorkshire Clinical Commissioning Group.

c) Due to the contract of employment at North Yorkshire CCG, Dr C Ives does not contribute towards a North Yorkshire CCG NHS Pension Scheme.

d) One member of the governing body has applied for the 2019/20 NHS Annual Allowance Compensation Scheme. As the closing date for this scheme was 31st March 2022 the financial consequences are not reflected in the figures above. The compensation cost will be covered by NHS England & Improvement and not NHS North Yorkshire CCG).

14.7 2020/21 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 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (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 2021	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr C Parker Clinical Chair/GP	0.0-2.5	(0.0-2.5)	20-25	55-60	440	14	473	-
Mrs A Bloor Chief Officer	0.0-2.5	(0.0-2.5)	60-65	130-135	1,099	26	1,165	-
Mrs J Hawkard Chief Finance Officer	0.0-2.5	(0.0-2.5)	45-50	95-100	848	24	906	-
Mrs W Balmain Director of Strategy and Integration	0.0-2.5	0.0-2.5	20-25	35-40	392	28	444	-
Mr S Cox Director of Acute Commissioning	0.0-2.5	(0.0-2.5)	50-55	60-65	740	21	791	-
Mrs S Peckitt Chief Nurse	5.0-7.5	15.0-17.5	40-45	130-135	823	131	982	-

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 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (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 2021	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mrs J Warren Director of Governance and Performance	0.0-2.5	(0.0-2.5)	40-45	80-85	698	21	747	-
Dr P Billingsley GP	(0.0-2.5)	(0.0-2.5)	15-20	25-30	275	(14)	280	-
Dr A Ingram GP	(0.0-2.5)	(0.0-2.5)	15-20	35-40	305	(4)	308	-
Dr B Willoughby GP	0.0-2.5	0.0-2.5	40-45	100-105	739	27	792	-

Further Pension Declaration Notes

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

b) Dr M Hodgson does not contribute towards an NHS Pension Scheme as part of his employment at North Yorkshire Clinical Commissioning Group.

c) Due to the contract of employment at North Yorkshire CCG, Dr C Ives does not contribute towards a North Yorkshire CCG NHS Pension Scheme.

14.8 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.

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.

14.8.1 Real increase in CETV

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

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

No payments have been made to any senior managers of the CCG for loss of office in 2021/22.

14.10 Payments to Past Members (subject to audit)

No payments have been made to any past senior managers of the CCG in 2021/22.

14.11 Fair Pay Disclosure

14.11.1 Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	nil%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	8.5%	n/a

The table above shows that whilst the salary of the highest paid director (£187,500 - figure is mid-point in £5,000 bandings) did not move, the average salary within the organisation, including agency staff, increased by 8.5%. This increase arises from cumulation of the NHS pay award, the increase in higher banded posts, and the increased reliance on agency staffing.

Please note that the top remuneration does not appear in the 'Senior Manager Remuneration 2021/22' table above because several members of North Yorkshire Clinical Commissioning Group Governing Body are employed on a part-time basis.

14.11.2 Pay Ratio Information

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

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

The banded remuneration of the highest paid director/member of the Governing Body of North Yorkshire Clinical Commissioning Group in the financial year 2021/22 was £187,500 (figures are mid-point in £5,000 bandings) with nil% movement against 2020/21 of £187,500, and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year		25th percentile	Median	75th percentile
2021/22	Total Renumeration	£65,664	£45,511	£31,679
	Salary Component of Total Renumeration	£65,664	£45,511	£31,679
	Pay Ratio	2.86:1	4.12:1	5.92:1
2020/21	Total Renumeration	£63,990	£44,392	£30,615
	Salary Component of Total Renumeration	£63,990	£44,392	£30,615
	Pay Ratio	2.93:1	4.22:1	6.12:1

The change in the figures in the above table, between 2020/21 and 2021/22 is consistent with the NHS pay award of 3%.

The ratios are the staff remuneration against the mid-point of the banded remuneration of the highest paid director.

In both 2021/22 and 2020/21 no employees received remuneration in excess of the highest-paid director/member.

15 CCG Staff Report

15.1 Number of Senior Managers (subject to audit)

Pay Band (annual salary range)	Number	Pay Band (annual salary range)	Number
GP pay-scale	9	Band 8d (£75,914 - £87,754)	7
VSM (£60,000 - £150,000)	7	Band 8c (£63,751 - £73,664)	8

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

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

15.2 Staff Numbers and Costs (subject to audit)

On the 31 March 2022 the CCG employed 169 directly employed staff. This equates to 148.56 full-time equivalents of directly employed staff.

The CCG is the employer for the Medicines Management team and the Human Resources (HR) team who provide services to other organisations. A proportion of the staffing costs are recharged to other local CCGs according to the memorandum of understandings in place.

For further staffing information, including the breakdown of staff between ‘permanently employed’ and ‘other’, please see the CCG’s statutory accounts note 3.

15.3 Staff Composition

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

Staff Group	Male	Female	Transgender	Total
Governing Body	7	7	0	14
Council of Members (not employees of the CCG)	34	23	0	57
Other Senior Managers	9	9	0	18
All other staff	22	112	0	135

15.4 Sickness Absence

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.

As at 31 March 2022, the average level of absence for the last 12 months for employees of the CCG is 2.52%. Absence continues to be proactively managed.

15.5 Staff Turnover

As at 31 March 2022 the figure for staff turnover was 0.98%. This is in comparison to 1.96% at 31 March 2021.

15.6 Staff Policies

Currently all Human Resources policies and procedures are aligned to the three former CCGs' policies, the parent page for which can be found on the CCG's website.[34] In preparation for the transition into the ICS it is planned that a new suite of policies will be provided for the new organisation.

The CCG is committed to attracting, retaining and developing a diverse and skilled workforce. To ensure the CCG meets these goals we have:

- A bank of HR Policies and Procedures is available to support the workforce with equality impact assessments
- Statutory/mandatory training in equality and diversity which is monitored monthly and reviewed quarterly by the Audit Committee
- Involve staff on equality and inclusion via all staff briefings and a Staff Engagement Group
- Promoting key events and celebrations through all staff communications
- Identify and support the needs of diverse staff through appraisals and 1-1 risk assessments
- Collect, evaluate and monitor our workforce data.

[34] https://www.northyorkshireccg.nhs.uk/home/about-us/policies/

The CCG's Equality and Diversity Plan is available on the CCG website[35] which sets out the CCG approach to promoting equality in commissioning decisions and valuing the diversity of service users and employees. The CCG NHS People Plan Action Plan also includes a number of national and regional initiatives to develop equality and diversity.

15.7 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 North Yorkshire CCG does not employ any trade union representatives.

15.8 Other Employee Matters (not subject to audit)

15.8.1 Social Partnership Forum

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

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

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

15.8.2 Obtaining Staff Opinions

Due to the COVID-19 pandemic CCG staff have been working from home for much of 2021/22. We worked closely with our people to make sure they felt safe and supported as we continued to work in pandemic conditions. This included regular staff surveys and action plans, COVID-19 secure measures in place for staff who did need to travel into the office or have face-to-face contact with patients or the public, and enhanced support to ensure suitable remote workspaces.

[35] https://www.northyorkshireccg.nhs.uk/home/about-us/equality-and-diversity/

A Staff Engagement Group continued to provide a forum for gaining staff input into some of the new North Yorkshire CCG policies and to explore ways in which the health and wellbeing of staff could be supported, as well as organising social events such as the NYCCG Spring and Christmas quizzes to support morale.

15.8.3 Employee Health and Wellbeing

All CCG staff have continued working from home due to the COVID-19 pandemic. This presented a variety of challenges in relation to the technical arrangements for home working and also ensuring health and wellbeing support for our staff. Plans are now being developed to enable staff to return to office working in a planned and safe way. Health and wellbeing initiatives have continued to be provided to support CCG staff. These included undertaking further individual risk assessments for all our staff, with a particular focus on at risk categories such as ethnic minority staff, pregnant workers and those with underlying health conditions and were followed up with 1-1 health and wellbeing conversations. Throughout the year further individual support was provided along with regular staff briefings and innovative on-line support sessions. This has included the CCG Staff Portal which provides a wealth of information and access to support sessions in the CCG, the Humber and North Yorkshire ICS and national initiatives.

The CCG continued implementing actions within the NHS People Plan including Freedom to Speak Up Guardians and a Health and Wellbeing Guardian including Menopause Champions.

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

Workforce Race Equality Standard reporting during 2021 was completed for NHS North Yorkshire CCG, the submission for 2021/22 is due for completion in August 2022.

15.9 Expenditure on Consultancy

During 2021/22 the clinical commissioning group did not spend any funding on consultancy. For comparison, £85,000 was through 4 companies in 2020/21for work related to capital project due diligence, VAT review, accommodation review, and data cleansing

15.10 Expenditure on Agency Staff (not subject to audit)

During 2021/22 the clinical commissioning group spent £648,000 (£349,000 in 2020/21) on agency staff. This was for 17 different posts, from 9 different agencies, covering a total of 408 weeks, at an average weekly cost of £1,588.00 (£1,497.00 in 2020/21).

15.11 Off-payroll Engagements

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

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31st March 2022 for more than £245* per day and that last longer than six months:	**Number**
Number of existing engagements as of 31 March 2022	3
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	1

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

As noted in the table above, the CCG had three off-payroll engagements as of the 31st March 2022 where it paid more than £245 per day and that have lasted longer than six months. Details of these engagements are:

- In August 2016 the CCG engaged the services of a GP with a special interest in prescribing as the legacy CCG's lead for prescribing. This GP remained employed by their practice and invoiced the CCG accordingly for their time spent undertaking this role.
- In April 2020 the CCG engaged the services of a GP with a special interest in elderly care as the CCG's lead for frailty. This GP remained employed by their practice and invoiced the CCG accordingly for their time spent undertaking this role.
- In September 2021 the CCG engaged the services of a specialist financial systems merger and transfer manager to lead on the abolishment of CCGs and the creating of Integrated Care Boards in 2022/23, as outlined in the Health and Care Bill. The costs are paid to a limited company of which the manager is a Director.

The CCG can confirm that all existing off-payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, and where necessary, assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1st April 2021 and 31st March 2022, for more than £245(1) per day:	**Number**
No. of temporary off-payroll workers engaged between 1st April 2021 and 31st March 2022	11
Of which:	
No. not subject to off-payroll legislation(2)	8
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	3
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	

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

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

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1st April 2021 and 31st March 2022:	**Number**
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-
Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	28

15.12 Exit Packages (subject to audit)

No exit packages have been made during 2021/22.

15.13 Going Concern

The CCG's accounts, which are attached at the end of this annual report at page 201, have been prepared on a going concern basis. Whilst the Health and Care Bill was given Royal Assent and became an Act of Parliament on the 28th April 2022, which will see the abolishment of CCGs on the 30th June 2022 and the establishment of Integrated Care Boards (ICB), these new ICBs will take on the commissioning functions of CCGs. As a consequence, all the CCG's assets and liabilities will therefore transfer to an ICB on the 1st July 2022. For NHS North Yorkshire Clinical Commissioning Group, this transfer will be to NHS Humber & North Yorkshire Integrated Care Board.

16 Parliamentary Accountability and Audit Report (subject to audit)

NHS North Yorkshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report starting at page 201. An audit certificate and report is also included in this Annual Report below.

17 Independent Auditor's Report to the Governing Body of NHS North Yorkshire Clinical Commissioning Group

Report on the audit of the financial statements

This will be done in June 2022.

Opinion on the financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

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

requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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

We draw attention to notes 1.2 (going concern) and 20 (events after the end of the reporting period) of the financial statements, which highlight that the Health and Care Act 2022 gained Royal Assent on 28 April 2022. As disclosed in notes 1.2 and 20 of the financial statements, it is the intention that the CCG's functions will transfer to a new Integrated Care Board from 1 July 2022. Given services will continue to be provided by another public sector entity, the financial statements are prepared on a going concern basis. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

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

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

Other information

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Responsibilities of the Accountable Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the CCG, we identified that the principal risks of non-compliance with laws and regulations related to the

National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

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

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

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

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

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

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

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of

financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in December 2021.

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

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

Matter on which we are required to report by exception

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

We have not completed our work on the CCG's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

We will report the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

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

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

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

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

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

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

We are required to report to you if:

- in our opinion the 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; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the members of the Governing Body of NHS North Yorkshire 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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.


Mark Kirkham (Jun 21, 2022 14:37 GMT+1)

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

21 June 2022

ANNUAL ACCOUNTS

Amanda Bloor

Accountable Officer

June 2022

North Yorkshire CCG - Annual Accounts - 31st March 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the Year Ended 31st March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(1,534)	(2,496)
Other operating income	2	-	(452)
Total Operating Income		**(1,534)**	**(2,948)**
Staff costs	3	8,982	9,024
Purchase of goods and services	4	861,626	783,924
Other operating expenditure	4	420	400
Total Operating Expenditure		**871,028**	**793,348**
Net Operating Expenditure		**869,494**	**790,400**
Net (gain)/loss on transfer by absorption		-	42,843
Total Net Expenditure for the Financial Year		**869,494**	**833,243**
Other Comprehensive Expenditure			
Comprehensive Expenditure for the Year		**869,494**	**833,243**

Statement of Financial Position as at 31st March 2022

	Note	31st March 2022 £'000	31st March 2021 £'000
Current Assets:			
Trade and other receivables	7	3,933	2,466
Cash	8	266	2
Total Current Assets		**4,199**	2,468
Total Assets		**4,199**	2,468
Current Liabilities			
Trade and other payables	9	(64,027)	(52,008)
Total Current Liabilities		**(64,027)**	(52,008)
Assets less Liabilities		**(59,828)**	(49,540)
Financed by Taxpayers' Equity			
General fund		(59,828)	(49,540)
Total Taxpayers' Equity		**(59,828)**	(49,540)

The notes on pages 7 to 23 form part of this statement

The financial statements on pages 3 to 6 were approved by the Audit Committee on 6th June 2022 and signed on its behalf by:

J Hawkard

Jane Hawkard
Chief Finance Officer
6th June 2022

Amanda Bloor
Chief Accountable Officer
6th June 2022

Statement of Changes In Taxpayers' Equity for the Year Ended 31st March 2022

Changes In Taxpayers' Equity for 2021-22

	General Fund £'000
Balance at 1st April 2021	(49,540)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22	
Net operating expenditure for the financial year	(869,494)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(869,494)**
Net funding	859,206
Balance at 31st March 2022	**(59,828)**

Changes In Taxpayers' Equity for 2020-21

	General Fund £'000
Balance at 1st April 2020	-
Transfer between reserves in respect of assets transferred from closed NHS bodies	(42,843)
Adjusted NHS Clinical Commissioning Group balance at 1st April 2020	**(42,843)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21	
Net operating costs for the financial year	(790,400)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(790,400)**
Net funding	783,703
Balance at 31st March 2021	**(49,540)**

The notes on pages 7 to 23 form part of this statement

Statement of Cash Flows for the Year Ended 31st March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(869,494)	(790,400)
(Increase)/decrease in trade & other receivables	7	(1,467)	3,421
Increase/(decrease) in trade & other payables	9	12,019	3,442
Net Cash Inflow (Outflow) from Operating Activities		**(858,942)**	(783,537)
Cash Flows from Financing Activities			
Grant in aid funding received		859,206	783,703
Net Cash Inflow (Outflow) from Financing Activities		**859,206**	783,703
Net Increase (Decrease) in Cash	8	**264**	166
Cash at the Beginning of the Financial Year		**2**	(164)
Cash at the End of the Financial Year		**266**	2

The notes on pages 7 to 23 form part of this statement

1. Notes to the Financial Statements

1.1 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 2021-22 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.

1.2 Going Concern

These accounts have been prepared on a going concern basis.
The Health and Social Care Bill was introduced into the House of Commons on 6th July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and the abolishment clinical commissioning groups. ICBs will take on all of the commissioning functions of Clinical Commissioning Groups. The Bill was given Royal Assent and became an Act of Parliament on the 28th April 2022. The intention is that all the CCG functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published government 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.
The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

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.

NHS North Yorkshire Clinical Commissioning Group was formed on the 1st April 2020 through 100% absorption of the following NHS entities:

- NHS Hambleton, Richmondshire & Whitby Clinical Commissioning Group
- NHS Harrogate & Rural District Clinical Commissioning Group
- NHS Scarborough & Ryedale Clinical Commissioning Group

The resulting impact of transferring in the assets and liabilities of the above entities resulted in a loss of £42.843m which is recognised in the prior year Statement of Comprehenive Net Expenditure comparrison figures on page 3. A further breakdown of the assets and liabilties can be found in the 2020/21 accounts.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

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

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

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

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

1.4.1 Pooled Budgets - Better Care Fund

On the 1st April 2020 the clinical commissioning group took over responsibility for the Section 75 contractual arrangement, with North Yorkshire County Council as the host entity, for a pooled budget arrangement as part of the NHS 'Better Care Fund' national policy initiative. This arrangement was initially approved on the 1st April 2015 by the former North Yorkshire clinical commissioning group entities. The following organisations are the other members of this pooled budget;

- NHS Bradford & Airedale Clinical Commissioning Group
- NHS Vale of York Clinical Commissioning Group
- North Yorkshire County Council

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

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

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

1. Notes to the Financial Statements

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.5.1 Critical Judgements in Applying Accounting Policies

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

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

1.5.2 Key Sources of Estimation Uncertainty

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

Prescription Services (part of NHS Business Services Authority) undertake the monitoring of activity and associated costs on behalf of all clinical commissioning groups. Based on the information they have provided, NHS North Yorkshire Clinical Commissioning Group has made an informed calculation on accounting for a £13.251million (£12.946million in 2020/21) accrual in these accounts.

1.5.3 Gross to Net Accounting Arrangements for Hosted Services

1.5.3.1 Host Organisation

NHS North Yorkshire Clinical Commissioning Group is the host organisation for the following teams/services.

Adults & Children's Safeguarding
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

Childrens CHC Team
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

Human Resources Team
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

Legal Services Team
- Hosted on behalf of NHS North Yorkshire CCG and NHS East Riding of Yorkshire CCG.

Medicines Management Team
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

Primary Care Safeguarding
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

Strategic Clinical Networks
- Hosted on behalf of NHS North Yorkshire CCG, NHS East Riding of Yorkshire CCG, NHS North Lincolnshire CCG and NHS Vale of York CCG.

Transforming Care Programme, Mental Health & Learning Disability (Adults) Commissioning
- Hosted on behalf of NHS North Yorkshire CCG and NHS Vale of York CCG.

1.5.3.2 Benefactor from other Organisations as Host

NHS North Yorkshire Clinical Commissioning Group benefits from the following teams/services hosted by other organisations.

Digital Apps & Development Team
- Hosted by NHS North East Lincolnshire CCG. All payments relating to these services are transacted through NHS North East Lincolnshire CCG's ledger and expenditure is recharged on a population split basis.

Infection, Prevention & Control Team
- Hosted by NHS East Riding of Yorkshire CCG. All payments relating to these services are transacted through NHS East Riding of Yorkshire CCG's ledger and expenditure is recharged on a population split basis.

Referral Support Service
- Hosted by NHS Vale of York CCG. All payments relating to these services are transacted through NHS Vale of York CCG's ledger and expenditure is recharged on a risk share basis.

Specialist Neurological Rehab Commissioning Team
- Hosted by NHS Vale of York CCG. All payments relating to these services are transacted through NHS Vale of York CCG's ledger and expenditure is recharged on a risk share basis.

Serious Incidents Investigation Team
- Hosted by NHS Vale of York CCG. All payments relating to these services are transacted through NHS Vale of York CCG's ledger and expenditure is recharged on a risk share basis.

IFRS 15 determines that the nature of these hosted arrangements constitutes an agency relationship, and therefore 'net' accounting principles are applicable. Therefore only NHS North Yorkshire Clinical Commissioning Group's share of costs and staff numbers are represented in these accounts.

1. Notes to the Financial Statements

1.6 Revenue

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

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, 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.

1.7.2 Retirement Benefit Costs

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

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

1.8 Other Expenses

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

1.9 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.

1.10 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.11 Clinical Negligence Costs

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

1.12 Non-clinical Risk Pooling

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

1.13 Contingent Liabilities

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.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.14 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

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.

1.14.1 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. Notes to the Financial Statements

1.14.2 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.

1.15 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.

1.15.1 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.

1.16 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.

1.17 Accounting Convention

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

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

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

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

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

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

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

The application of IFRS 16 Leases from 1st April 2022 will mean that building leases currently classified as operating leases will be brought on to the Statement of Financial Position. They will be recognised as right-of-use assets offset by lease liabilities representing the financing. The right-of-use assets will be depreciated with depreciation and interest being charged through the Statement of Comprehensive Net Expenditure. Were this standard applied in 2021-22 right-of-use assets of approximately £576,000 would be included on the Statement of Financial Position. The Clinical Commissioning Group's lease for photocopiers is deemed to be low value under IFRS 16 and as such no adjustment is required.

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

2. Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**10**	-
Non-patient care services to other bodies	**35**	1,440
Other Contract income	**1,489**	1,042
Recoveries in respect of employee benefits	**-**	14
Total Income from sale of goods and services	**1,534**	**2,496**
Other operating income		
Other non contract revenue	**-**	452
Total Other operating income	**-**	**452**
	1,534	**2,948**

3. Employee Benefits and Staff Numbers

3.1.1 Employee Benefits for 2021-22

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	6,437	560	**6,997**
Social security costs	711	-	**711**
Employer Contributions to NHS Pension scheme	1,249	-	**1,249**
Other pension costs	5	-	**5**
Apprenticeship Levy	20	-	**20**
Gross Employee Benefits Expenditure	**8,422**	**560**	**8,982**
Less recoveries in respect of employee benefits (note 3.1.2)	**-**	**-**	**-**
Total - Net Employee benefits for 2021-22	**8,422**	**560**	**8,982**

3.1.1 Employee benefits for 2020-21

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	6,712	320	7,032
Social security costs	719	-	719
Employer Contributions to NHS Pension scheme	1,253	-	1,253
Other pension costs	-	-	-
Apprenticeship Levy	20	-	20
Gross Employee Benefits Expenditure	8,704	320	9,024
Less recoveries in respect of employee benefits (note 3.1.2)	(14)	**-**	(14)
Total - Net Employee benefits for 2020-21	8,690	320	9,010

3.1.2 Recoveries in respect of employee benefits

	2021-22 Permanent Employees £'000	2021-22 Other £'000	2021-22 Total £'000	2020-21 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	(11)
Social security costs	**-**	**-**	**-**	(1)
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	(2)
Total recoveries in respect of employee benefits	-	-	-	(14)

3.2 Average Number of People Employed in 2021-22

	Permanently Employed Number	Other Number	Total Number
Total	**137**	**7**	**144**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

3.2 Average Number of People Employed in 2020-21

	Permanently Employed Number	Other Number	Total Number
Total	131	14	145
Of the above:			
Number of whole time equivalent people engaged on capital projects	-	-	-

3.3 Exit Packages Agreed in the Financial Year

NHS North Yorkshire CCG has not incurred any exit packages during 2021/22 or 2020/21.

3.4 Pension Costs

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

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. From 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.

3.4.1 Accounting Valuation

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

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

3.4.2 Full Actuarial (Funding) Valuation

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

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

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

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

4. Operating Expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of Goods and Services		
Purchase of healthcare from NHS bodies		
Services from other CCGs and NHS England	2,514	2,837
Services from foundation trusts	518,011	452,115
Services from other NHS trusts	43,899	42,392
Purchase of healthcare from non-NHS bodies	105,569	107,331
Prescribing costs	78,081	77,743
General Ophthalmic services	365	348
GPMS/APMS and PCTMS	81,691	74,809
Supplies and services – clinical	462	440
Supplies and services – general	28,192	23,436
Consultancy services	-	86
Establishment	1,031	786
Transport	325	281
Premises	895	927
Audit fees*	78	83
Other non statutory audit expenditure**		
· Internal audit services	-	-
· Other services	12	42
Other professional fees***	316	113
Legal fees	52	76
Education, training and conferences	133	79
Total Purchase of Goods and Services	**861,626**	783,924
Other Operating Expenditure		
Chair and non executive Members	197	181
Expected credit loss on receivables	15	13
Other expenditure	208	206
Total Other Operating Expenditure	**420**	400
Total Operating Expenditure	**862,046**	784,324

* Mazars are North Yorkshire Clinical Commissioning Group's external auditors. The fee includes non-recoverable VAT.

** Other non-statutory audit expenditure is in respect to the reasonable assurance audit work undertaken by Mazars with regard to NHS North Yorkshire Clinical Commissioning Group's achievement of the Mental Health Investment Standard (MHIS). This is a requirement by the regulating authority NHS England which stipulates that CCGs must obtain reasonable assurance from an independent reporting accountant, that their investment in mental health expenditure rises at a faster rate than their overall published programme funding. There was no accrual in 2019/20 for that year's MHIS with the total cost of £27,000 charged to 2020/21 accounts. A further £15,000 is accrued for the 2020/21 MHIS assurance audit. Within the 2021/22 accounts there is an accrual of £12,000 for that year's MHIS assurance audit. Costs are inclusive of non-recoverable VAT.

*** Internal audit service costs, provided by Audit Yorkshire, are included within 'other professional fees' and amounted to £48,000 in 2021/22 (£48,000 in 2020/21). Audit Yorkshire is a trading name only and the actual contract is with NHS York & Scarborough NHS Foundation Trust.

5. Better Payment Practice Code

5.1 Measure of Compliance	2021-22		2020-21	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	15,592	216,988	15,989	215,440
Total Non-NHS trade Invoices paid within target	15,239	212,675	15,377	208,496
Percentage of Non-NHS Trade Invoices Paid within Target	**97.74%**	**98.01%**	**96.17%**	**96.78%**
NHS Payables				
Total NHS trade invoices paid in the year	787	567,643	1,783	502,806
Total NHS trade invoices paid within target	755	566,867	1,591	495,970
Percentage of NHS Trade Invoices Paid within Target	**95.93%**	**99.86%**	**89.23%**	**98.64%**

6. Operating Leases

6.1 As lessee

NHS North Yorkshire Clinical Commissioning Group's significant leasing arrangements are for office accommodation in the following locations:

- Unit 1, St James Business Park, Knaresborough, North Yorkshire.
  - This property is leased from NHS Property Services with the lease running from 28th March 2013 to 27th April 2023, with a break clause of the 2nd May 2018. Rent is charged on a commercial basis. Standard restriction apply to the leasing arrangement, namely that the building can only be used for office accommodation.

- Unit 2, St James Business Park, Knaresborough, North Yorkshire.
  - This property is leased from NHS Property Services with the lease running from 1st October 2018 to 27th April 2023, with no break clause. Rent is charged on a commercial basis. Standard restriction apply to the leasing arrangement, namely that the buidling can only be used for office accommodation.

- Town Hall, Scarborough, North Yorkshire.
  - This property is leased from NHS Property Services with the lease running from 27th March 2017 to 26th March 2022, with a break clause of the 26th March 2020. Rent is charged on a commercial basis. Standard restriction apply to the leasing arrangement, namely that the space can only be used for office accommodation. This lease was not renewed on the 26th March 2022.

- County Council Headquarters, Racecourse Lane, Northallerton, North Yorkshire.
  - This property is leased from North Yorkshire County Council. The signed Heads of Terms lease commenced on the 1st February 2021 for one year, with the option to extend for a further one year, on a rolling basis until terminated by either party. Standard restriction apply to the leasing arrangement, namely that the space can only be used for office accommodation.

- Castle House, Elders Street, Scarborough, North Yorkshire.
  - This lease agreement from North Yorkshire County Council, which commenced on the 1st September 2021, remains unsigned. These accounts include costs incurred in 2021/22 but do not account for future year commitments.

- Kingswood Surgery, Harrogate, North Yorkshire.
  - This lease agreement from NHS Property Services remains unsigned. These accounts include costs incurred in 2021/22 but do not account for future year commitments.

6.1.1 Payments Recognised as an Expense			2021-22			2020-21
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payments Recognised as an Expense						
Minimum lease payments	337	4	**341**	410	3	413
Total	**337**	**4**	**341**	410	3	413

6.1.2 Future Minimum Lease Payments			2021-22			2020-21
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payable:						
No later than one year	175	-	**175**	282	-	282
Between one and five years	11	-	**11**	224	-	224
After five years	-	-	**-**	-	-	-
Total	**186**	**-**	**186**	506	**-**	506

6.2 As Lessor

NHS North Yorkshire Clinical Commissioning Group does not act as a lessor for any operating leases.

7. Trade and Other Receivables

7.1 - Trade and Other Receivables

	31st March 2022 £'000	31st March 2021 £'000
NHS receivables: Revenue	2,366	1,300
NHS accrued income	142	51
Non-NHS and Other WGA receivables:		
Revenue	530	272
Non-NHS and Other WGA prepayments	17	416
Non-NHS and Other WGA accrued income	86	68
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	719	290
Expected credit loss allowance-receivables	-	(13)
VAT	73	82
Total Trade & other receivables	**3,933**	2,466

Outstanding debt is mainly due from local organisations that the CCG works in partnership with, such as NHS England, North Yorkshire County Council and NHS Vale of York Clinical Commissioning Group.

Prepayments arose in 2020/21 from the advance payment mechanism in place for people in receipt of a Personal Healthcare Budget (PHBs). However, this approach was reviewed during 2021/22 and NHS North Yorkshire CCG no longer makes the payment a month in advance, but at the start each and every month.

7.2 Receivables Past Their Due Date But Not Impaired

	31st March 2022 DHSC Group Bodies £'000	31st March 2022 Non DHSC Group Bodies £'000	31st March 2021 DHSC Group Bodies £'000	31st March 2021 Non DHSC Group Bodies £'000
By up to three months	2,098	81	550	158
By three to six months	-	91	86	22
By more than six months	-	213	366	4
Total	**2,098**	**385**	1,002	184

As at 26th May 2022 £1,070,389 of the amount above has subsequently been recovered post the statement of financial position date.

No collateral is held by NHS North Yorkshire Clinical Commissioning Group for any outstanding debt.

7.3 Loss Allowance on Asset Classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 1st April 2021	(13)	**(13)**
Lifetime expected credit losses on trade and other receivables-Stage 3	(16)	**(16)**
Amounts written off	29	**29**
Total	**-**	**-**

8. Cash

	31 March 2022 £'000	31 March 2021 £'000
Balance at 1st April 2021	2	(164)
Net change in year	264	166
Balance at 31st March 2022	**266**	2
Made up of:		
Cash with the government banking service	266	2
Cash in Statement of Financial Position	**266**	2
Balance at 31 March 2022	**266**	2

9. Trade and Other Payables

	31 March 2022 £'000	31 March 2021 £'000
NHS payables: revenue	200	3,045
NHS accruals	1,854	449
Non-NHS and Other WGA payables: revenue	7,192	6,364
Non-NHS and Other WGA accruals	53,309	40,859
Social security costs	116	108
Tax	103	101
Other payables and accruals	1,253	1,082
Total Trade & Other Payables	**64,027**	**52,008**

NHS North Yorkshire Clinical Commissioning Group does not have any future years liabilities under arrangements to buy out the liability for early retirement.

Other payables include £892,011 outstanding pension contributions at 31 March 2022 (£750,915 at 31 March 2021).

10. 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 8 cases requiring assessment for North Yorkshire Clinical Commissioning Group with 9 having been assessed during 2021/22. Of these 9 cases 5 were found to be eligible. The impact of this is included in these accounts. The remaining 4 were not found to be eligible, or were withdrawn, although they do have the right to appeal and 2 of these cases are currently going through the appeals process. A number of uncertainties impact upon the North Yorkshire Clinical Commissioning Group's ability to assess a reasonable provision are:

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

11. Financial Instruments

11.1 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.

11.1.1 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.

11.1.2 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.

11.1.3 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.

11.1.4 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.

11.2 Financial Assets

	Financial Assets Measured at Amortised Cost 31st March 2022 £'000	Financial Assets Measured at Amortised Cost 31st March 2021 £'000
Trade and other receivables with NHSE bodies	2,308	816
Trade and other receivables with other DHSC group bodies	199	535
Trade and other receivables with external bodies	1,336	630
Cash	266	2
Total at 31st March 2022	**4,109**	1,983

11.3 Financial Liabilities

	Financial Liabilities Measured at Amortised Cost 31st March 2022 £'000	Financial Liabilities Measured at Amortised Cost 31st March 2021 £'000
Trade and other payables with NHSE bodies	797	1,058
Trade and other payables with other DHSC group bodies	1,258	2,436
Trade and other payables with external bodies	60,862	47,554
Total at 31st March 2022	**62,917**	51,048

12. Operating Segments

NHS North Yorkshire Clinical Commissioning Group only has one operating segment, namely the commissioning of national health services.

13. Joint Arrangements

13.1 Interests in Joint Operations

	2021-22			
Name of Arrangement, Parties to the Arrangement & Description of Principal Activities	**Assets** **£'000**	**Liabilities** **£'000**	**Income** **£'000**	**Expenditure** **£'000**
Mental Health Commissioning in North Yorkshire NHS North Yorkshire CCG, Tees Esk Wear Valleys NHS Foundation Trust. A formal joint arrangement for the commissioning of Mental Health Services in North Yorkshire	-	-	-	72,906
North Yorkshire Better Care Fund (BCF) NHS North Yorkshire CCG, NHS Bradford & Airedale CCG, NHS Vale of York CCG, North Yorkshire County Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	-	-	30,732
Integrated Community Care NHS North Yorkshire CCG, Harrogate & District NHS Foundation Trust, North Yorkshire County Council, Tees Esk Wear Valleys NHS Foundation Trust. A formal joint commissioning and service delivery of integrated health and social care community teams.	-	-	-	5,351

	2020-21			
Name of Arrangement, Parties to the Arrangement & Description of Principal Activities	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Mental Health Commissioning in North Yorkshire NHS North Yorkshire CCG, Tees Esk Wear Valleys NHS Foundation Trust. A formal joint arrangement for the commissioning of Mental Health Services in North Yorkshire	-	-	-	63,225
North Yorkshire Better Care Fund (BCF) NHS North Yorkshire CCG, NHS Bradford & Airedale CCG, NHS Vale of York CCG, North Yorkshire County Council. A formal pooled budget arrangement for the delivery of Better Care Fund requirements.	-	-	-	29,307
Integrated Community Care NHS North Yorkshire CCG, Harrogate & District NHS Foundation Trust, North Yorkshire County Council, Tees Esk Wear Valleys NHS Foundation Trust. A formal joint commissioning and service delivery of integrated health and social care community teams.	-	-	-	5,206

13.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

NHS North Yorkshire Clinical Commissioning Group does not have any interests in entities not accounted for under IFRS10 or IFRS11.

14. Related Party Transactions

14.1 Related Party Transactions 2021-22

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
The following organisations are Member GP Practices of NHS North Yorkshire CCG;				
Ampleforth & Hovingham Surgeries	1,306	-	179	-
Beech House Surgery	985	-	55	-
Brook Square Surgery	1,677	-	49	-
Castle Health Centre	1,104	-	65	-
Catterick Village Surgery	874	-	72	-
Central Dales Practice	818	-	66	-
Central Healthcare	4,276	-	145	-
Church Lane Surgery York	1,682	-	128	-
Danby Surgery	551	-	54	-
Derwent Practice	2,765	-	177	-
Dr A Ingram & Partners	1,018	-	72	-
Dr Akester & Partners	908	-	62	-
Dr Bannatyne & Partners	1,407	-	86	-
Dr Casey & Partners	1,108	-	91	-
Dr Moss & Partners	2,253	-	148	-
Dr Parker & Partners Thirsk	472	-	69	-
Drs Hodgson & Keavney	681	-	49	-
East Parade Surgery	1,025	-	72	-
Eastfield Medical Centre	2,231	(9)	203	-
Eastgate Medical Group	1,561	-	94	-
Egton Surgery	446	-	34	-
Filey Surgery	1,887	-	61	-
Friary Surgery	845	-	101	-
Glebe House Surgery	1,734	-	155	-
Great Ayton Health Centre	777	-	43	-
Hackness Road Surgery	1,186	-	127	-
Harewood Medical Practice	1,523	-	324	-
Hunmanby Surgery	635	-	59	-
Kingswood Surgery	984	-	(4)	-
Lambert Medical Centre	1,252	-	84	-
Leeds Road Practice	1,720	-	191	-
Leyburn Medical Practice	1,234	-	60	-
Mayford House Surgery	1,498	-	110	-
Mowbray House Surgery	3,204	-	249	-
Nidderdale Group Practice	1,702	-	137	-
North House Surgery Ripon	1,211	-	85	-
Park Parade Surgery	1,055	-	46	-
Quakers Lane Surgery	923	-	66	-
Reeth Medical Centre	331	-	45	-
Ripon Spa Surgery	941	-	91	-
Scarborough Medical Group	2,259	-	138	-
Scorton Medical Centre	733	-	31	-
Sherburn & Rillington Practice	962	-	93	-
Sleights & Sandsend Medical Practice	982	-	75	-
Spa Surgery	2,034	-	149	-
Spring Bank Surgery	979	-	81	-
Staithes Surgery	656	-	54	-
Stockwell Road Surgery	912	-	47	-
Stokesley Medical Practice	1,633	-	215	-
West Ayton Surgery	1,576	-	166	-
Whitby Group Practice	2,577	-	184	-
The following organisations are local networks, owned by member GP Practices of NHS North				
Hambleton, Richmondshire & Whitby GP Alliance	929	-	-	-
Yorkshire Health Network Ltd	4,022	-	175	-
Yorkshire Doctors Urgent Care	38	-	-	-
Yorkshire Local Medical Committee Ltd	465	-	-	-
LMC Services Yorkshire Ltd	96	-	-	-

14.1 Related Party Transactions 2021-22 Continued

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
The following organisations are local councils which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.				
City of York Council	272	(1)	-	-
North Yorkshire County Council	43,119	(9)	6,562	(485)
The following organisations are non government entities which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.				
Avalon	437	-	-	-
BMI Healthcare Ltd	3,458	-	397	-
City Healthcare Partnership Hull	73	-	4	-
Community First Yorkshire	171	-	17	-
Eyecatchers Opticians	1	-	-	-
Intergra Care Ltd	143	-	-	-
IntraHealth Ltd	955	-	-	-
Marie Stopes International	122	-	12	-
Oakdale Centre	4	-	6	-
QA Ltd	34	-	14	-
St Michaels Hospice	1,076	-	68	-
Vocare Ltd	1,010	-	-	-

The following organisations are Primary Care Networks (PCNs), owned by member GP Practices of NHS North Yorkshire CCG;

Heart Of Harrogate PCN	- included within Yorkshire Health Network Ltd
Knaresborough & Rural PCN	- included within Yorkshire Health Network Ltd
Mowbray Square PCN	- included within Yorkshire Health Network Ltd
Ripon & Masham PCN	- included within Yorkshire Health Network Ltd
Reeth PCN	- Included within Reeth Medical Centre
Filey And Scarborough PCN	- included within Hackness Road Surgery
Scarborough Core PCN	- included within Eastfield Medical Centre
North Riding Healthy Community PCN	- Included within Ampleforth Surgeries
Hambleton North PCN	- included within Stokesley Medical Centre
Hambleton South PCN	- Included within Glebe House Surgery
Richmondshire PCN	- included within Harewood Medical Practice
Whitby Coast & Moors PCN	- included within Whitby Group Practice

The following organisations are local NHS entities which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.

Department of Health & Social Care	Leeds Teaching Hospital Trust
Bradford Teaching Hospital NHS Foundation Trust	Mid Yorkshire Hospitals NHS Trust
East Lancashire Hospitals NHS Trust	NHS England
Harrogate & District NHS Foundation Trust	Northumberland, Tyne & Wear NHS Foundation Trust
Health Education England	South Tees Hospitals NHS Foundation Trust
Hull & East Yorkshire Hospitals NHS Trust	Tees, Esk, Wear Valleys NHS Foundation Trust
Humber Teaching NHS Foundation Trust	York & Scarborough Hospitals NHS Foundation Trust
Leeds Clinical Commissioning Group	Yorkshire Ambulance Services

The Department of Health & Social Care is the parent organisation of NHS North Yorkshire Clinical Commissioning Group

14.2 Related Party Transactions 2020-21

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
The following organisations are Member GP Practices of NHS North Yorkshire CCG;				
Ampleforth & Hovingham Surgeries	1,174	-	85	-
Beech House Surgery	995	-	50	-
Brook Square Surgery	1,563	-	71	-
Castle Health Centre	906	-	-	-
Catterick Village Surgery	904	-	68	-
Central Dales Practice	850	-	64	-
Central Healthcare	4,346	-	214	-
Church Lane Surgery York	1,695	(9)	137	-
Danby Surgery	573	-	37	-
Derwent Practice	2,859	-	118	-
Dr A Ingram & Partners	999	-	53	-
Dr Akester & Partners	922	(4)	66	-
Dr Bannatyne & Partners	1,397	-	72	-
Dr Casey & Partners	1,100	-	69	-
Dr Moss & Partners	2,263	-	127	-
Dr Parker & Partners Thirsk	459	-	54	-
Drs Hodgson & Keavney	665	-	47	-
East Parade Surgery	1,070	-	46	-
Eastfield Medical Centre	1,976	(16)	136	-
Eastgate Medical Group	1,549	-	65	-
Egton Surgery	438	-	34	-
Filey Surgery	2,006	-	68	-
Friary Surgery	821	-	76	-
Glebe House Surgery	1,639	-	63	-
Great Ayton Health Centre	788	-	39	-
Hackness Road Surgery	831	-	64	-
Harewood Medical Practice	1,546	-	46	-
Hunmanby Surgery	649	-	45	-
Kingswood Surgery	957	-	(15)	-
Lambert Medical Centre	1,277	-	78	-
Leeds Road Practice	1,671	-	248	-
Leyburn Medical Practice	1,219	-	39	-
Mayford House Surgery	1,483	-	96	-
Mowbray House Surgery	3,162	-	238	-
Nidderdale Group Practice	1,714	-	145	-
North House Surgery Ripon	1,202	-	86	-
Park Parade Surgery	1,055	-	37	-
Quakers Lane Surgery	914	-	67	-
Reeth Medical Centre	342	-	41	-
Ripon Spa Surgery	926	-	73	-
Scarborough Medical Group	2,174	-	126	-
Scorton Medical Centre	746	-	41	-
Sherburn & Rillington Practice	1,100	-	98	-
Sleights & Sandsend Medical Practice	966	-	92	-
Spa Surgery	2,146	-	124	-
Spring Bank Surgery	978	-	107	-
Staithes Surgery	631	-	53	-
Stockwell Road Surgery	895	-	39	-
Stokesley Medical Practice	1,624	-	170	-
West Ayton Surgery	1,692	-	153	-
Whitby Group Practice	2,588	-	118	-
The following organisations are local networks, owned by member GP Practices of NHS North				
Hambleton, Richmondshire & Whitby GP Alliance	1,058	-	-	-
Yorkshire Health Network Ltd	2,808	-	84	-
Yorkshire Doctors Urgent Care	4	-	3	-
Yorkshire Local Medical Committee Ltd	495	-	-	-

14.2 Related Party Transactions 2020-21 Continued

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
The following organisations are local councils which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.				
City of York Council	279	(1)	-	-
North Yorkshire County Council	60,204	(15)	1,828	(107)
The following organisations are non government entities which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.				
Avalon	431	-	31	-
Community First Yorkshire	40	-	-	-
Aura Creative Media Ltd t/a Digital Zest	7	-	-	-
Eyecatchers Opicians	1	-	-	-
Haxby Group Practice	131	-	-	-
HBG Ltd	93	-	-	-
Intergra Care Ltd	136	-	10	-
IntraHealth Ltd	821	-	-	-
Marie Stopes International	145	-	-	-
Mowbray Square Medical Ltd	1	-	-	-
QA Ltd	2	-	-	-
St Catherines Hospice	2,465	-	-	-
St Michaels Hospice	1,281	-	6	-
Yorkshire Health Solutions Ltd	97	-	-	-

The following organisations are Primary Care Networks (PCNs), owned by member GP Practices of NHS North Yorkshire CCG;

Heart Of Harrogate PCN	- included within Yorkshire Health Network Ltd
Knaresborough & Rural PCN	- included within Yorkshire Health Network Ltd
Mowbray Square PCN	- included within Yorkshire Health Network Ltd
Ripon & Masham PCN	- included within Yorkshire Health Network Ltd
Reeth PCN	- Included within Reeth Medical Centre
Filey And Scarborough PCN	- included within Hackness Road Surgery
Scarborough Core PCN	- included within Eastfield Medical Centre
North Riding Healthy Community PCN	- Included within Ampleforth Surgeries
Hambleton North PCN	- included within Stokesley Medical Centre
Hambleton South PCN	- Included within Glebe House Surgery
Richmondshire PCN	- included within Harewood Medical Practice
Whitby Coast & Moors PCN	- included within Whitby Group Practice

The following organisations are local NHS entities which employees/member GPs have made a declaration of interest. This is mainly because either they have an income from that entity or that their spouse or other close family member is employed by them.

Department of Health & Social Care	Mid Yorkshire Hospitals NHS Trust
Bradford Teaching Hospital NHS Foundation Trust	NHS England
Harrogate & District NHS Foundation Trust	Northumberland, Tyne & Wear NHS Foundation Trust
Humber Teaching NHS Foundation Trust	South Tees Hospitals NHS Foundation Trust
Leeds Clinical Commissioning Group	Tees, Esk, Wear Valleys NHS Foundation Trust
Leeds Teaching Hospital Trust	York & Scarborough Hospitals NHS Foundation Trust
Leeds & York NHS Foundation Trust	Yorkshire Ambulance Services

The Department of Health & Social Care is the parent organisation of NHS North Yorkshire Clinical Commissioning Group

15. Events After the End of the Reporting Period

There is one non-adjusting post balance sheet event. This relates to the Health and Care Bill which was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England. ICBs will take on the commissioning functions of Clinical Commissioning Groups. The Bill was passed on 28th April 2022 and the intention is that the Clinical Commissioning Group functions, assets and liabilities will therefore transfer to an ICB on the 1st July 2022.
There we no events after the end of the reporting periods for 2020-21.

16. Losses and Special Payments

16.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2021-22	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21	Total Value of Cases 2020-21 £'000
Administrative write-offs	5	29	5	2
Total	**5**	**29**	5	2

16.2 Special Payments

NHS North Yorkshire did not make any special payments in either 2022/21 or 2020/21.

17. 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:

	2021-22		
	Target £000s	**Performance £000s**	**Achieved?**
Expenditure not to exceed income	871,217	871,028	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	
Revenue resource use does not exceed the amount specified in Directions	869,683	869,494	Yes
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	8,262	7,361	Yes

	2020-21		
	Target £000s	Performance £000s	Achieved?
Expenditure not to exceed income	793,466	793,348	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	
Revenue resource use does not exceed the amount specified in Directions	790,518	790,400	Yes
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	8,258	7,915	Yes