NHS
Calderdale
Clinical Commissioning Group

NHS CALDERDALE CLINICAL COMMISSIONING GROUP

ANNUAL REPORT 2019/20

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PERFORMANCE REPORT

NEIL SMURTHWAITE
Interim Accountable Officer
23 June 2020

The Performance Report - Overview

This section of the Annual Report provides our Interim Accountable Officer's view of the performance of the CCG over the past twelve months. It includes information about the CCG and a summary of our purpose and activities and how we have performed during the year, highlighting any key risks to the achievement of our strategic objectives.

NHS Calderdale CCG is a membership organisation consisting of 21 general practices[1].Information about how the CCG fits into the NHS structure can be found at the link below.
https://www.calderdaleccg.nhs.uk/about-calderdale-clinical-commissioning-group-ccg-2/

The CCG is organised into a series of services, each with a head. The teams are as follows – primary care, service improvement, quality, finance, corporate, continuing health care and contracting/procurement.

Our purpose is to improve the health and lives of the estimated 222,057[2] people living in Calderdale and/ or registered with a Calderdale GP practice.

We work collaboratively with our partners and stakeholders in Calderdale and as part of the West Yorkshire and Harrogate Health and Care Partnership to:

- Ensure that healthcare is available for anyone who needs it;
- Keep people safe;
- Ensure continued improvements in the quality of care;
- Support people to maintain a healthy lifestyle;
- Address health inequalities locally, as well as ensuring financial sustainability.

The CCG has a number of different strategies that can be found at the link below
https://www.calderdaleccg.nhs.uk/key-documents/

[1] At the start of 2019/20, NHS Calderdale CCG had 25 Member Practices. During the year, Horne Street Surgery merged with Boulevard Medical Practice and Queen Road Surgery and Southowram Surgery merged with Spring Hall Group Practice. These changes reduced the number of CCG member practices by three. Meadow Dale Group Practice ended its provision of primary medical services on the 31st March 2020.
[2] NHS Digital – registered GP population at 1 May 2020

Summary of activities

Our overall budget allocation was £337m in 2019-20 which we have used to commission health and care services in a range of areas including mental health, learning disabilities, continuing health care, emergency and urgent care, hospital and community services, primary care and services for children and young people. The performance analysis section of this report contains further detail of our financial position and plan for 2020-21.

Throughout 2019-20, we have continued to work with our partners on the transformation agenda across Calderdale as a Place and across Calderdale and Greater Huddersfield on the hospital change programme (Right Care, Right Time and Right Place – RCRTRP).

The Strategic Outline Case (SOC) for the capital expenditure of £196.5 million was approved by Calderdale and Huddersfield NHS Foundation Trust Board in April 2019 and by NHS England and Improvement in November 2019.

We have worked hard with partners to sustain improvements in access to general practice services. Whilst there have been real challenges in achieving and maintaining some of the National Constitutional Standards, the level of performance in the Calderdale system remains strong when compared with others regionally and nationally. There has been a consistent delivery of standards associated with reducing delays in transfers of care (DToC), in Cancer Waiting Times and in cancelled operations.

We have also maintained a strong focus on keeping people safe and improving the quality of care.

All our work is supported by a full public and patient engagement programme, so that everything we do is informed by people who use the services, by local communities and key stakeholders including people who deliver those services.

The level of performance is also a product of strong partnership working across Calderdale and the shared ambition to improve services for patients and local people through an evidence based approach to the delivery of care.

With our partners, we have:

- Worked closely with the Health and Wellbeing Board to refresh the Wellbeing Strategy - building on the Single Plan for Calderdale and as part of Calderdale Cares. The strategy was approved by the Health and Wellbeing Board in October 2019 and can be accessed at the link below; https://www.calderdaleccg.nhs.uk/download/calderdale-wellbeing-strategy-2019-2024/

- Continued to strengthen the role of the Integrated Commissioning Executive as part of our future integrated commissioning system;
- Continued to support the development of a community improvement agenda, which forms the basis of our future community alliance – delivering new models of integrated community services;
- Jointly led with the Council the implementation of population health management in our system, to enable us to better plan integrated services and improve health outcomes for local people;
- Continued our strong partnership working on local safeguarding boards and the Community Safety Partnership;
- With our colleagues in Calderdale Council, led on the work to improve emotional wellbeing services for our children and young people;
- Worked with Greater Huddersfield CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) on System Resilience;
- Played a full and active role as part of the West Yorkshire and Harrogate Health and Care Partnership (formerly known as the Sustainability and Transformation Partnership).

Further information on our activities throughout the year can be found on pages 12 to 41.

Key Issues or Risks

The issues and risks being experienced by the CCG reflect those across the system, the region and nationally.

These risks together with the challenges to the resilience of the urgent care system are reflected in the high level risks identified by the CCG in 2019-20 and onward for 2020-21. Other high level risks relate to waiting times for children and young people with potential Autism Spectrum Disorder, achievement of the CCG running costs target and the Alternative Provider of Medical Services contract.

Further detail on our approach to the management of risk can be found in the Governance Statement, and a summary of the in-year risks classed as 'Serious' on our Corporate Risk Register can be found in the Governance Statement: Appendix 2.

Summary of Performance

Overall the CCG and partners have dealt well with the challenge of increasing pressure in the system, which have affected all areas of the country. Whilst not all NHS Constitution targets have been achieved, we have continued to perform well on cancer waiting times, c-diff and cancelled operations, and performance on others is better than many other areas, specifically A & E waits.

There has been a clear focus upon a number of key issues of performance. We have worked hard with partners to further improve the Delayed Transfer of Care (DTOC) position in Calderdale, which currently ranks as one of the strongest nationally. Additionally, the emergence of new targets which focus upon the length of hospital stays, have been anticipated, and the current position of the system on people with a length of stay of seven days or more is strong.

We have strengthened the reporting and assurance processes in relation to the delivery of cancer standards, and have sought and received assurance about the strength of the locality and West Yorkshire arrangements.

The Performance Report – Performance Analysis

This section of the Annual Report provides a more detailed performance analysis and reports on key performance measures and how the CCG assesses itself against them.

Performance measures

The CCG uses a number of key performance indicators to measure and manage performance across the system. These include the Improvement and Assessment Framework (IAF) indicators[3] reported to NHS England, NHS Constitution Standards and Better Care Fund Targets.

Performance against these targets and standards is included in the CCG's finance, contracting and performance report which is presented to the Governing Body at each of its meetings. Additional scrutiny of our financial recovery plans and delivery against the IAF indicators is undertaken by the Quality Finance and Performance Committee.

Quality and Safety reports which focus on the quality and safety of commissioned services, highlighting any risks and mitigating actions are also presented at each Governing Body meeting as well as at the Quality Finance and Performance Committee.

These reports, together with the high level risk report, enable the Governing Body to receive the right level of assurance about the management of those risks.

Further detail is provided in performance dashboards which are produced for the Quality Finance and Performance and Commissioning Primary Medical Service Committees. Information provided includes that on patient experience and engagement activity, complaints and incident reporting and monitoring of national and local Commissioning for Quality and Innovation Schemes (CQUINS). These data provide the CCG with a comprehensive view of the performance and pressures being faced by the local health and care system.

System-wide ownership of performance management is facilitated through the relevant partnership groups including the System Resilience Group, Partnership Transformation Board, the Integrated Commissioning Executive, the A&E Delivery Board and the Contract Management and Quality Boards. Operational oversight is provided by the Senior Management Team.

[3] Being replaced by the NHS Oversight Framework

Further information about the operation and activities of the CCG's Governing Body and Committees, the Integrated Risk Management Framework, anti-corruption and anti-bribery matters can be found in the Governance Statement.

CCG Improvement and Assessment Framework (IAF) / NHS Oversight Framework

Since 2016-17, all CCGs have been assessed against the NHS England CCG IAF. The framework contains indicators aligned to the key priorities in the NHS and covers four domains and six clinical priority areas. Calderdale CCG had a rating of **GOOD** for its overall performance against the CCG Improvement and Assessment Framework 2018-19. The IAF has been replaced by the NHS Oversight Framework from 2019-20. The CCG's performance against this framework will be published on its website when available.

Performance against the NHS Constitution standards

Performance against the standards of the NHS Constitution has been strong throughout the year with a good proportion of the constitutional standards being achieved (see appendix 1 of the performance report)

Accident and Emergency 4 hour waits

Sustaining performance against the A&E four hour target continues to prove challenging for our system, with periods of underperformance during the year. Whilst the position compares favourably with the reported performance across the region and nationally (CHFT was consistently ranked in the best performing quartile throughout the year) it remains below the NHS Constitutional Standard. This is reflected in our risk rating and the close scrutiny by our Quality Finance and Performance Committee, with action being taken forward through the A&E Delivery Board.

Better Care Fund

The Better Care Fund is a national initiative to promote integrated out of hospital care and is seen as an important enabler for system transformation and integrated commissioning. The Better Care Fund has four main indicators against which we measure our performance:

- Number of non-elective admissions compared to target;
- Delayed Transfers of Care - actual days delayed compared to target;
- Permanent admissions of older people (65 and over) to residential and nursing care homes, per 100,000 population;

- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

Performance is monitored through the A&E Delivery Board, the Integrated Commissioning Executive on behalf of the Health and Wellbeing Board and the CCG's Quality Finance and Performance Committee.

Other measures of performance

In addition to national mandated measures, the Better Care Fund targets and NHS Constitution Rights, we also use other measures of performance including a variety of patient experience measures and the quality premiums.

Quality Premiums

The Quality Premium is an NHS England scheme to reward CCGs for improvements in the quality of services they commission. The quality premium paid to CCGs in 2019-20 reflects the quality of services commissioned in the previous year. The measures cover a combination of national and local priorities, the financial reward available and the achievement in Calderdale. The total reward available to the CCG in 2019-20 was £104,000.

Financial Duties

CCGs have a number of financial duties under the NHS Act 2006 (as amended). The CCG's performance against those duties is included in the finance section on pages 37 - 42.

Appendix 1 – CCG performance at March 2020 against NHS Constitution Rights and Pledges 2019/20

	Measure	Target / Baseline	2019/20 Actual	2019/20 RAG
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	73.6%	-
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	86.0%	-
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	N/A	Participating in national Clinical Review of Standards	
	Patients on incomplete pathways waiting more than 52 weeks	0	84	
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	93.3%	
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	87.5%	
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	9	
Cancer Waits - 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	98.8%	
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	100.0%	
Cancer Waits - 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	100.0%	
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	95.8%	
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	
Cancer Waits - 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	90.0%	
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	tba	100.0%	tba
Ambulance Calls	Category 1 **	00:07:00	00:08:01	
	Category 2 **	00:18:00	00:23:53	
Mixed Sex Accomodation	Minimise breaches	0	1	
MRSA	Number of MRSA reported infections	0	3	
C_Diff	Number of C_Diff reported infections	38	36	
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission , for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice	0	0	
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period	95%	96.0%	

The Performance Report - Key Activities throughout the year

The following section highlights the key activities of the CCG during the year:

- **Transforming the way that health and care is provided;**
- **Sustainable Development;**
- **Improving quality;**
- **Engaging people and communities;**
- **Reducing health inequality;**
- **Calderdale wellbeing strategy;**
- **Managing our resources effectively**

TRANSFORMING THE WAY THAT HEALTH AND CARE IS PROVIDED

When working with our partners on transforming the way that health and care is provided, our focus is in three main inter-connected areas:

- Calderdale as a Place
- Across the Calderdale and Greater Huddersfield area
- West Yorkshire and Harrogate Health and Care Partnership

Calderdale as a Place

The CCG works closely with partners through the Health and Wellbeing Board to achieve its shared vision of a sustainable health and care system for the people of Calderdale that delivers: improved health outcomes, reduced health inequalities, greater independence and a lower need for hospital based care. Calderdale Cares, led by Calderdale Council represents a place-based approach to the delivery of health and social care and sees the collaboration of a range of organisations that share common resources and deliver shared population health outcomes.

A wide range of Calderdale Cares activities were delivered during the year, both at a Calderdale-wide and Primary Care Network footprint. These include:

- Development of a Wellbeing Hub for people with Severe Mental Illness in North Halifax
- Strengthening of the offers provided by the joint Equipment Loan Store at Salterhebble
- Development of a roadmap for the integration of commissioning activities across the CCG and CMBC
- Development of a strategic direction for people with dementia
- Development of community urgent care offers
- Development of technological offers to support Care Closer to Home and Multi-Disciplinary Team working.
- Learning from the first year of the new Voluntary Sector Infrastructure Alliance – building capacity and capability in the third sector.

Care Closer to Home

The Care Closer to Home (CC2H) programme aims to give people in Calderdale access to the care they need in their localities, whether this be at home or in the community.

We are working with our partners, including those in the third sector, to reduce the dependence on hospital services and provide smarter health care services which work together for the benefit of people across Calderdale. Local people are already benefiting from services introduced as part of the Care Closer to Home programme.

In 2018-19 we produced a community prospectus to support the development of an alliance to deliver services as part of Care Closer to Home. The aim is that this will bring together commissioners and providers to address the different health needs of each of Calderdale's five Primary Care Network[4] (PCN) populations by:

- Using population health data (such as demographic, lifestyle, utilisation of health services data), allowing care providers to be flexible and to provide services that meet the needs of patients in each locality; to facilitate prevention, and reduce levels of unplanned care.
- Providing proactive holistic patient-centred care;
- Promoting prevention and self-care.

The CC2H programme requires our system to collaborate and expand beyond the traditional statutory sector agencies and incorporate the important contribution made by the third sector, and independent sector organisations. This requires changing the ways in which organisations and their staff work. We need to make sure it is easier for people to make healthy choices and ensure a relentless focus on health

[4] Information about Primary Care Networks is set out on page 16

outcomes and not just on service delivery. We need to change the nature of the relationship between people and services, and the relationship between people and their own health – changing the way our staff see their roles; their day job and the constant improvement of the work they do.

- Focusing on prevention, self-management and technology (Active Calderdale is a priority in this)
- Integrating health and care commissioning
- Incentivising the development of integrated health and care delivery models – creating seamless pathways for those who use health and social care.
- Improving the interface between community and hospital care
- Promoting evidenced based practice and innovation.
- Primary Care Network working across Calderdale; aligning budgets and determining the spread of resources across PCNs

Engagement and consultation activities have taken place in Calderdale from March 2013 to August 2019 on services that directly or indirectly related to community. This was conducted with a large range of health care community services, Calderdale & Huddersfield NHS Foundation Trust (CHFT) and general practice, primary care, staff and patients. The aim of the activity was to gather patient experience within community settings to help to inform the CC2H programme. A report of the findings from the engagement process was produced in July 2019. This report can be found at https://www.calderdaleccg.nhs.uk/community-services-composite-report-2013-2019/

The key emerging themes are set out below: what people have said they want to see in any future remodelling – we must consider all the points that may be relevant to a service change

- Right staff in the right setting: people have told us they want to see the right person first time in a setting that is suitable to their needs. Suitable settings vary for example young people want young people friendly environments with free WIFI and more use of contact through technology.
- More services closer to home and single point of contact: Anything that can be closer to home should be, this means having services in local settings. Local settings may not always be clinical settings - they could be voluntary and community groups or schools, for example. One way of contacting the NHS would help navigate the system.
- Improved access to services and waiting times reduced: Being able to book an appointment quickly and easily, and being able to choose a time and day that is convenient is important to people. Not waiting too long for an appointment, which means making sure appointments are timely and available when needed – particularly in an urgent situation.

- GP capacity to be increased: People want to better access to a GP. They also want to see the same GP for the same issue. Patients have told us that being able to see a GP will help keep services in a community setting and prevent visits to hospital.
- Co-ordinated services working together to deliver integrated health and social care (from grass roots – community - hospital): People want services to work together at every stage, this includes teams who work together in health and social care and systems that talk to each other with data shared where appropriate.
- Improve communication, information and sign posting (NHS 111): A key area for improvement is how we communicate and inform local people. This includes leaflets, letters, posters and the availability of information when you need it. People have told us that NHS111 needs to improve if this is the gateway to care.
- More on prevention and support to self-care: people want access to the right information and support which will help them to help themselves. There is a wealth of information available which can feel confusing and sometimes conflicting. People want more face to face contact at the onset to help them navigate. More peer to peer support and investment in voluntary and community sector.
- Utilise estates and consider travel and transport (including parking): people want all NHS buildings to be used effectively. Sharing buildings and using buildings owned by different agencies to help keep services in local settings. Reducing the need to travel and thinking about transport (including bus and trains) and parking as part of any service design is important.
- More involvement of the Voluntary and Community Sector (VCS) in delivering services: The VCS are valued by the public and the services they deliver are often closer to home. People want to see more support and investment for groups who support health and wellbeing.
- A workforce that can represent the community they serve: providing services in local settings with people who represent the community is important particularly for communities who have a diverse population. This includes male and female GPs, staff who can speak community languages and who understand cultural approaches.
- One size does not fit all: children and young people, frail elderly, diversity and mental health all require adjustments to approaches. The CCG need to reflect on equality and diversity intelligence when planning services.

We are using the key themes that patients and staff told us about during this engagement activity. This intelligence is supporting us to develop integrated service pathways under the CC2H / Population Health Model with our alliance partners and PCNs.

We require providers to be innovative and offer solutions that provide the right skills, in the right numbers and the ability to flex service offers to meet the needs of the people across Calderdale and in localities. Therefore we wish to commission a new community model for the people of Calderdale that will:

- Keep them healthy and help them stay well
- Detect problems early and stop them getting worse
- Help people to stay out of hospital and long term care
- Manage admissions to hospital and long term care and make sure that when people are well enough to leave that they are supported to be discharged as soon as possible

A CC2H Alliance Board has been established to undertake the business required in creating and delivering an Alliance approach.

Primary Care Networks

The formal introduction of Primary Care Networks (PCNs) through the new GP contract in 2019 enabled local organisations to build on the work started through localities and the Primary Care Home sites in North Halifax and Central Halifax.

PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. They aim to bring about a change from reactively providing appointments to proactively caring for the people and communities they serve.

Five PCNs have been established in Calderdale, as follows:

- North Halifax
- Central Halifax
- Calder and Ryburn (South Halifax)
- Lower Valley
- Upper Valley

Medicines management

Our medicines management team have a number of initiatives to support practices to improve the quality of care provided to patients and to deliver efficiency savings which are reinvested in care. These include:

Antibiotic Campaign

Calderdale has been improving on antibiotic prescribing - steadily decreasing - over the last few years. Despite this, we continue to be in the worst 15% of prescribers in England for total antibiotic items per STAR-PU (prescribing benchmark unit).

This year, the medicines management team and communications team have worked together to launch a local public facing campaign ‘Let’s Get a Grip on Antibiotics’ with the aim of achieving a bigger impact on reducing antibiotic prescribing. The campaign aims to raise awareness of antibiotic use across Calderdale.

Engagement and pre-work started in September 2019, however, due to election purdah and the Christmas period, the campaign was launched on the 4th February. Resources have been developed to support the campaign including a customisable poster, videos and a dedicated website which encourages people to pledge to keep antibiotics working.

We have engaged with CCG staff, including Governing Body members, GP practices, the council and local schools to promote the campaign and asked them to have their photograph taken with a ‘get-a-grip’ stamp to show their support. Also, on the 6th March Phoenix Radio interviewed Nicola Booth (Medicines Management Pharmacist) and Dr Caroline Taylor (Governing Body GP) to encourage listeners to always take the advice of their healthcare professional and keep antibiotics working.

We plan to take the campaign forward into next year and develop further resources support clinicians and the public.

National prescribing guidance

Ongoing work on the implementation of the NHS England Low Priority Prescribing Programme (LPP), phase 3 was released in June 2019. As part of the medicines management action plan, the external medicines optimisation team (North East Commissioning Support (NECS) support practices by identifying patients on one of the LPP medicines and, where appropriate, stopping or switching to an alternative treatment.

Since phase 1 was released in 2017, we have seen with a significant drop in the prescribing of these items.

PINCER

A quality improvement tool, PINCER (Pharmacist-led information technology intervention for reducing clinically important errors in medication management) has been rolled out across the CCG, to help identify and reduce important and common medication errors in general practice. The intervention tool should reduce clinically important prescribing errors, the number of medication-related hospital admissions and deaths, and make a cost saving to the NHS.

Safety Audits
The NECS team carry out safety and antibiotic audits every quarter in each practice. In 2019/20, these included acute sinusitis, acute sore throat, identifying COPD patients suitable for triple therapy, identifying patients who have had a splenectomy or have a dysfunction spleen with missing or incomplete vaccinations and/or not taking prophylactic antibiotics as directed by the specialist. The results from these audits are shared with individual practices and a CCG summary is discussed at the Medicines Advisory Group and key messages/learning shared with practices where appropriate.

Service Improvement
The CCG's service improvement team have continued to work with partners to improve the health and care available for local people. Some examples of this work are given below.

The Integrated Living Model
Emergency admissions and prolonged hospital stays, particularly in the frail elderly population, lead to deconditioning and the need for higher levels of care following discharge from hospital. In Calderdale, we have significantly reduced delayed transfers of care, however, there is more which could be done. At times of crisis or escalating needs, we know it improves outcomes for people if we can maintain their independence and keep them at home for longer. Improved responsiveness of community services through flexible, multi-disciplinary teams working holistically to meet the needs of the individual will improve outcomes whilst avoiding unnecessary emergency admissions.

Building on the foundations already laid through Care Closer to Home, the following work has been undertaken over the past year to work towards these improvements:

- Reviewing out of hospital services and pathways that provide 'short-term' interventions/support (up to 6 weeks) with health and social care staff to determine if they are fit for purpose; meet the needs of the Calderdale population; and are in line with what people have already told us they want their community care and support to look like. This has included: Reablement, Intermediate Care, Dementia, Stroke Rehabilitation services.
- Developing draft models of care for crisis response (at home); step up (to community services or acute); step down (to home or community).
- Developing and implementing a new model of care and pathway for reablement; commencing a 7-day service; increased capacity in the team;.
- Increasing flexibility of community beds, thus meeting an increased cohort of patients such as those with dementia.
- Holding a staff engagement event in February 2020 to gather feedback and insight into draft new models of care

The Open Minds Partnership – emotional health and wellbeing support for children and young people

Since 2015, providers and commissioners of emotional health and wellbeing services have been working ever more closely together to transform and improve the offer for and experiences of children and young people of Calderdale.

In 2018, Children & Young People's Tough Times Group told us they wanted a new name for Calderdale's Child & Adolescent Mental Health Services (CAMHS). The new name for the organisations providing emotional wellbeing and mental health support to children, young people, carers and families in Calderdale is **the Open Mind Partnership (OMP)**.

Northpoint Wellbeing and South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) work together to provide emotional wellbeing and mental health support. Online support is also provided by a service called Kooth, provided by XenZone. Together, these come under the umbrella of the Open Minds Partnership and are funded by NHS Calderdale CCG and Calderdale Council, the commissioners.

The OMP also includes a neurodevelopmental service for school-aged children, with referrals coming into the OMP First Point of Contact (FPoC). This includes the assessment and diagnosis of difficulties such as Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Conditions (autism). Pre-school autism referrals are managed through our early years' service delivered by Calderdale and Huddersfield NHS Foundation Trust

Exploratory work has begun to broaden the Open Minds Partnership from spring 2020. This will allow greater partnership working between additional providers and stakeholders across Calderdale, and create a stronger approach to delivering improvements in emotional health and wellbeing services for children and young people.

Delivering 'Thrive' in Calderdale

The Open Minds Partnership (OMP) has moved away from the Children and Adolescent Mental Health Services (CAMHS) 'Tiered Model', developed in 1995. In Calderdale the mental health and wellbeing needs of children, young people, parent carers/families are now being met through implementation of the national Anna Freud Centre 'Thrive' model.

Thrive is based on the concept that around 80% of children and young people at any one time experience the normal ups and downs of life but do not need individualised advice or support around their mental health issues. They are considered to be **'Thriving'**. For the remaining 20%, the Thrive approach means that children and young people can receive support at any time from the most appropriate service that

meets their needs, in the form of ‘Getting Advice’, ‘Getting Help’, ‘Getting More Help’ or ‘Getting Risk Support’.

Under ‘Thrive’, mental health and wellbeing is everyone’s business. When a parent, child or young person needs help, the OMP approach is to work closely together and share knowledge so a young person should only tell their story once. Children and young people are provided with personalised care that focusses on supporting and meeting their holistic needs and goals, *rather* than them fitting into a service. Children, young people and their families have a central role in deciding what success would look like for them, knowing that there will be ‘no decisions about me, without me’. The support and help provided is based on focused, evidence-based treatment.

The OMP Vision is: *To move away from a system defined by services and organisations to one built around the needs of children, young people and their families, offering choice and control, intervening early and building long term resilience*. Applying the ‘Thrive’ model will mean the people of Calderdale are more likely to live healthy and independent lives secure in the knowledge that, if they need them, services will be there to keep them safe, supported and cared for.

Calderdale Children and Young People’s Local Area Special Educational Needs and/or Disabilities (SEND) Inspection

In March 2019 Calderdale’s frontline education and health and care provision services supporting those with special educational needs and disabilities (SEND) were scrutinised by Ofsted and the Care Quality Commission (CQC) as part of the national framework for inspecting local areas.

The Ofsted/CQC report, published in May 2019, found that:

- We engage well with children and young people with SEND and their families.
- Children and young people with SEND have a strong voice in shaping provision and services.
- We know the strengths and weaknesses in our local area’s SEND arrangements.
- Local area leaders are ambitious for children and young people with SEND in Calderdale.
- We are making strong progress in implementing the 2014 reforms.
- ’Leaders know children and young people’s needs very well. Strategic decisions to expand opportunities for social development, employment and independent living in Calderdale fully reflect the aspirations of young people.”

The inspection, led by the Local Authority and the CCG, considered how everyone in the area is identifying, meeting needs and improving outcomes for children and young people with SEND.

The inspectors held a range of focus groups and visited a number of settings. They met with parents and with children, young people. Parents were also able to contribute directly to the inspectors and participate in a webinar. The Local Authority and CCG were grateful to the parents, children and young people for their contribution to the inspection.

The report can be found at https://www.calderdaleccg.nhs.uk/calderdale-children-and-young-peoples-local-area-send-inspection/

Calderdale Children and Young People's ASD Summit 2020: "Find Your Brave"
During National Children's Mental Health Week in February 2020, Calderdale Young People with Autism Spectrum Disorder (ASD) designed and led a Marketplace event and stakeholder summit, 'Find your Brave', at North Bridge Leisure Centre, Halifax. Partner staff, summit attendees and young people also attended Training 2 Care's Autism Experience.

'Find Your Brave' followed Calderdale's first Children and Young People's ASD summit in January 2019. Our Young People told participants their personal stories and what their dreams for Calderdale are. System leaders gave an update on the 2019 pledges to transform the experiences and outcomes of children and young people, and take positive action on autism. Partners celebrated the progress made since then and participants identified together how we all can continue the journey together in transforming the way we think, organise and operate in Calderdale.

The Summit provided renewed focus, energy and commitment by partners to transforming ASD services for the Children and Young People of Calderdale. The ideas and actions it generated will be used to inform Calderdale system working under the 'Thrive' model of emotional wellbeing and mental health care for children and young people, and next steps for ASD, aligned to Calderdale's all-age Autism Strategy.

Wheelchairs Service
Wheelchair services are commissioned jointly by Calderdale, Greater Huddersfield and North Kirklees CCGs. What people told the CCGs during extensive engagement was used to develop a new service specification, for procurement and a new contract starting on 1st October 2019.

In July 2019, NHS Calderdale CCG, NHS Greater Huddersfield CCG and NHS North Kirklees CCG announced that the new posture and mobility (wheelchairs) contract was awarded to Ross Care Ltd. The evaluations of tender submissions made by potential providers were carried out by a qualified and experienced panel, including a service user reference group and their two nominated representatives.

Ross Care (working with partners Blatchford) has been delivering the new service since October 2019, prioritising people with open episodes of care, focusing on those waiting longest and with the greatest need. Additional clinics have been held and out-of-area staff brought into the service to support this work. Meet-and-Greet sessions held by Ross Care during October were well attended by service users and professionals.

The CCGs and Ross Care continue to focus on service developments, including: stakeholder mapping and partnership working, service user communications, Personal Wheelchair Budgets, data monitoring and reporting.

Supported living for adults with enduring mental health conditions
Over the last eighteen months, the CCG worked with the Council to commission ten supported living flats in Halifax to enable adults with enduring mental health conditions who had previously been in an inpatient rehabilitation unit or a care home to secure their own tenancies to enable them to live independently in the community with support. The flats are now occupied and the residents are settling in very well.

The learning from this work is being used to identify/develop further opportunities for people to gain independence in a safe, supportive environment.

Working across Calderdale and Greater Huddersfield

Right Care, Right Time, Right Place
In December 2018 the Department of Health and Social Care (DHSC) confirmed that capital funding of £196.5m had been allocated to support implementation of the plans to reconfigure hospital services and that to take this forward, approval of a Strategic Outline Case, Outline Business Case and Full Business Case by NHSI, DHSC, Ministers and HM Treasury would be required.

The Strategic Outline Case (SOC) was approved by Calderdale and Huddersfield NHS Foundation Trust Board in April 2019. The SOC builds on significant public, stakeholder and clinical engagement since 2012 and is informed by the formal public consultation undertaken in 2016 and the recommendations of the Independent Reconfiguration Panel.

Letters of support for the SOC were provided by Calderdale CCG and Greater Huddersfield CCG confirming that: the proposals described in the SOC will improve clinical care and outcomes for the Calderdale and Greater Huddersfield population; the proposals are affordable to commissioners, and; the proposals will improve and achieve the financial sustainability of the Calderdale and Huddersfield system of care. The West Yorkshire and Harrogate Health and Care Partnership agreed the proposals described in the SOC as its top priority, confirming that the Partnership is

confident the proposals fit with the overall strategy for the development of better health and social care services for West Yorkshire and Harrogate as a whole.

The Strategic Outline Case for capital expenditure of £196.5 million was submitted by the Trust to NHS England and NHS Improvement in April 2019 and approved in November 2019.

Local people, key stakeholders and the Joint Health Scrutiny Committee continue to be fully involved in the next steps to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield. During 2019, members of the public and colleagues were involved in the development of a Design Brief that will inform and support the development of future detailed design and construction schemes at both Huddersfield Royal Infirmary and Calderdale Royal Hospital.

Improving timeliness of cancer treatment

Access standards have been a key element of the NHS's approach to improving the timeliness of treatment for people with cancer since they were introduced in the NHS Cancer Plan in 2000.

One of the key indicators to assess progress is the time it takes for a patient to receive treatment they need - which follows the whole patient pathway from GP referral to their receipt of treatment. Based on the strong and consistent levels of performance we have achieved with our partners at CHFT in this area, we have been recognised as a high performing system by the West Yorkshire & Harrogate Cancer Alliance.

This achievement relies on strong partnership working combined with rigorous management and oversight of the pathway. In recognition of this, the Alliance has asked colleagues from our system to work with their core team and act as a critical friend to other organisations in West Yorkshire and Harrogate in reviewing pathways and recovery plans based on our track record of delivery. This builds on our collaborative approach to improvement with an openness to learn from each other about what works in what environment and 'stress test' each other's plans and business cases.

This recognition puts Calderdale in an excellent position to support the requirements of the NHS Long Term Plan with the ambitions to improve early cancer diagnosis and accelerating access to diagnosis and treatment.

Working across the wider and West Yorkshire and Harrogate footprint

West Yorkshire and Harrogate Health and Care Partnership (HCP) is made up of a wide range of organisations from health, Local Authorities, voluntary and the community sector. The partnership works closely together to plan services and address the challenges that face the health and care sector in the area.

In November 2019, the HCP published its five year plan 'Better health and wellbeing for everyone'. The priorities in the plan are set out below.

The CCG is fully involved in the work to improve the health and care of local people. Some examples of the work we have done together are shown below.

The Healthy Hearts improvement Project

The first phase of the project aims to identify people who may have high blood pressure who are not yet diagnosed, and those who need to better control their hypertension to a safe target below 140/90. From Jan 2019 to Jan 2020 more than 7,500 new people were added to the hypertension register. This means they are more closely monitored. There was also an increase in the number of people, nearly 8,000, who now have their hypertension better controlled to safe

limits. Importantly this could help prevent 65 deaths, 122 strokes and 82 heart attacks over the next five years.

West Yorkshire and Harrogate policy for cataract surgery
This new policy is being implemented across the HCP. It states that a person's total circumstances will be considered before surgery is offered, not just their visual acuity which is the sharpness or clarity of vision. Community optometrists will spend more time evaluating an individual's suitability and willingness for cataract surgery, discussing options with them before a shared decision is made whether to go ahead with the surgery or not. It is expected that this will lead to fewer unnecessary referrals as patients will be better informed about the procedure and likely benefits and risks before seeing a cataract service provider. Patients who have had uncomplicated routine cataract surgery will have their follow-up checks carried out by a community optometrist. This will reduce the number of times patients need to visit a hospital which will result in a more convenient and timely appointment.

West Yorkshire and Harrogate 'Looking out for our neighbours' campaign
This campaign, which aims to combat loneliness across the region, has inspired hundreds of people to take conscious steps to look out for those around them through simple, everyday interactions like saying hello and sharing a cup of tea. Commissioned by the HCP, the campaign launched on the 15 March 2019 and has received support from over 350 supporters including high-profile organisations such as the Jo Cox Foundation, Andy's Man Club and Yorkshire Ambulance Service. The campaign has also been a hit on social media, with the hashtag #OurNeighbours being used more than 2,000 times. In addition to more than 35,000 helpful neighbour packs distributed, a further 1,200 people have downloaded a digital version of the pack from the campaign website.

Across the HCP, there has also been a focus on working better together, introducing a 'do once and share' approach to quality and equality impact assessments, ensuring that the public and patient voice informs decisions; developing new collaborative working between commissioners and providers.

Further information on the West Yorkshire and Harrogate Health and Care Partnership and its work can be found at: https://www.wyhpartnership.co.uk/

Further information on the West Yorkshire and Harrogate Joint Committee of CCGs can be found in the Governance Statement.

SUSTAINABLE DEVELOPMENT

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means building healthy and resilient communities, supporting healthy workforce, the smart and efficient use of natural resources and spending public money well.

By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We continue to carry out activities that contribute to sustainable development. We have provided a flavour of those below:

Corporate approach

- As a commissioning organisation and employer, we have a Governing Body lead for sustainable development and have Sustainable Development Management plan which will be refreshed in 2020.

Travel and logistics

- Our Expenses Policy sets out our commitment to sustainability;
- We assess the travel, transport and accessibility of locations for engagement and consultation meetings and follow up any events with a questionnaire to participants which informs future choice of venues – our preferred model is to go where people are, rather than expecting people to come to us. This is supported by working with our engagement champions. (https://www.calderdaleccg.nhs.uk/get_involved/)
- We use technology to reduce the number of journeys being made by our staff – who are increasingly working across West Yorkshire as we develop collaborative working as part of the Health and Care Partnership. Reducing the amount of travelling required contributes to an improvement in staff health and wellbeing, increases efficiency, reduces our impact on the environment and reduces running costs. During 2019/20 we have held an estimated 246 teleconferences involving 1,570 people and 15 videoconferences involving an estimated 120 people (this latter figure is a reduction on the previous year due to the move of

Greater Huddersfield CCG, with whom the CCG shares a number of staff, to an office without videoconferencing facilities).

Adaptation

Responding to the effects of climate change is embedded in our Emergency Planning, Resilience and Recovery (EPRR) work as part of fulfilling our responsibilities under the Civil Contingencies Act 2004. We work closely with partners across the system on business continuity planning, ensuring that Surge and Escalation Plans as well as heatwave and winter plans are in place. We also take part in flood planning exercises with partners across Calderdale.

In October 2019 we self-assessed **'full'** compliance against the national EPRR core standards (see also system resilience – performance report).

Our emergency planning systems proved themselves robust when Storm Ciara caused widespread flooding in Calderdale in February 2020.

Sustainable care models

Building sustainable care models is central to all our work with partners across Calderdale as a Place, across Calderdale and Greater Huddersfield as a shared acute hospital footprint and across the West Yorkshire and Harrogate Health and Care Partnership. Sustainability principles are embedded in our commissioning plans. Details of our work on Care Closer to Home, Calderdale Cares and other areas, can be found in the Performance Report – Key Activities.

We also have a sustainable engagement model in partnership with our local community which ensures the public voice is central to commissioning. (See the Performance Report).

Climate emergency

Calderdale Council declared a climate emergency at the beginning of 2019 and that as a response the CCG has appointed Dr Steven Cleasby as the Governing Body Champion for Climate Change with operational responsibility from the Corporate Systems Manager, Rob Gibson. The CCG is supporting the Climate Emergency Steering Group and Working Party at the Council in its ambition to reduce carbon dioxide emissions by 40% by 2020 and by 80% by 2050.

The NHS contributes about 7% of carbon emissions through its estate, transport costs of staff and patients and its heating costs, and we aim to do all we can to become a leading CCG in our response to the climate emergency.

We are thinking how as individuals working at the CCG we can reduce our own carbon footprint in our individual lives, how we can use smarter ways of working through digital and other means to rescue our environmental impact and also how through leadership discussions and through contracting and procurement means we can influence the wider system.

Our people – Encouraging a healthy workforce

Calderdale CCG is proud of, and committed to maintaining an engaging and inclusive workplace culture. Our staff forum promotes and leads a wide range of activities that support the physical, social and psychological wellbeing of all staff. These enable each individual, team and the organisation to be the best they can be at work, and deliver high quality services for the communities of Calderdale, and West Yorkshire & Harrogate. Our staff forum activities are only made possible because of the energy and enthusiasm shown by our people.

This year, some key staff forum highlights include:

- Charitable giving: over £199 raised through the year for local and national charities - Andy's Man Club and the British Heart Foundation;
- Promoting local, regional and national campaigns, such as Get A Gr!p on Antibiotics, Our Neighbours, Time To Talk Day, and the 2019 Flu Campaign;
- Encouraging staff to take their weekly Wellbeing Half Hour – time out during their working week to focus on a mental or physical wellbeing activity;
- Taking steps to promote sustainability – including supporting the national 'Clean Air Day';
- Maintaining positive relationships with each other through the always popular monthly "coffee, cake and catch-up" sessions and our new Garden 'Swap Shops'.

Resource usage in 2019-20

Resource	Quantity (kWh)		tCO2 emissions		Cost (Inc. VAT) (£)	
	2018-19	2019-20	2018-19	2019-20	2018-19	2019-20
Gas (note 1)	93531	55530	20	12	3,746	2,405
Electricity	47449	49397	21	22	9,061	10,182
Water (note 2)	--	--	--	--	--	--
General waste (note 3)	--	--	--	--	--	--
Recycling (including confidential waste)	--	--	--	--	2,633	2,569
	Miles	Miles				
Business Travel	55,877	48,019			37,978	26,891
Business Travel – Car Share	2,600	1951	-	-	130.00	97.00

Note 1: Data for 2018-19 subject to validation.
Note 2: The charge for water usage is contained within the general service charge and is not separated out.
Note 3: General waste disposal forms part of the cleaning contract and is not separated out.

IMPROVING QUALITY

During the year we have maintained a clear focus on the quality of services and on ensuring that patients are safe. We have done this by:

- Building on the close working relationships with our providers through, for example the Quality Boards.
- Participating in quality visits with colleagues at Calderdale and Huddersfield NHS Foundation Trust, focusing on specific areas of quality and safety. These have tested whether front line staff are aware of and are implementing processes such as learning from serious incidents, falls and medicines management.
- Participating in quality visits with colleagues at South West Yorkshire Mental Health Partnership NHS Foundation Trust to understand the level of progress made against the latest CQC inspection - identifying those areas where commissioning decisions could assist improvement.
- Working with care home providers to ensure safe delivery of care for clients and, where they are struggling, to support them with the improvements required. In the homes that have been rated inadequate by CQC the input and support provided by the CCG has contributed to an improvement in the CQC ratings.
- Maintaining a rigorous grip on quality performance through the scrutiny of the quality and safety dashboards.

- Encouraging member practices to report incidents, identifying themes and sharing learning in order to improve safety in the way services are provided.
- Monitoring quality and safety in primary care, through “critical friends” visits where concerns have been raised. We use the NHS England Quality Assurance Process to support this process.
- Embedded the Quality Impact Assessment process within the organisation and working with partners across West Yorkshire and Harrogate Health and Care Partnership to develop a single approach to Quality and Equality Impact Assessment.
- Promoting the Quality for Health assurance system developed by the CCG and Voluntary Action Calderdale for the voluntary sector
- Sharing patient stories at every Governing Body meeting in order to learn about experience of health services and how we can improve those services for our patients.

Some of examples of our work are:

Learning Disability Mortality Riews (LeDeR)

The Learning Disabilities and Mortality Review programme was established as a result of one of the key recommendations of the Confidential Enquiry into the premature deaths of people with learning disabilities.

The programme, which was commissioned in 2017 by Healthcare Quality Improvement Partnership on behalf of NHS England, has continued this year and supports local retrospective reviews the deaths of people with learning disabilities aged 4 to 74 across England.

The key aim of the LeDeR Programme is to identify lessons that are learned or best practice from the review so that any recommendations for improvement can be taken forward.

The work forms part of the wider Transforming Care agenda and NHS England’s commitment to address health inequalities experienced by people with learning disabilities.

Within the CCG, the LeDer programme is coordinated within the Chief Nursing and Quality Team, but with learning and sharing good practice being relevant to all our partners in health and social care

We have continued to identify this year is that care is good when:

- *The learning disability nurse is able to support people in hospital as well as services to support people with learning disabilities in the community*

- *We have seen some very good care for people with learning disabilites who have been at the end of their life*
- *The same people support a person and get to know them well; so the care is better when the same carers are the same*
- *The hospice is involved in end of life care planning.*
- *More people with learning disabilities are having Annual Health checks*

We have learned that these are some of the things that could be better:

- *There is still a need to keep working on good planning for end of life care*
- *Support for families after someone dies;*
- *There is still a need to ensure that people with learning disabilities have Annual Health Checks.*

We continue to work hard in Calderdale not only to improve the outcomes of people with learning disabilities but also to engage with the self-advocates themselves so that they can help support and guide our work on improving services for people with learning disabilities. We have and we have continued to seek their thoughts and support for work both to help us.

Some of the examples of the work we have been doing include:

- We are working on making sure that people with learning disabilities have access to their own Health Action Plan.
- The LD Matron in CHFT, that the CCG help to fund and commission, has been working to improve the care of people with learning disabilities who are admitted to hospital
- We have been looking at how we can make sure that people with learning disabilities access annual health checks and we are going to continue to work on the quality of those health checks to make sure they help to support and meet the health needs of those with learning disabilities.

The Calderdale, Kirklees and Wakefield 'Learning into Action' Group that includes attendance of all our key partners from health and social care and a self-advocate has continued to meet regularly. The group is chaired and facilitated by the CCG, and helps us take a shared approach to turning learning into action across the system. In 2019 the group committed to self- advocates setting challenges for the group to be worked on to improve the lives of people with learning disabilities.

This year the challenges have included:

1) To find out what plans there are to support people with learning disabilities when they become very ill or are dying
2) To make services more aware of VIP Passports and improve how they are used

3) To make a system so that all the right people know about what we have learnt from the reviews and the bulletins

Safeguarding Adults and Children

The CCG has a legal responsibility to ensure that the principles and duties of safeguarding children and adults at risk are holistically, consistently and conscientiously applied, with the well-being of those children and adults at the heart of everything that is done.

The CCG's Safeguarding team has responsibility for and continues to seek assurance that our commissioned service providers deliver safe and effective systems for safeguarding children and adults, including provision for Children in Care and a Child Death Overview Panel.

In the previous year the CCG Designated Nurse for Safeguarding Children also took on the role of the Designated Nurse for Children Looked After (CLA) and Care Leavers. This enabled the provider of the CLA Service to develop a full wrap around service for those looked after children in Calderdale who are placed within and outside the district. This has resulted in the CLA Service seeing the delivery of high standard assessments, continuity of care for these children and includes the provision of health passports for all care leavers.

Throughout the year the team has also continued to support and manage the expanding field of safeguarding including the Mental Capacity and Deprivation of Liberty Safeguards, the Prevent agenda, Human Trafficking and Modern Slavery, Child Sexual Exploitation, Forced Marriage, Domestic Abuse and Female Genital Mutilation and contextual Safeguarding.

This has included:

- Working with health providers to protect people from abuse and neglect; The team has continued to provide a health leadership role and be fully engaged in local arrangements for Safeguarding Practice Reviews, Safeguarding Adults reviews and Domestic Homicide Reviews.
- Delivering the Health and Wellbeing Board Domestic Abuse Pledge – the team have engaged fully in the work of the partnership and led on the delivering of a single point of contact for all health agencies within the local domestic abuse hub;
- Further development of safeguarding in primary care by facilitating quarterly meetings with safeguarding lead GPs - providing group supervision, training, shared learning from case reviews, template policies and regular safeguarding newsletters.

- Developing CCG systems so that those people whose care and treatment has to be particularly restrictive in order to keep them safe are also afforded human rights' protections through the Deprivation of Liberty Safeguards. We have also started to work with our partners on how we will deliver the new Liberty Protection Safeguards.
- Playing a full role on the Local Calderdale Safeguarding Children Partnership & Calderdale Safeguarding Adults Board. The new Calderdale safeguarding children's partnership (CSCP) arrangements are well embedded following the publication and recommendations of the 2018 'Working Together to Safeguard Children'. Work with the Calderdale Safeguarding Adults Board has included the continued development of the quality and performance scorecard, multi-agency audits, work to improve personalised safeguarding practice and an ongoing review of the deaths of five people living street based lives, which has led to rapid service and system improvements.

ENGAGING PEOPLE AND COMMUNITIES

Calderdale CCG has a published Public and Patient Involvement and Experience Strategy which sets out the CCG's approach to involving local people and the legislation the CCG must work to. The duty to involve local people is set out in sections 242 and 244 of the Health and Social Care Act 2012, The NHS Constitution and the Equality Act 2010.

The CCG has involved over 2,000 local people over the year in 2019/20 on the following areas:

- Alternative Primary Medical Services (APMS) engagement on the future of two practices
- Equality Delivery System (EDS) and improving access to GP Practices for young people and people who are who are Lesbian, Gay, Bisexual, Transsexual or Questioning (LGBTQ) – see example below
- Improving Access to Talking Therapies for adults (IAPT) engagement

Reports of all the findings from these pieces of work can be found on our website.https://www.calderdaleccg.nhs.uk/get_involved/engagementandconsultation/

A separate engagement annual report provides more information on how both the CCG and providers the CCG commissions have involved local people in the development, design and delivery of services throughout the year. This report is currently in development and will be uploaded to the CCG website later in the year.

The report sets out who has been involved, what people have told us and what has happened as a result (we asked, you told us, we listened). Each section is a summary account with links to the published reports. An example is given below.

> ***We asked, you told us, we listened:***
> We asked young people to tell us about their experiences of using GP services in Calderdale and around support for those who identified as LGBTQ.
>
> Young people told us that practices could make people feel more supported by using more child friendly language and inform of all choices. Young people also said to have more gender awareness of current issues and support and increased support for mental health and autism. We were also told that waiting rooms need to be more inclusive and to have more access to appointments
>
> We worked with our GP practices, who are now taking up training with 'The Pride in Practice' to empower staff to give excellent care to LGBTQ patients and practices are reviewing the recommendations from the survey for service improvements.
>
> The work we did in Calderdale has also been recognised as best practice and shared with the National Programme Board for Pride in Practice.

A key priority during 2019-20 for the CCG and partners has been the development of a new system wide strategy to 'involving people' in Calderdale.

The strategy will create opportunities to build on existing approaches and maximise the resources and assets that are available in our communities (people who live there, the organisations and services that have a home within those communities).

We will continue to strengthen the approach to communication and engagement with our population, maximising opportunities for meaningful conversation and co-production.

Organisations across Calderdale see the involvement of local people at the heart of the design, development and implementation of interventions that improve health and wellbeing. This is a critical element of delivery of our Wellbeing Strategy and Calderdale Cares – creating a new relationship with our unique communities (as described in Vision 2024).

You can read Calderdale's 'involving people' strategy on our website.
https://www.calderdaleccg.nhs.uk/download/engagement-and-experience-strategy-for-local-people-in-calderdale-2015-2018/

REDUCING HEALTH INEQUALITY

Working together

The CCG has set out within all its published strategic plans, a clear intention to work with the local health and care partners to better integrate health and care services for the benefit of the people that we serve. We have taken this approach because when we have engaged and consulted with local people, they have been clear that we should work more effectively together to improve health and prevent illness and empower people to take control of their own health. This intention is in line with the commitments made in Calderdale Cares published in 2018.

In response to the delivery of Calderdale Cares, we have worked with our partners across Calderdale to develop five localities, which have developed into Primary Care Networks (PCNs) (see page 16). The PCNs build on formal and informal community networks and groups of general practices seeking to develop the provision of services, based on the specific needs of each locality, thereby tackling the specific health needs of localities and reducing the health inequalities gap.

This work, which is being taken forward through the Health and Wellbeing Board and the Integrated Commissioning Executive (ICE) includes:

- Clear collaboration on the content of the Calderdale Joint Strategic Needs Assessments;
- A key focus in the Wellbeing Strategy for Calderdale on tackling the wider determinants of health;
- Delivery of the Triple Aim of Improving Health, Quality and Value;
- The Council's Directors of Public Health and of Adults and Wellbeing are advisors to the CCG's Governing Body;
- The Council's Public Health Consultant attends our Quality Finance and Performance Committee and the Local Medical Committee Executive;
- A number of joint improvement activities led by ICE, including development of models for Gateway to Care Plus and enhanced reablement, continuing to work together on plans to strengthen personalisation and strategic direction for dementia

Equality and Diversity

We are committed to ensuring that equality and diversity is a priority when planning and commissioning local healthcare. To help us do this we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs. Our Equality and Diversity Strategy ensures that all activity puts equality at the centre of what we do both as commissioners and employers.

Highlights of some of the work we have been doing in the last year include:

- Bespoke training for Governing Body members on equality for decision makers;
- Supporting the Calderdale Equality Health Panel, which provides a platform for community groups to engage in regular dialogue with local healthcare organisations;
- Our work as part of the Equality Delivery System **(**EDS2) outcomes to inform the Equality Objectives for 2018-2022;
- Making sure that equality is embedded into systems and processes to support delivery of system recovery;
- Performance against the delivery of our equality and diversity duties is reported into the Quality Finance and Performance Committee on a quarterly basis, with the Annual Report being submitted to the Governing Body.

The CCG's Public Sector Equality Duty Report 2020 can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/download/public-sector-equality-duty-report-2019/

CALDERDALE WELLBEING STRATEGY

The CCG plays an active role on the Health and Wellbeing Board and the development of the new Wellbeing Strategy for Calderdale. Further information on the work being taken forward across Calderdale can be found in the Performance Report.

The Health and Wellbeing Board is attended by The Chief Officer and Chair of the CCG and oversight of delivery of the plans is provided by the joint officers group. The CCG has taken an active role in delivery of the Wellbeing Strategy which builds on Calderdale Cares and is aligned to the Inclusive Economy Strategy as well as national policy and established good practice. The new Strategy takes a life course approach to focus on activities that support: starting well, developing well, staying and working well, aging well and dying well – tackling wider determinants of health, reducing inequalities and improving health life expectancy.

Vision	
	People are empowered to take greater control over their lives and outcomes – living in good health, happy and connected
	Resources and assets are used to address the wider determinants of health and support wellbeing
	The system shifts towards prevention – changing the ways in which organisations and their staff work

A set of outcomes have been develop to support delivery of the vision:

Outcomes	Healthy mothers and healthy babies
	Parenting for a bright future: All young children given a strong foundation
	Good mental health and wellbeing for children and young people
	Parenting for a bright future: Children and young people equipped to become healthy and successful adults
	Good mental health and wellbeing for working age adults
	Healthy lifestyles for working age adults
	Older people remaining physically active and independent
	Good support in older age and end of life

More details can be found in the strategy document at the link below.
https://www.calderdaleccg.nhs.uk/download/calderdale-wellbeing-strategy-2019-2024/

The Health and Wellbeing Board is using an outcomes based accountability framework to build up the indicators and trajectories needed to measure success, and this work has progressed well.

MANAGING OUR FINANCES EFFECTIVELY

Financial Performance

The CCG has had a challenging financial year in 2019-20. The financial plan for the year was to deliver an in year breakeven position and maintain an accumulated surplus position of £4.6m.

In order to achieve this plan, the CCG had a Quality Innovation Improvement and Productivity (QIPP) savings target of £6.2m (2%). A summary of Calderdale CCG's allocations and expenditure is set out in the table below:

I am pleased to say that the CCG has been able to deliver its financial plan for 2019-20, despite the financial challenges. In addition the CCG was able to support the ICS system control total by increasing the CCG surplus by £1m. The CCG was able to achieve this due to underspends on its running cost allocation and contingency budget. The CCG successfully delivered £5.5m QIPP savings however the shortfall against the planned £6.2m savings was able to mitigate this pressure through its contingency budget.

Calderdale CCG:	Allocation	Expenditure	Variance
Summary of allocations and expenditure (2019-20)	**£'000**	**£'000**	**£'000**
Accumulated surplus brought forward	-4,552	0	-4552
Programme allocation	-303,096	302,791	-305
Primary medical services allocation	-30,310	30,310	0
Running cost allocation	-4,850	4,138	-712
Total allocation	-342,808	337,239	-5,569
In year surplus		0	- 1,017
Accumulated surplus	-4,552	0	- 5,569
Capital resource allocation	-50	46	- 4

This has been the second year of an Aligned Incentive Contract with our main acute provider (Calderdale and Huddersfield NHS Foundation Trust) which has enabled the CCG to mitigate the usual volatility in acute cost pressures and has developed our partnership working to focus on system sustainability pressures rather than the potential negative effects of Payment by Results contracts. This approach resulted in the CCG being able to manage the fluctuations in its medicines management costs and other contract variations within existing resources.

The CCG has a number of statutory financial duties and targets against which our performance is monitored. Although we have experienced significant financial challenges, I am pleased to be able to report that we have met all our statutory financial duties. The table below shows a summary of the CCG's performance against these targets in 2019-20

Financial Duty	Achieved / Not Achieved	Performance in 2019-20
Achieve operational financial balance	Achieved	Delivered an increased in year surplus of £1,017k
Revenue administration resource use does not exceed the amount specified in Directions	Achieved	The CCG underspent on its administration by £712k
Maintain capital expenditure within Capital Resources	Achieved	The CCG underspent on its capital by £4k
Manage cash within the CCG's Cash Limit	Achieved	Cash balance of £5k
Better Payment Practice Code - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty)	Achieved	97.7%

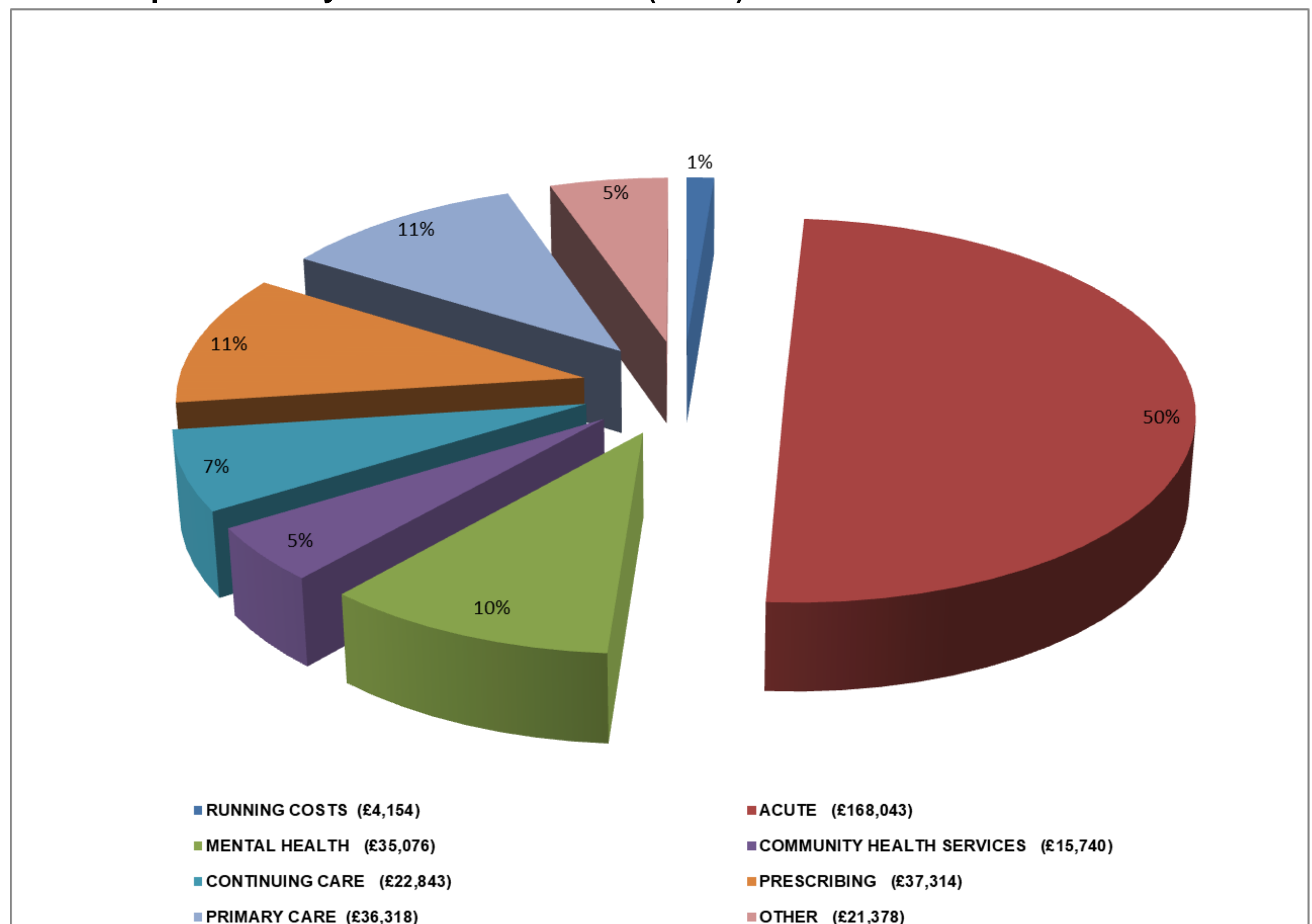
Investments in services

During 2019-20 we invested over £337m to improve the health and care of local people through the commissioning of high quality services. The CCG made a number of specific new investments in health care services during the year. These included:

- Investments into Primary Medical Services to support the delivery of the GP Forward View;
- Delivery of the Mental Health Investment Standard and investments to support the delivery of the Five Year Forward View for Mental Health;
- Investment into Children and Young People's Mental Health and Eating Disorders;
- Posture and Mobility Services;
- Investments into NHS 111 services;
- Investment into Yorkshire Ambulance Services;
- Investments into Continuing Healthcare and Funded Nursing Care.

The actual expenditure in the different sectors as well as the proportion of spend against the CCG's management cost allowance is set out in the diagram below:

Actual expenditure by the CCG in 2019-20 (£'000)



A copy of the contracts register can be found on the CCG's website at https://www.calderdaleccg.nhs.uk/key-documents/

Financial planning for 2020-21

The plan for 2019-20 is to again deliver an in-year breakeven position and to maintain a cumulative surplus of £5.6m. The CCG has received growth in its allocations which are shown in the table below:

Calderdale CCG 2020-21 allocations	Programme	Delegated Primary Medical	Running Costs	Total
	£'000	£'000	£'000	£'000
Allocation	312,497	31,522	4,115	348,134
% uplift	3.36%	4.00%	-13.34%	-

The CCG submitted an outline financial plan for 2020/21 to NHS England and Improvement in January. Since then due to the response to the impact of Covid-19, the initial operational planning guidance has been suspended. The CCG is therefore expecting to have to resubmit plans for 2020/21 once further guidance is issued. In the interim the CCG will use its initial plan as a basis for budget monitoring and will still be planning to deliver its control total of a breakeven position.

Running costs

The CCG has been set a target by NHS England to reduce CCG running costs by 20% in real terms by the beginning of the financial year 2020-21. The CCG is reviewing its running cost budgets in response to this challenge and has delivered a significant level of savings during 2019-20 in preparation for this reduction in allocation.

The CCG is continuing to review its running cost budgets to ensure that the running cost target for 2020-21 can be achieved.

Financial Risk

As part of our planning process the CCG has identified a number of risks that threaten delivery of our 2020-21 financial plan which are reflected on our corporate risk register (see appendix 2: Governance Statement: risks to the CCG), these include:

- That spending in hospitals providing acute services, increases above that currently forecast;
- That prescribing spend is higher than that forecast in plan;
- That continuing care spend continues to grow above the level that we have forecasted in plan;
- That QIPP schemes do not deliver the required level of cash releasing savings.

Our strategy to manage and mitigate these risks is to ensure that we have robust financial and contract management processes in place which ensure that:

- Investments are only committed if there is robust assurance that they are affordable and aid financial recovery/sustainability;
- Opportunities for disinvestment and reinvestment in healthcare are identified and realised, to improve outcomes and ensure that the money is directed where it can do most good; and
- We continue to adopt a collaborative approach with partners to ensure that resources are deployed effectively.

ACCOUNTABILITY REPORT

NEIL SMURTHWAITE
Interim Accountable Officer
23 June 2020

The Accountability Report – The Corporate Governance Report

The Corporate Governance Report is divided into:

- Members' Report
- The Statement of Interim Accountable Officer's Responsibilities
- Governance Statement

Members report

Members' profile

The CCG is a membership organisation and consists of the 21 GP practices[5] that are based in Calderdale:

Bankfield Surgery	Longroyde Surgery
Beechwood Medical Practice	Northolme Practice
Boulevard Medical Practice	Plane Trees Group Practice
Brig Royd Surgery	Rastrick Health Centre
Calder Community Practice	Rosegarth Surgery
Caritas Group Practice	Rydings Hall Surgery
Church Lane Surgery	Spring Hall Group Practice
Hebden Bridge Group Practice	Stainland Medical Centre
Keighley Road Surgery	Station Road Surgery
King Cross Practice	Todmorden Group Practice
Lister Lane Surgery	

The practices work together throughout the year to improve the quality of care, access to services and experience for local people. They do this in a number of ways; through meetings of the Practice Commissioning Leads, Locality meetings, the Medicines Advisory Group and the Practice Managers Action Group. Building on previous locality work, the practices have formed themselves into five Primary Care Networks – details can be found on page 16.

[5] At the start of 2019/20, NHS Calderdale CCG had 25 Member Practices. During the year, Horne Street Surgery merged with Boulevard Medical Practice and Queen Road Surgery and Southowram Surgery merged with Spring Hall Group Practice. These changes reduced the number of CCG member practices by three. Meadow Dale Group Practice ended its provision of primary medical services on the 31st March 2020.

Member Practices

Over the past year, we have continued to develop strong clinical engagement, as well as address local needs. Building on the work undertaken over the previous years, and taking into account the current challenging financial climate; the scheme involved the CCG's membership working together to:

- Promote continuous improvement of services, quality of patient care and access to services;
- Support each other in identifying and sharing of best practice;
- Enable the review of existing services and service redesign;
- Incentivise and encourage practices to analyse referrals and their own referral behaviour;
- Encourage practices to manage a greater proportion of demand within a primary care/community based setting, where appropriate;
- Reduce variation in referral rates between practices.

The member practices worked together during the year to support the delivery of the CCG's strategic priorities in the following ways:

Practice Commissioning Leads

Each practice has nominated a Practice Clinical Commissioning Lead, to be a two way conduit between the practices and the Governing Body. This includes sharing information about issues for local people at practice level, representing practice views and acting on behalf of the practices in matters relating to the CCG – including the shaping of priorities, testing plans and proposals and taking forward projects aligned to those priorities. Work with the member practices is steered by the CCG's Commissioning Development Forum.

Performance of the membership

The performance of the membership is assessed in a number of ways:

- Attendance at meetings –The CCG held five Practice Commissioning Leads' meetings in 2019/20. There was excellent attendance at these meetings;
- The sharing of peer review of referrals and non-elective admissions and A&E activity at the Practice Commissioning Leads events;
- Evaluation of the effectiveness and value of each Practice Commissioning Leads meeting carried out to inform future planning;
- The end of year collaboration report is used by the CCG to identify any opportunities for further development as well as assessing the effectiveness of clinical engagement during the year.

The practices and their Practice Commissioning Leads are shown below.

Primary Care Network	Practice	Practice Commissioning Lead
Calder & Ryburn	Bankfield Surgery	Dr E O'Leary
	Brig Royd Surgery	Dr L Pickles
	Stainland Road Medical Centre	Dr F Azam
	Station Road Surgery	Dr A Kazi
Central Halifax	Boulevard Medical Practice	Dr P Rajeswari
	King Cross Practice	Dr H Bolland
	Rosegarth Practice	Dr P Sawczyn
	Spring Hall Group Practice	Dr Felicity Price
Lower Valley	Church Lane Surgery	Dr S Khan
	Longroyde Surgery	Dr J Grant
	Northolme Practice	Dr S Santhanam
	Rastrick Health Centre	Dr F Javid
	Rydings Hall Surgery	Dr A Wilkinson
North Halifax	Beechwood Medical Centre	Dr L King
	Caritas Group Practice	C Gill
	Keighley Road Surgery	Dr K Simpson
	Lister Lane Surgery	Dr K Kumar
	Plane Trees Group Practice	Dr D Kumar
Upper Valley	Calder Community Practice	Vacancy
	Hebden Bridge Group Practice	Dr K Moore
	Todmorden Group Practice	Dr Vivekanathan

CCG Chair and Accountable Officer/Interim Accountable Officer
Dr Steven Cleasby is the CCG's Chair and Dr Matt Walsh was the CCG's Accountable Officer in 2019/20. Dr Walsh left the CCG on 15th April 2020. Neil Smurthwaite is the CCG's Interim Accountable Officer.

The Governing Body and its Committees

The CCG's membership has delegated authority to the Governing Body to oversee the work of the organisation and make decisions on its behalf as set out in the Scheme of Reservation and Delegation incorporated in the CCG's Constitution. The composition of the Governing Body as set out in the CCG's Constitution can be found below.

<table>
<tr><th colspan="3">Composition of the Governing Body 2019-20 (and up to the signing of the Annual Report and Accounts for 2019/20 on 23 June 2020)</th></tr>
<tr><td rowspan="7">Seven GPs as elected by the member practices, including the clinical chair.</td><td>Dr Steven Cleasby</td><td>Chair</td></tr>
<tr><td>Dr Majid Azeb</td><td>Clinical Vice Chair (until 31 March 2020)</td></tr>
<tr><td>Dr Helen Davies</td><td>(until 31 March 2020)</td></tr>
<tr><td>Dr James Gray</td><td></td></tr>
<tr><td>Dr Farrukh Javid</td><td></td></tr>
<tr><td>Dr Caroline Taylor</td><td></td></tr>
<tr><td>Dr Nigel Taylor</td><td>(Until 30 June 2019)</td></tr>
<tr><td rowspan="4">Three lay members (including the deputy chair)</td><td>David Longstaff</td><td>Deputy CCG Chair , Lay Member (Audit, Conflicts of Interest Guardian and Freedom to Speak Up Guardian)

(Until 31 December 2019 but remained on the Governing Body until 29 February 2020 as a non-voting member)</td></tr>
<tr><td>Professor Peter Roberts</td><td>Lay Member (Audit Conflicts of Interest Guardian and Freedom to Speak Up Guardian)
(from 1 December 2019)</td></tr>
<tr><td>John Mallalieu</td><td>Lay Member (Finance and Performance)

(Deputy CCG Chair in principle from 23 January 2020 - awaiting agreement of constitutional variation from NHS England to allow confirmation)</td></tr>
<tr><td>Alison Macdonald</td><td>Lay Member (Patient and Public Involvement)

(from 1 December 2019)</td></tr>
</table>

Lay Advisor to the Governing Body		
Secondary Care Specialist and Registered Nurse	Dr Robert Atkinson	Secondary Care Specialist
	Professor Rob McSherry	Registered Nurse
Accountable Officer	Dr Matt Walsh	*(Until 15th April 2020)*
Interim Accountable Officer	Neil Smurthwaite	*(From 16th April 2020)*
Chief Finance Officer/ Deputy Chief Officer	Neil Smurthwaite	
Interim Chief Finance Officer	Lesley Stokey	*(From 16th April 2020)*
Chief Quality and Nursing Officer	Penny Woodhead	
Invitations to assist the Governing Body		
Director of Adult Services or another Director that holds a health and social care portfolio (Calderdale Council)	Ian Baines	Director of Adult Health and Wellbeing
Director of Public Health (Calderdale Council)	Paul Butcher Debra Harkins	Director of Public Health *(until 31st March 2020)* *Director of Public Health (from 1st April 2020)*

Committees, including Audit Committee

Details of the Governing Body and Committee membership (including the composition of the Audit Committee), terms of reference and attendance during the reporting year can be found in the Governance Statement and in the Remuneration and Staff Report (Remuneration and Nomination Committee).

Register of Interests

Clinical Commissioning Groups are required to make arrangements to manage actual or potential conflicts of interest so that decisions by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest[6]. The CCG has a number of systems and processes in place to manage conflicts of interests. These are set out in the CCG's Constitution, our Policy on the Management of Conflicts of Interest and our Standards of Business Conduct.

The registers of interest for our Governing Body and Committees, Associates and Subject Specialists, Senior Management Team and CCG members can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/register-of-interests/ .

Further information on the internal audit of our arrangements for the management of conflicts of interest is contained within the Governance Statement.

Personal data related incidents

During 2019-20, we reported one personal data-related incident that met the required threshold for notification to the Information Commissioner's Office. Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject).

Date of Incident	Nature of Incident	No. of patients affected	How the patients were informed	Lessons learned
15/08/2019	Confidentiality breach due to theft of paperwork from a staff member's car.	5	Data subjects were contacted on the morning of the 29th August by a service manager and notified of the data breach and the name and contact details of the CCG's Data Protection Officer.	Ensure that staff understand the importance of following confidentiality and data protection policies which include the need to keep confidential information being transported out of sight and should not be left in cars overnight.

[6] Section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act; CCG Constitution (as revised August 2018)

In compiling this report, we have considered breach incidents for data for which we were the data controller, as defined by the General Data Protection Regulation and the Data Protection Act (2018).

Statement of Disclosure to Auditors

- Each individual who is a member of the CCG's Audit Committee at the time that 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.

Modern Slavery Act

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

- Home Office research in 2018 revealed the devastating impact of modern slavery. The data estimates that the economic and social costs to the UK are up to £4.3 billion each year. Each instance of the crime is estimated to cost around £330,000, including the cost of support, lost earnings and law enforcement but most significantly the physical and emotional harms suffered by individuals, who are often exploited over months and sometimes years. This places each modern slavery crime as second only to homicide in terms of harm to its victims and society.

- The main focus for health partners (as part of Calderdale's partnership Modern Slavery Action Plan 2019-20) is to improve the skills and knowledge for all frontline health professionals who have face to face contact with victims.

- The CCG's safeguarding team plays an integral leadership role on Modern Slavery across the health community, ensuring that providers are highly trained and responsive in order to appropriately identify potential victims of modern slavery and ensure that the right support is offered at the right time. The Quality Finance and Performance Committee has oversight of this work and it is included in the CCG's Safeguarding Annual Report.

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

Governance Statement

Introduction and context

NHS Calderdale CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2020, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Interim 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 the 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.

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.

Governance Framework
The Governance Framework for the CCG is set out in our Constitution. It covers the:

- Statutory duties and responsibilities of the CCG;
- Detail of how we are configured, our governance structure and decision-making processes;
- The roles and responsibilities of the Governing Body and committees;
- The vision and values of the organisation and adherence to the Nolan principles on Standards in Public Life and the NHS Constitution.

The provisions of the CCG's Constitution are supported by our Standing Financial Instructions and Standing Orders as well as a suite of policies and procedures.

Responsibilities of the CCG membership body
The CCG is a membership body which consists of the 21 general practices[7] in Calderdale. The member practices are responsible for agreeing the vision and values and overall strategic direction of the CCG. A number of decisions are reserved to the membership and these are set out in the CCG's Scheme of Reservation and Delegation, including approval of:

- Applications to NHS England on any variation to the CCG's Constitution;
- The overarching Scheme of Reservation and Delegation;
- The arrangements for appointing GPs or Nurse Practitioners to represent the membership on the Governing Body; and for the recruitment, appointment and removal of non-practice representatives;
- The establishment of committees of the CCG (such as the West Yorkshire and Harrogate Joint Committee of CCGs), delegating to them the exercise of any CCG functions as appropriate.

Further detail on the key responsibilities, membership, attendance and highlights of the membership's work over the year is contained within the Members' Report.

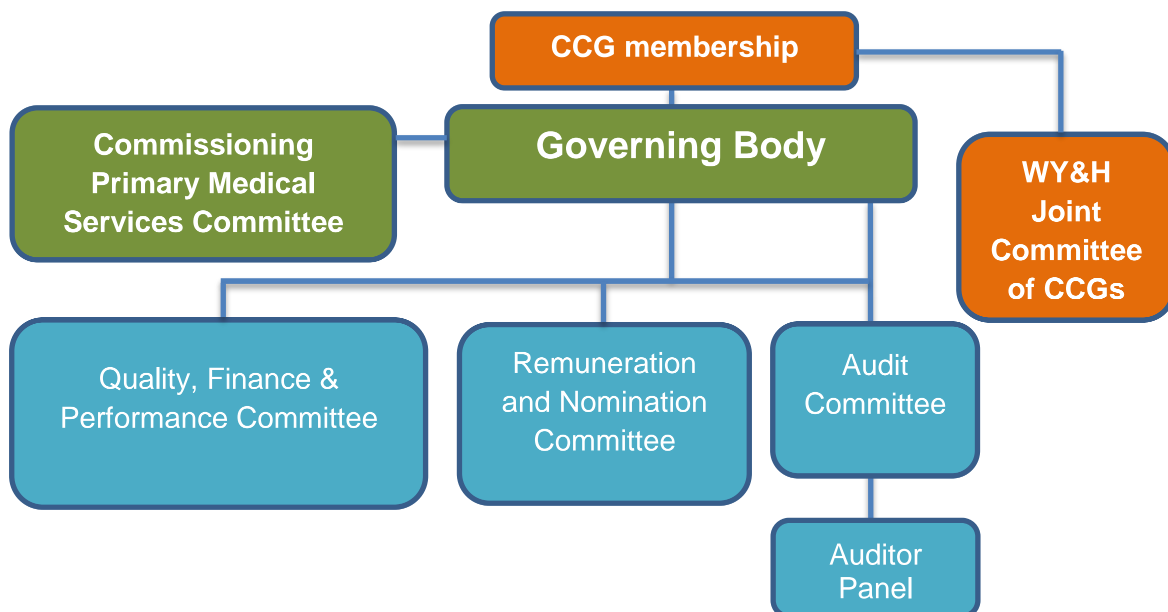
[7] At the start of 2019/20, NHS Calderdale CCG had 25 Member Practices. During the year, Horne Street Surgery merged with Boulevard Medical Practice and Queen Road Surgery and Southowram Surgery merged with Spring Hall Group Practice. These changes reduced the number of CCG member practices by three in 2019/2020. Meadow Dale Group Practice ended its provision of primary medical services on the 31 March 2020.

The CCG's Scheme of Reservation and Delegation sets out those decisions that are delegated by the membership to the Governing Body and its committees. These include approval of:

- The arrangements for discharging the CCG's statutory duties associated with its commissioning functions;
- The CCG's commissioning plan following engagement with member practices;
- The CCG's operating structure, corporate budgets and risk management arrangements;
- The arrangements for co-ordinating the commissioning of services with other CCGs and/ or with the Calderdale Council, where appropriate;
- Arrangements for any risk sharing or pooled budgets;
- Process for the appointment of the CCG's external auditors.

The governance structure of the CCG is set out below.

Governance Structure of the CCG



Changes to Formal Governance Arrangements in 2019/20

During the year the Governing Body and Senior Management Team reviewed the CCG'S formal governance arrangements in response to the publication of the NHS Long Term Plan, the development of locality working as part of Calderdale Cares, the establishment of Primary Care Networks and the requirement to achieve an overall 20% cost reduction in running costs by 2020/21. Several discussions took place between the Governing Body and Senior Management concerning how existing governance arrangements could be streamlined to ensure a greater focus on effective meetings and decision making, reduce duplication and making better

use of manager and Governing Body capacity including releasing clinical leadership at a locality level to support the delivery of the new GP contract and the development of Primary Care Networks. This process resulted to the following changes:

- The number of GP/Nurse Practitioner Governing Body members as defined in the Constitution was reduced from seven (including the clinical chair) to the Clinical Chair and three GP/Nurse Practitioner members. This change was accompanied by a commitment by the CCG to maintain as a minimum the CCG's current level of investment in clinical leadership. The change was approved by the CCG Membership.

- The CCG's Quality Committee and its Finance and Performance Committee were merged to form the Quality, Finance and Performance Committee. The new committee met for the first time under its combined Terms of Reference on 19th December 2019.

- The number of scheduled Governing Body and Committee meetings was reduced.

Separate to this process:

- The CCG's Remuneration and Nominations committee also met for the first time on the 18th July 2019 under its extended remit to include responsibility for nomination matters as set out in its Terms of Reference. This change was in order to provide more robust oversight for these arrangements within the CCG.

The membership of the Governing Body and its committees and sub-committees, together with the attendance records is set out in Appendix 1 at the end of the Governance Statement. Attendance at the Remuneration and Nomination Committee is set out in the Remuneration and Staff Report.

Work of the Governing Body

The role and responsibility of the Governing Body is to ensure that the CCG has appropriate arrangements in place so that it can exercise its functions effectively, efficiently and economically and with openness, transparency and candour. In practical terms this means that the role of the Governing Body is to formulate and hold the organisation to account for the delivery of its strategy; provide leadership in terms of shaping a healthy culture across the CCG and seek assurance that our systems of internal control are robust and reliable.

Governing Body key activities in 2019-20

The Governing Body is actively involved in the formulation of the CCG's strategic priorities and ensuring their delivery. Supported by the management team, this

activity is taken forward by the Governing Body's clinical leads, through our Clinical Development Forum and the Governing Body Development workshops and through the business of our formal Governing Body meetings held in public. Key areas of activity this year have been:

- Working with the Health and Wellbeing Board and its partners:
  - On the delivery of the Single Plan for Calderdale through the mechanism of Calderdale Cares;
  - In revising and sign up to a new Wellbeing Strategy for Calderdale which will support the delivery of Calderdale Cares and Vision 2024.

- Developing primary and community care, including the development and award of contract for a new Posture and Mobility (Wheelchair) Service

- Working with Calderdale Council and the CCG Membership to support the delivery of Active Calderdale and the ambition that everyone in Calderdale is able to live a larger life, for longer through physical activity.

- Continuing to transform mental health services across Calderdale including care for adults, children and young people with Autism and older adults' in need of intensive support.

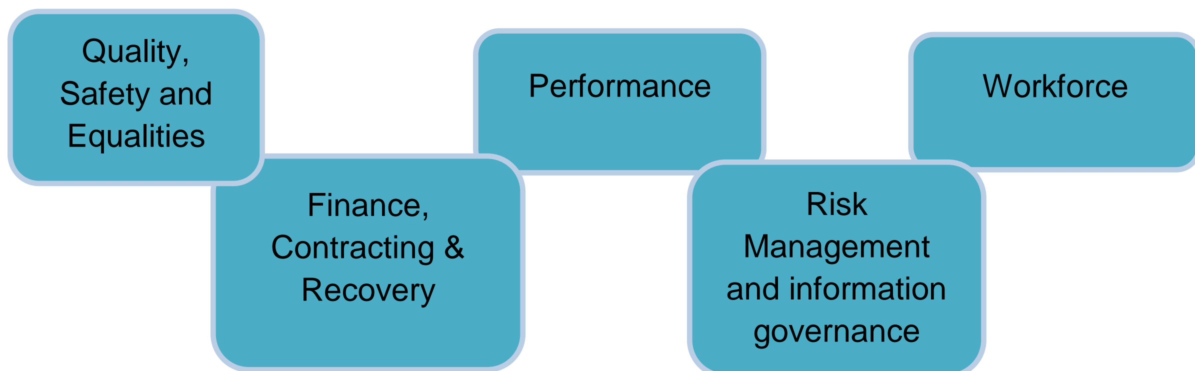
- Right Care, Right Time, Right Place – hospital service change.

- The CCG's response to the Climate Emergency.

- Oversight of Care Closer to Home and the support of Primary Care Networks.

Performance management and compliance with statutory and regulatory duties

Throughout the year the Governing Body and its committees have continued to maintain a strong focus on the CCG's performance and performance across the system. It has sought and received assurance in five key areas:



The Governing Body has received the Annual Statement of Public and Patient Engagement, the Joint Safeguarding Annual Report and the Annual Report on our

Emergency Preparedness, Resilience and Recovery (EPRR) together with the self-assessment of **'full'** compliance against the national core standards.

During the year, the Governing Body has been updated in public session on the national expectations on CCGs related to the United Kingdom leaving the European Union. The CCG has complied with all relevant national requirements. We have looked in detail at the risks and issues in relation to EU-Exit and are satisfied that we have identified and mitigated those which are within our gift.

Governing Body Members have also been kept informed of and provided direction on the CCG's response to COVID 19 during the latter part of the year; assuring themselves of robustness of the CCG's response and its participation in the local, regional and national efforts to tackle the pandemic.

The Governing Body has also had a strong focus on partnership working with its member practices, across Calderdale and with the wider West Yorkshire and Harrogate Integrated Care System.

Further information on our key activities during the year, including our partnership working can be found in the Performance Report.

Governing Body Performance

Under the leadership and oversight of the Governing Body, the CCG has delivered its financial plan and has met all its statutory financial duties. Whilst there have continued to be real challenges in terms of performance on some of the National Constitutional Standards, the level of performance in the Calderdale system remains strong when benchmarked with others nationally.

The committees have demonstrated the right level of focus and grip, enabling them to provide the Governing Body and NHS England with the assurance needed on the quality of services being commissioned, the financial position, system-wide performance and compliance with statutory and regulatory duties.

The clear focus of the Finance and Performance Committee, and latterly the Quality, Finance and Performance Committee this year has been upon financial recovery/resilience and a number of key performance issues, such as reducing delays in the transfer of care. The Quality Committee has been presented with a clear view of the quality and safety issues that are being addressed by our providers and with actions being undertaken to support an improvement in these areas.

The Commissioning Primary Medical Services Committee has made a number of important decisions about GP practice contracts demonstrating a high level of scrutiny and commitment to ensuring that patients are receiving good quality care

and that mitigating actions are in place to support effected including the vulnerable. It also agreed the process for the establishment of Primary Care Networks, approving their establishment and agreeing a spending plan to support their development and improve training and retention.

The Audit Committee has continued to provide important assurance to the Governing Body about the robust risk management arrangements and systems of internal control that are in place. This assurance is supported by the independent audit reports produced by Audit Yorkshire.
Finally, the Remuneration and Nomination Committee has considered and made recommendations to the Governing Body on remuneration and made good progress on discharging its responsibilities for Nominations matters under its wider remit.

There has been excellent attendance at meetings by Governing Body members, advisors and officers, providing the right level of scrutiny and discussion in the meetings. (See committee terms of reference at:
https://www.calderdaleccg.nhs.uk/key-documents/#ToR

Further detail on the activities and performance of the CCG can be found in the Performance Report.

Governing Body and Committee effectiveness
The Governing Body reviewed and considered its effectiveness during the year as part discussions concerning proposed changes to the formal governance arrangements of the CCG, considering the Governing Body's composition, culture and priorities.

The Governing Body committees carried out their annual self-assessment between January and March 2020. Compliance with committee terms of reference was reviewed as well as committee membership, culture and effectiveness. The outcome of the assessment demonstrated that appropriate governance arrangements were in place and that the responsibilities of the committees as set out in the terms of reference were being discharged appropriately.

Actions identified for 2020-21
- Following changes to the CCG formal governance arrangements in 2019/20, the Governing Body has agreed that there should be a continued focus on the development and implementation of these arrangements in 2020/21 to ensure they are operating effectively and delivering the anticipated efficiencies. This would include ensuring the composition of the governing body is sufficient to enable it to discharge its responsibilities; that there are sufficient meetings to support the effective flow of business within the organisation; and that balance between routine and exception reporting is releasing capacity and bringing an increased focus on the organisation's strategic priorities.

- Toward the end of 2019/20, the response to the Covid-19 pandemic required swift changes to the CCG's Governance arrangements, in terms of finance, quality and decision making, many of which were in response to national guidance issued by NHS England (NHSE) and NHS Improvement (NHSI). As the response to the pandemic continues and moves into a phase of stabilisation and reset, the Governing Body recognises both the challenges that lay ahead but also the need to take forward the positive developments in practice and other innovations which will continue to be of benefit to the CCG and wider system in the future:

▪ The Governing Body recognises that COVID 19 continues to present a significant risk to public health and its chief priority will be to be assured of the CCG's work within the system and regionally to deliver health and care services that function to keep the public safe and well during the public health emergency.

▪ It also recognises that a thorough review of the CCG's response and decisions made during its response to the pandemic will be needed, this will include its emergency planning and business continuity response, but also in terms of changes to services, so as to identify the positives it may wish to seek to maintain and/or develop further, such as the innovations and developments in Primary Care, as well those which might offer opportunities for learning, improvement and change.

▪ NHSE&I has issued temporary financial guidance for the period 1st April 2020 to 31st July 2020 which has replaced the CCG's original financial plan for 2020/21. New planning guidance for the period from 1st August 2020 onwards is anticipated. The Governing Body recognises that the requirements of the new planning round both in terms of Finance and Performance trajectories may be challenging for the CCG and for the local system and that this will require careful management and response during the next phase which will be overseen by the Governing Body and its Quality Finance and Performance Committee.

▪ NHSE&I issued guidance in March 2020 on Quality requirements during the pandemic requiring temporary changes to quality governance. As part of reset and stabilisation phase the Governing Body and Quality, Finance and Performance Committee will need to consider quality governance requirements during phase 2, taking the opportunity to learn from the different practice adopted during phase 1.

▪ Guidance from NHSE&I required that all CCG meetings now take place on virtual platforms. The Governing Body recognises its constitutional commitment to holding it meetings and those of the Commissioning Primary Medical Services committee in public in the interests of transparency and good governance, and

that it will need to explore further opportunities for virtual meetings in order that they can again be made accessible to the public. However, it will also use this opportunity to consider the wider benefits of holding meetings virtually in the future in terms of increased levels of public engagement in CCG decision making and reductions in carbon emissions and costs.

- The Governing Body also recognises the importance of it continuing to ensure that CCG staff and staff at providers' organisations are supported in terms of their well-being and development during what has and will continue to be a period of significant challenge and change.

Work of the Governing Body committees

➢ **Quality Finance and Performance Committee (QFPC)**

The CCG's Quality Committee and Finance and Performance Committee merged during 2019/20 to form the Quality Finance and Performance Committee. The new Committee met for the first time on 19 December 2019 continuing the work of the previous committees under its approved Terms of Reference.

The role of the Quality, Finance and Performance Committee is to support the Governing Body by providing assurance that:

- Effective quality arrangements underpin all services provided and commissioned by the CCG, including general practice;
- Statutory and regulatory requirements are met;
- Patient safety is continually improved to deliver a better patient experience
- And by advising and supporting the Governing Body in scrutinising and monitoring the delivery of key financial and service priorities, outcomes and targets as set out in the CCG's strategic and operational plans.

QFPC Highlights

- Approved four service specifications including those for the Open Minds Partnership THRIVE; the Older Adults' Mental Health Intensive Support Service; the Mental Health Community Rehabilitation Service and the General Practice Access Scheme for Additional Urgent/on the day Appointments.
- Continued to seek and receive assurance in relation to the quality of services we commission.
- Worked with partners to achieve a further improvement of the Delayed Transfer of Care (DTOC) position in Calderdale, which currently ranks as one of the strongest nationally.
- Strengthened the reporting and assurance processes in relation to the delivery of Cancer standards.

Commissioning Primary Medical Services Committee

The Commissioning Primary Medical Services Committee (CPMSC) has responsibility for the management of the functions and powers delegated to the CCG by NHS England. The Committee makes decisions on the review, planning and procurement of primary medical care services in Calderdale. In order to support this, the Committee receives regular financial reports on the delegated and non-delegated budgets; as part of the primary care assurance report and tool, and on work supporting the delivery of the General Practice Forward View and the CCG's strategic intent for primary care. The Committee continues to make sound decisions whilst ensuring that conflicts of interest are managed appropriately.

Work of the CPMSC: Highlights

- Investment of Primary Medical Services premium funding and monitoring progress throughout the year.
- Use of the Primary Care Assurance Report (PCAR) to consider metrics at a Practice and Locality Level
- Making a decision on the future of two Alternative Provider of Medical Services (APMS) having noted the consultation process undertaken and confirmed their confidence that the impact upon patients had been captured and mitigations recognised in the recommendations. The Committee approved a separate solution for patients in the Upper Calder Valley to enable the continued provision of primary care in Todmorden for a further two years and endorsed the agreed recommendation for the locally managed allocation of patients registered at the Park, Ovendon, Elland and Sowerby Bridge sites.
- Implementation of the Improved Access Service delivery model.
- Approval of the procedure for the management decision of appeals following referral to the Special Allocations Scheme.
- It also agreed the process for the establishment of Primary Care Networks, approving their establishment and agreeing a spending plan to support their development and improve training and retention.
- Approved two practice merger applications and one incorporation.
- Reviewed and supported applications to reduce a practice boundary.

Remuneration and Nomination Committee

The Remuneration and Nomination Committee has responsibility for making recommendations to the Governing Body on the remuneration of the Governing Body, Very Senior Managers and Associates, whilst ensuring the robust management of conflicts of interest. It also functions to ensure the Governing Body and its committees have the appropriate balance of skills, knowledge, experience and independence among their members to enable them to discharge their duties and responsibilities. The Governing Body has also delegated authority to the committee for reviewing and approving Human Resources Policies.

Work of the Remuneration Committee: Highlights

- The annual review of Non-Agenda for Change pay awards for VSM's, Governing Body and Associates, managing conflicts of interest appropriately and making recommendations to the Governing Body.
- Made recommendations to Governing Body concerning the membership of the newly formed Quality, Finance and Performance Committee.
- Oversaw the process of recruiting a new Audit Lay Member, Patient and Public Engagement Lay Member and Lay Advisor to the Governing Body.
- Oversaw and made recommendations to the Governing Body on changes to Governing Body positions and committee memberships for 2020/21 and Governing Body Member tenures.

Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, information and compliance with finance laws, regulations and directions to the CCG. The committee also scrutinises the CCG's risk management arrangements, systems of internal control, emergency preparedness and business continuity, counter fraud, local security management and the management of conflicts of interest.

Work of the Audit Committee: Highlights

Sought and received assurance on:

- the progress towards achieving compliance with the Data Security and Protection Toolkit.
- the systems of internal control in place, as part of the internal audit programme of work.
- the Annual Report and Financial Statements 2018/19 approving these on behalf of the Governing Body

Auditor Panel
The Auditor Panel is established by the CCG in accordance with requirements set out in the Local Audit and Accountability Act 2014. The Panel is a sub-committee of the Audit Committee and made up of a selection of its members. Its key role is to advise the Governing Body on the selection and appointment of an external auditor service for the CCG.

Work of the Auditor Panel

The Panel was convened in February 2020 to oversee a procurement exercise for an external audit service for the CCG as the current contract of service was due to expire. The Panel agreed that the NHS Shared Business Services Framework would be used for this purpose. The Panel reconvened on 14th May 2020 to consider the outcomes of the procurement exercise and, having assured itself that a robust process had taken place in line with the organisation's normal procurement rules, determined an award of contact under delegated authority from the CCG's Governing Body.

West Yorkshire and Harrogate (WY&H) Joint Committee of CCGs
The Joint Committee is part of the West Yorkshire and Harrogate (WY&H) Health and Care Partnership. The Committee enables the WY&H Clinical Commissioning Groups to work together effectively – making sure that when it makes sense, work is done once and is then shared across WY&H. The Committee has delegated authority from the CCGs to take collective decisions on agreed priorities. As well as taking formal decisions, the Committee also makes recommendations to the CCGs when a joint approach will help to achieve better outcomes.

The Committee is made up of two representatives from each of the WY&H CCGs – usually the Clinical Chair and the Accountable Officer. To make sure that decision making is open and transparent; the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the Partnership team and NHS England also attend.

The terms of reference for the WY&H Joint Committee of CCGs can be found on the CCG's website: https://www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs

Work of the Joint Committee: Highlights

- Agreed commissioning policies which improve equity in access to services, help reduce health inequalities and tackle the 'postcode lottery':
- Agreed a pathway to address high demand and variation in musculoskeletal (MSK) services across WY&H. The pathway aims to ensure that all but the most urgent MSK cases are managed in primary care or through referral to an MSK service.
- Agreed WY&H policies covering surgical and non-surgical procedures for a range of conditions relating to shoulder pain and instability, knee pain and hip problems. Evidence-based clinical thresholds mean that surgical procedures are carried out only when they are clinically effective, and where alternative non-surgical options have been ineffective.
- Agreed a WY&H-wide pathway and policy for cataract surgery, including proposals to make better use of community optometrists. Making better use of community optometrists will release specialist capacity in hospitals to see higher risk patients with potentially sight-threatening conditions.
- Agreed a WY&H commissioning policy for flash glucose monitors. These are small sensors worn on the skin for monitoring the glucose levels of people with diabetes, and reduce the need for 'finger prick' testing.
- Agreed the recommendations of the NHS England and NHS Improvement Medicines Value Programme. The Committee agreed that primary care prescribers should not initiate and in many cases should de-prescribe items, mainly relating to skin and cardiac conditions.
- To support Phase 2 of the WY&H Healthy Hearts project, the Committee approved simplified guidance for treating people with high cholesterol. By the end of January 2020, the project had seen an increase of nearly 8,000 patients with controlled blood pressure and more than 7,500 patients had been added to hypertension registers. Over the next five years these interventions have the potential to prevent 65 deaths, 82 heart attacks and 122 strokes.
- In December 2018, the Committee approved a new approach to Integrated Urgent Care services. A progress report showed that the changes had increased access to clinical advice for patients and had also increased the ability for patients to book face to face appointments in primary care.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, as the UK Code is based on the underlying principles of good governance (accountability, transparency, probity and sustainability of the organisation over the longer term) the CCG has ongoing regard for the code and takes the principles relevant to the CCG into account reviewing it systems, processes and governance arrangements.

In 2019/20 we identified one area for development.

Standard 3: Composition, succession and evaluation
This standard contains three principles relating to:

1) The need for a formal, rigorous and transparent recruitment procedure for Governing Body members and effective succession planning – both of which should be based on merit and objective criteria and, within this context, also promote diversity of gender, social and ethnic backgrounds, cognitive and personal strengths;

2) The Governing Body and its committees having the right combination of skills, experience and knowledge;

3) The annual self-assessment which should consider its composition, diversity and how effectively members work together to achieve objectives.

CCG Action:
During 2019/20, the role of the Remuneration Committee was developed to include the functions of a Nomination Committee as recommended by the UK Code with a revised Terms of Reference being approved by the Governing Body in April 2019. This change enabled the Governing Body to take a more systematic and formalised approach to:

- Ensuring that the Governing Body and its committees have the right balance, knowledge, skills and attributes in order to continue to operate effectively within a changing environment;
- Ensuring that the leadership needs of the organisation are kept under review enabling the CCG to continue to deliver its strategic objectives within a changing environment;
- Provide oversight to succession planning for Governing Body members, Very Senior Managers and the Chief Quality and Nursing Officer.

The Committee met on three occasions during the year and developed a workplan in accordance with the requirements of the standards and has completed its first cycle under its wider remit. The delivery of the of committee's workplan in 2020/21 will see the continued development of the committee's arrangements for discharging these responsibilities.

An important aspect of the self-assessments undertaken by the Governing Body and Committees was the focus on the balance of the Governing Body and committee membership, how effectively the committee members were working together and how effectively the values of the organisation were being demonstrated to staff. These reviews informed the development discussions undertaken by the Governing Body leading to changes in the Governing Body's composition and formal governance arrangements during the year. They also contributed to the content of committee development plans for 2020/21.

Discharge of Statutory Functions

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

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

Further information on how the CCG has fulfilled its statutory duties can be found in the Performance Report. This includes compliance with the duty to consult the Health and Wellbeing Board when reviewing the extent to which the CCG has contributed to the delivery of the joint Wellbeing Strategy.

Risk management arrangements and effectiveness

The CCG's Integrated Risk Management Framework (IRMF) describes our approach to managing risk:
https://www.calderdaleccg.nhs.uk/download/integrated-risk-management-framework/

During 2019 a review of the IRMF and the risk cycle took place in light of a wider review of governance arrangements within the CCG. The following changes took place:

- Merger of Quality and Finance & Performance Committees - called the Quality Finance and Performance Committee

- **Frequency of meetings**
  - Governing Body from six to four times per annum
  - Commissioning of Primary Medical Services Committee (CPMSC) from six to four times per annum
  - Quality, Finance and Performance Committee from six to four times per annum
  - Audit Committee from four to three times per annum
  - Remuneration and Nomination Committee two times per annum

- **Frequency of review of risks on the corporate risk register:**
  - Governing Body from six to four times per annum
  - Commissioning of Primary Medical Services Committee (CPMSC) will now review and monitor all risks in respect of CPMSC instead of only risks scoring 15 or above.
  - Quality, Finance and Performance Committee from six to four times per annum
  - Senior Management Team (SMT) from six to four times per annum with serious risks (15 or above) being reported to SMT by exception only outside this quarterly review

The CCG manages and reports on risk in two ways:

- The Governing Body Assurance Framework (GBAF), which focusses on principal risks to the delivery of the CCG's strategic objectives. The GBAF is seen as a 'live' document but is formally reviewed and updated twice per annum. An online GBAF has been developed and went live in August 2019. More detail regarding the Governing Body Assurance Framework is provided in the Internal Control Framework section of this report.

- The Corporate Risk Register focusses on operational risks that may rise and fall within relatively short time periods. The CCG now operates four risk review and reporting cycles per annum.

The process that we use to identify, evaluate and control risks is set out below.

➢ Risk Identification

Table 1: Risk Matrix

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

A risk can only be managed if it is identified. Triangulation of information from different sources provides assurance that all significant risks have been captured. The key sources of information used by the CCG to check completeness of risk capture are:

- Performance indicators reporting variance from plan within commissioning performance contracts and related reports;
- The results of planned reviews of compliance with statutory and regulatory requirements e.g., Care Quality Commission (CQC) standards and reviews, Ofsted reviews, fire and health and safety regulations, information governance systems including the Data Security and Protection Toolkit;
- Routine review of serious incidents and complaints to identify emerging risks, themes or specific concerns;
- Utilisation of intelligence through partners and stakeholders;
- Ensuring contact with regional and national professional associations that provide early warning of serious adverse events;
- Review of the West Yorkshire Community Risk Register;
- Risk review and discussion through operational meetings (Senior Management Team, project or programme management or contract management meetings) and the formal governance arrangements, i.e. Governing Body and its Committees, which highlight risks that need to be reflected in the Risk Register, assessing the mitigating/management actions and risk rating.

Risk assessment and risk rating
A 5x5 (Likelihood x Impact) matrix is used to arrive at the risk rating. The target score is identified by assessing the additional controls that can be put in place together with level at which the risk can be accepted (risk tolerance) - taking into account the CCG's risk appetite.

Risk Recording, Reviewing and Monitoring
The CCG has an integrated approach to risk, supported by the on-line risk register. This system consists of an auditable review process and supports the monitoring and updating of risks within review deadlines.

Once every risk cycle, the Senior Management Team (SMT) reviews all the risks on the register, identifies any new risks; assesses the actions to manage/mitigate the risk and the risk rating. Any risks (15 or above) are reported to SMT by exception only outside this quarterly review. The Quality, Finance and Performance Committee reviews those risks relating to their remit. Risks rated as 'Serious' i.e. at 15 or above are submitted to each of the Governing Body meetings. All Commissioning Primary Medical Services risks are reported into the CPMS Committee. A 'Critical Risk' report, with an associated action plan is produced for risks rated 20 or above.

Risk Appetite
The CCG's aim is to minimise the risk of harm wherever possible to service users, the public, staff, members and other stakeholders. However, the CCG also recognises the need to take considered risks in some areas (for example, transformation / re-design of services) and that an overly risk averse approach can be a threat to the achievement of some strategic objectives.

All risks on the CCG Risk Register specify the target risk rating (i.e. the level at which the risk can be tolerated). The acceptability of the target risk score is subject to review by the Senior Management Team and relevant Committee as part of the normal review and reporting process for the Risk Register.

The Governing Body has worked over the year to develop its risk appetite taking into account the changing context in which the CCG is operating. This work has resulted in a risk appetite statement and will inform our approach to decision making.

Embedding risk management in the CCG's Activity
Our risk management system is complemented by other control mechanisms which are designed to deliver assurance on the identification, mitigation and/or management of risks. These control systems include our systematic approach to completing impact assessments in equality, quality and data privacy as part of our service improvement processes and recovery plans.

The risk management of potential fraud, bribery and corruption, data security and conflicts of interest are all supported with the appropriate policies, mandatory training, briefings as well as compliance audits. These systems are audited on an annual basis by our internal auditors (Audit Yorkshire), External Audit (KPMG) and NHS Counter Fraud Authority. All these mechanisms, together with the use of the intelligence provided by performance, quality and safety and primary care assurance dashboards as well as partner and stakeholder engagement puts us in a stronger position to prevent/manage risks to the CCG.

Incident reporting
An indicator of good staff and patient safety management is the incident reporting culture. One of the key complementary systems is the CCG's incident reporting system.

The CCG uses the DATIX online reporting system and encourages all staff to report incidents or near misses in order to provide learning and enable the CCG to reduce the likelihood of the incident re-occurring. Feedback on the learning is provided to staff in an anonymised form through the CCG's communication channels including the monthly staff workshop where appropriate.

GP Practices are actively encouraged to report all incidents on DATIX. The more incidents that are reported the more information the CCG has to act upon in order to learn from incidents and consequently prevent recurrence. A quarterly GP incident report is provided to the Quality, Finance and Performance Committee for review and identification of themes. More detailed data is provided on those themes relating to patient safety and medication incidents.

Involving partners and other stakeholders
The CCG has close working relationships with a number of stakeholders and has a strategic risk management objective to develop risk management arrangements for key partnerships and for major programmes of work.

The CCG has adopted a programme management approach for all major transformation activities. Risk and issues logs are produced for all programmes and are reported to the relevant Programme Board and through to the corporate risk register as required.

The key partnerships for the CCG include a number of NHS providers, Pennine GP Alliance, Calderdale Council and the third sector, voluntary and community groups, patient and service user groups. In addition to having robust internal scrutiny arrangements, partnership organisations are required to contribute to relevant joint programme / project risk registers and frameworks.

The CCG endeavours to manage risk across organisational boundaries and involve partners in aspects of risk management as appropriate to support the delivery of system-wide objectives.

This is achieved by the following:

- Maintaining a corporate record of the key partnerships for the organisation.
- Prioritised implementation of programme / project risk registers for those areas categorised as high risk. The Risk Registers are reviewed through appropriate opinion
- and external governance frameworks.

Risks relating to the provision of commissioning support services are managed through contract management meetings.

Capacity to Handle Risk
The CCG has a robust and systematic approach to risk management. Leadership is provided by the Governing Body and Accountable Officer to ensure that the CCG has a positive and open approach to the identification and management of risk. The Integrated Risk Management Framework (IRMF) sets out the governance structures and responsibilities for risk management:

Effectiveness of Governance Structures
The Governing Body receives assurance on the effectiveness of the governance and risk management structures, systems and processes through its internal assurance processes:

The Governing Body is responsible for approving the Governing Body Assurance Framework (GBAF) and for receiving reports on 'serious' risks (i.e. those rated 15 or above) at each of its formal meetings as well as a separate report on 'Critical' risks (i.e. those risks rated 20 or above). The Commissioning Primary Medical Services Committee receives reports on all its risks at each of its meetings in public and an update on all relevant risks on a six monthly basis.

Responsibilities of the Senior Management Team and Committees
The roles and responsibilities of staff as risk owners, and Senior Management Team as reviewers are clearly set out in the IRMF. This ensures that there is clarity about the levels of accountability for the management and monitoring of risks. The Senior Management Team ensures that there are robust control measures in place and that the appropriate assurances are generated. This risk review process includes an assessment as to whether the risk should be incorporated into the GBAF or the corporate risk register – depending upon the strategic or operational nature of the risk.

Reporting lines and accountabilities between the Governing Body, its Committees and the Senior Management Team

The Senior Management Team undertakes the first formal review of all risks at the beginning of each reporting cycle and identifies any new risks or changes to risk score as they arise.

This is followed by a review in the Quality, Finance and Performance Committee. The committee has clear responsibility for the monitoring of existing risks and identification of further risks as set out in their terms of reference. The same approach is used for the GBAF, with senior managers and Governing Body leads reviewing the principal risks prior to review by this Committee and Governing Body.

The Audit Committee has the responsibility for providing assurance to the Governing Body on the effectiveness of the CCG's governance and risk management systems and processes.

It is supported in fulfilling its responsibilities by our internal audit providers (Audit Yorkshire) who report on the findings of the annual mandated audit of governance and risk management.

Timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's statutory obligations

The assessment of risks is a continuous process informed by:

- Senior Management Team identifying new risks or changes to risk profile;
- Financial, contracting, recovery, performance, quality and safety reports, which are submitted to the Quality, Finance and Performance Committee;
- Finance, contracting and primary care assurance reports submitted to each Commissioning Primary Medical Services Committee meeting in public.
- Scrutiny of the Risk Register and the Governing Body Assurance Framework at the Committees and Governing Body

Degree and rigour of oversight of CCG performance by the Governing Body

The Governing Body provides challenge and scrutiny of the suite of performance reports referred to above. These reports focus on the delivery of the key performance targets, quality and safety, financial and contractual requirements.

This level of oversight, which has been supported by the detailed work of the Committees, enables the Governing Body to maintain a clear grip on our performance, quality and financial targets.

Staff and Governing Body training

All risk owners, senior reviewers and Heads of Service are trained and equipped to manage risks in a way that is appropriate to their authority and duties. Bespoke training is provided to individuals and teams as required.

The Governing Body continues to assess its risk appetite in response to the ongoing shifts in our operating environment.

Learning from good practice

Our CCG is committed to the principles of creating a positive learning environment which is open and honest and which seeks to improve our systems and processes - keeping local people and staff safe. Whilst we work hard to put systems and processes in place that prevent incidents, we recognise that on occasion things go wrong. When that happens we want to learn from those incidents, improving the way that we do things. We also seek to learn from good practice elsewhere. Valuable learning information is provided to staff and our member practices through a variety of systems and activities:

- Incident and post incident reporting;
- Complaints received;
- Issues raised via Patient And Liaison Services (PALS);
- Feedback from Independent Contractors and their associated bodies.

Risk Assessment

Risk assessments in relation to governance, risk management and internal control are carried out through a number of mechanisms including:

- Through **internal governance arrangements** taking account of self-assessment activity, the review of the CCG Constitution and standing financial instructions, new national guidance or regulations and the findings from external inquiries;
- Through the **annual internal audit** and **anti-crime** audit plans carried out by Audit Yorkshire. These include the annual mandated reviews of the CCG's risk management and governance arrangements as well as audits in specified areas as identified following a risk assessment of all areas of the CCG's activities;
- Audit Yorkshire also attends the Audit Committee and meets with the Audit Committee members twice a year to discuss any concerns without the officers being present;
- Through **external audit** activity carried out by KPMG which includes attendance at the Audit Committee, meeting with Audit Committee members twice a year to discuss any concerns without the officers being present and focused pieces of external audit work as set out in the auditors annual work plan, culminating in the risk review undertaken prior to annual reporting and accounts.

The outputs and recommendations from each of these reviews are presented to the Audit Committee.

Major Risks to Governance, Risk Management and Internal Control

The risks classed as 'serious' 'major' or above on the Corporate Risk Register, (i.e. those with a score of 15 or above), that have been managed during the reporting year are summarised in Appendix 2 of this Governance Statement.

The CCG continues to take a rigorous approach to the management of the risks across the system. The pressures on the system and progress being made in managing or reducing those pressures are discussed at the weekly Senior Management Team (SMT) meetings, the financial recovery meetings and work taken forward through the different teams within the organisation including primary care, service improvement, continuing health care, quality, finance, corporate and contracting. The pressures, together with the actions being taken to address these whilst staying true to the values of the CCG in providing high quality, effective and safe care, are discussed on a regular basis with staff, the Governing Body and the member practices through the Practice Commissioning Leads' meetings.

The Quality Finance and Performance Committee maintains a robust oversight on the relevant risks through regular finance, performance and contract, quality and safety, primary medical commissioning reports and the review of the risk register.

The CCG is also proactive in working with partners across the system to discuss and find effective solutions to the pressures. The mechanisms for these performance management discussions include the Accident & Emergency Delivery Board, The Partnership Board, the System Recovery Group and Contract Management meetings.

Other sources of assurance

Internal Control Framework

The system of internal control is the set of processes and procedures in place that ensures that the CCG 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 potential impact, 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.

Governing Body Assurance Framework (GBAF)
The GBAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the CCG. The GBAF deals with strategic and long term risks / threats whereas the Risk Register is used to identify and manage performance based (operational) risks that may rise and fall within relatively short term periods. A summary of the principal risks to the CCG's licence and delivery of its strategic objectives is set out in appendix 3 to this governance statement.

The GBAF makes reference to relevant operational risks if they relate to the ability of the organisation to deliver on one or more of its strategic objectives.

All risks on the GBAF have a named Senior Manager Lead, Governing Body Lead and responsible Committee. The GBAF also details:

- The key controls in place to manage the risk;
- Mechanisms to provide assurance on controls (i.e. specific evidence that controls are effective and the risk is being managed);
- Any actions being taken to address gaps or the need to strengthen controls or assurance.

The GBAF is considered by the relevant Governing Body Committees twice a year prior to submission to the Governing Body for approval. This enables a detailed review of the strategic objectives, to ensure that these sufficiently reflect, for example, the increasing focus of our work with partners on the Health and Wellbeing Board to deliver the Single Plan for Calderdale, work with the West Yorkshire and Harrogate Health and Care Partnership and system financial recovery. An online GBAF was developed during 2019 and launched in August.

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

We have received an overall internal audit opinion of **'high assurance'** about the systems and processes in place to manage conflicts of interest.

Data Quality
The Data Quality Team is responsible for developing and improving quality, consistency and assurance in relation to primary care records and their management. We ensure the implementation of consistent approaches to data recording including the use of templates and structured data sets. The team supports

the information requirements of clinicians and commissioners, supporting quality, consistency and assurance through summarising and SNOMED coding training.

The responsibility of the CCG to improve the quality of physical healthcare for people with Severe Mental Illness (SMI) is one important part of a broader commitment across STPs to reduce premature mortality and address health inequalities. To this end we have been working closely with Calderdale clinicians to produce an SMI data entry template in conjunction with South and West Yorkshire Partnership NHS Foundation Trust. This template has been adopted by the Trust enabling standardised data entry and sharing of information across agencies. It is key to reporting and monitoring the success of clinical interventions and their effectiveness.

As well as working with the four local CCGs and their member practices we also work closely with West Yorkshire Research and Development and the West Yorkshire and Harrogate Healthy Hearts Project developing GP reports, resources and data extracts for these projects.

The team has supported the CCG project teams with the roll out of EPS4 across all SystmOne practices in all four CCGs. We have also provided advice and support to the GP practices involved in the two practice mergers and practice closures in Calderdale.

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 the Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect personal and corporate information We have undertaken the work to support the DSPT submission, however, in light of events of the COVID 19 response, we made the decision to delay the submission of our final assessment following a notification from NHS Digital that the deadline date for submissions has been extended to 30 September 2020.

We have an information governance management framework in place and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have a robust annual Information Governance work programme and work to ensure that all staff and Governing Body members complete the Data Security Awareness training. The information governance handbook is available to all staff so that they are aware of their information

governance roles and responsibilities. All staff are required to complete Data Security Awareness training annually and this is monitored by the Senior Management Team and Audit Committee. As referred to earlier in this report, there are processes in place for incident reporting and investigation of serious incidents. We have information risk assessment and management processes in place to fully embed the information risk culture throughout the organisation against identified risks. Assurance is provided through the Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving personal data security) on a routine basis, together with any learning points.

Business Critical Models
In line with best practice recommendations of the 2013 Macpherson review into the Quality Assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances
See 'Review of the effectiveness of governance, risk management & internal control' section.

Control Issues
During the year no significant internal control issues or gaps in control have been raised.

Review of economy, efficiency & effectiveness of the use of resources

The Chief Finance Officer/Deputy Chief Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Governing Body receives regular reports from the Quality Finance and Performance Committee regarding finance, contracting, performance and system recovery. In order to provide the necessary level of rigour and governance in support of the CCG's financial plan, an update is also submitted to the Quality Finance and Performance Committee.

These processes, taken together with the opinions available from the work of the CCG's internal and external auditors and the assurances from the Audit Committee, enable the Governing Body to make a determination on the economic, efficient and effective use of resources by the Clinical Commissioning Group.

Further information on our financial planning, in-year performance monitoring, central management costs and efficiency controls is included in the Performance Report. We maintain efficiency controls through our recovery and resilience processes and through the role of the Quality Finance and Performance Committee.

Calderdale CCG had a rating of **GREEN** for the Quality of Leadership indicator CCG Improvement and Assessment Framework (IAF) for 2018-19. The IAF has been replaced by the NHS Oversight Framework from 2019/20 and the CCG's rating for this indicator in the framework will be published when available.

Delegation of functions

The CCG has delegated some of its functions to the West Yorkshire and Harrogate Joint Committee of CCGs. The extent of the delegated authority and responsibilities are set out in the Memorandum of Understanding and Terms of Reference. The Chair and Interim Accountable Officer represent Calderdale CCG on that committee.

The minutes and reports of key decisions taken by the committee and its annual report are received by the Governing Body for scrutiny and assurance. The CCG's Interim Accountable Officer and Chair report back to the Governing Body on these at each public meeting. No issues of concern were identified from this feedback in-year. Further information on the role of the joint committee and highlights of its work during 2019-20 can be found on pages 62 and 63 above.

Counter fraud arrangements

The CCG's counter fraud arrangements are compliant with NHS Counter Fraud Authorities' Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the engagement of a qualified Local Counter Fraud Specialist (LCFS) from Audit Yorkshire under a formal Service Level Agreement, (the current LCFS was nominated, trained and approved by NHS Protect and accredited by the Counter Fraud Professional Board in 2016); and the implementation of a CCG wide countering fraud and corruption policy.

All fraud matters are overseen by the Chief Finance Officer/Deputy Chief Officer as Executive Lead and a member of the Governing Body.

Anti-Crime work is based on an annual risk assessment which identifies fraud risk areas for the CCG using local and national fraud intelligence. Risks areas are included within the annual Anti-Crime work plan. An annual work plan together with the annual report of fraud, bribery and corruption work is submitted to the Audit Committee for approval.

The LCFS reports on the progress of counter fraud work to the Chief Finance Officer/Deputy Chief Officer and the Audit Committee.

The annual assessment (self-review tool – SRT) of the CCG's compliance with the NHS CFA's Standards for Commissioners: Fraud, Bribery and Corruption was completed by the LCFS and approved by the Chief Finance Officer/Deputy Chief Officer. The self-review tool demonstrates compliance with the NHS Standards for

Commissioners. The reports comply with NHSCFA guidelines and provide a summary of the year's activity matched against the standards.

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. See Appendix 4: Head of Internal Audit Opinion.

The Head of Internal Audit concluded that:

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

During the year Internal Audit issued the following audit reports:

Audit Area	Assurance Level
Primary Care Co-Commissioning	High
Collaboration	High
Governance and Risk Management	High
Safeguarding	High
Data Security and Protection Toolkit: Stage Two	High
Conflicts of Interest	High
Core Financial Systems	Significant
QIPP	Significant
Data Security and Protection Toolkit: Stage One	N/A – Advisory Report
Continuing Healthcare (Controls Improvement Audit)	N/A – Advisory Report

During the year the Internal Audit issued no audit reports which identified governance, risk management and/or control issues which were significant to the CCG.

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed. I have been advised on the implications of the results of this review by:

- The **Governing Body** which keeps under review the systems of internal control through reports on risk management and the review of the Governing Body Assurance Framework (GBAF). It also receives performance, contracting, finance, quality and safety reports at each of its meetings in public. The GBAF is formally reviewed by the Governing Body twice a year and was last approved as a fair reflection of the principal risks to achieving our strategic objectives, in October 2018. The GBAF provides me with evidence that the effectiveness of controls that manage principal risks to the CCG achieving its strategic objectives have been reviewed.

- The **Audit Committee** which has oversight of the CCG's financial systems, financial information, risk management and systems of internal control, audit, information governance and business continuity. It is supported in its role by independent audit reports produced by Audit Yorkshire and regular meetings with the internal and external auditors.

- The **Quality Finance & Performance Commissioning Primary Medical Services Committees** which are responsible for keeping under review the governance arrangements relating to their remit. This includes review of all relevant operational risks and review of the principal risks as set out in the GBAF.

- The **external and internal auditors** provide independent assurance through the delivery of their annual work plans, as well as recommendations for further development of the system of internal control.

- **Self-assessment** of the risk management system and Committee governance arrangements is undertaken on an annual basis. An external review of different aspects of our governance arrangements is commissioned every three years.

- **Third Party Assurance.** Together with the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as NHS Shared Business Services, Primary Care Support England (Primary Medical Services Payments), EmBED Commissioning Support (Business Intelligence Services) and Leeds Community NHS Foundation Trust (provider of payroll services). At the time of writing no significant issues have been reported.

No significant internal control issues have been identified.

Appendix 1

CCG Governing Body and Committee Membership and Attendance

The below provides the composition of the Governing Body and its committees throughout the financial year and up to the signing of the ARA on 23 June 2020 and attendance for 2019/20 financial year.

Governing Body		
Member	**Role**	**Attendance**
Dr Steven Cleasby	Chair and GP Member	5/5
Dr Majid Azeb	Clinical Vice Chair and GP Member (Until 31 March 2020)	5/5
Dr Matt Walsh	Chief Officer (Accountable Officer until 15th April 2020)	4/5
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer (Interim Accountable Officer from 16th April 2020)	5/5
Lesley Stokey	Interim Chief Finance Officer (from 16th April 2020)	0/0
Penny Woodhead	Chief Quality & Nursing Officer	4/5
David Longstaff	Lay Member (Audit) and Deputy Chair *(Until 31 December 2019 but remaining on the Governing Body until 28 February 2020 as non-voting member)*	4/5
John Mallalieu	Lay Member (Finance and Performance) (Deputy CCG Chair in principle from 23 January 2020 - awaiting approval of constitutional variation from NHS England before formal confirmation)	4/5
Dr Rob Atkinson	Secondary Care Specialist	5/5
Dr Helen Davies	GP Member (Until 31 March 2020)	4/5
Dr James Gray	GP Member	5/5
Dr Farrukh Javid	GP Member	4/5
Alison Macdonald	Lay Member (Patient and Public Involvement) (from 1 December 2019)	1/1
Prof. Rob McSherry	Registered Nurse	4/5
Prof. Peter Roberts	Lay Member (Audit) (From 1 December 2019)	1/1
Dr Nigel Taylor	GP Member (Until 30th June 2019)	2/2
Dr Caroline Taylor	GP Member	5/5
Advisors to the Governing Body		
Denise Cheng-Carter	Lay Advisor (from 1 December 2019)	1/1
Paul Butcher	Director of Public Health (Calderdale Council) (Until 31 March 2020)	4/5
Debra Harkins	Director of Public Health (Calderdale Council) (from 1st April 2020)	0/0
Ian Baines	Director of Adults and Wellbeing (Calderdale Council)	2/5

Finance and Performance Committee (Last Meeting - 26 September 2019)		
Member	**Role**	**Attendance**
Dr Nigel Taylor	Committee Chair and GP Member (Until 30th June 2019)	3/5
Dr Matt Walsh	Chief Officer (Accountable Officer) and Vice Chair of the Committee	5/6
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	4/6
John Mallalieu	Lay Member (Finance and Performance)	6/6
Dr Farrukh Javid	GP Member	5/6

Quality Committee (Last Meeting – 25 July 2019)		
Member	**Role**	**Attendance**
Dr Majid Azeb	Committee Chair and GP Member	5/5
Dr Caroline Taylor	GP Member and Vice Chair of the Committee	4/5
John Mallalieu	Lay Member (Finance and Performance) deputised for Lay Member (Patient and Public Involvement) due to vacancy	5/5
Penny Woodhead	Chief Quality & Nursing Officer	5/5
Dr Helen Davies	GP Member (Deputised for GP Member)	1/1

Quality, Finance and Performance Committee (First meeting- 19 December 2019)		
Member	**Role**	**Attendance**
Dr Majid Azeb	Committee Chair and GP Member (Until 31 March 2020)	1/2
Dr Matt Walsh	Chief Officer (Accountable Officer)	0/2
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	2/2
Penny Woodhead	Chief Quality and Nursing Officer	2/2
John Mallalieu	Lay Member (Finance and Performance) (Vice Chair of the Committee from 1 April 2020)	2/2
Dr Caroline Taylor	GP Member	2/2
Dr Farrukh Javid	GP Member (Deputised for GP member) (Member and Chair from 1 April 2020)	1/1
Alison Macdonald	Lay Member (PPI) (from 1 December 2019)	2/2
Prof. Rob McSherry	Registered Nurse (from 17 December 2020)	2/2

Commissioning Primary Medical Services Committee		
Member	**Role**	**Attendance**
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	7/7
Alison Macdonald	Committee Vice Chair and Lay Member (Patient and Public Engagement) (from 1st December 2019)	0/0
Dr Matt Walsh	Chief Officer (Accountable Officer)	4/7
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	7/7
Dr Steven Cleasby	GP Member	5/7*
Dr Helen Davies	GP Member	3/7*
Dr James Gray	GP Member (Deputised for GP Member)	1/1
Dr Rob Atkinson	Secondary Care Specialist	3/3
Prof. Rob McSherry	Registered Nurse (Designated Deputy to the Secondary Care Specialist)	4/7

* Attendance not required at two meeting during the year due to Conflicts of Interest

Audit Committee		
Member	**Role**	**Attendance**
David Longstaff	Lay Member (Audit) (Until 31 December 2019)	2/2
Prof. Peter Roberts	Lay Member (Audit) (From 1 December 2019)	1/1
Denise Cheng-Carter	Lay Advisor (from 1st December 2019)	1/1
Dr Farrukh Javid	GP Member	3/3
Alison Macdonald	Lay Member (Patient and Public Involvement) (from 1st December 2019)	1/1
John Mallalieu	Lay Member (Finance and Performance)	3/3
Prof. Rob McSherry	Registered Nurse	3/3

Attendance at the Remuneration and Nomination Committee can be found in the Remuneration Report on page 95.

West Yorkshire and Harrogate Joint Committee of CCGs		
Calderdale CCG Member	**Role**	**Attendance**
Dr Steven Cleasby	Governing Body Chair	4/4
Matt Walsh	Chief Officer (Accountable Officer)	3/4
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	1/1

GOVERNANCE STATEMENT – APPENDIX 2: SUMMARY OF MAJOR RISKS TO CCG'S GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

Risk no	Risk summary	Action to manage risk	Means to assess outcomes
In year major risks that have a reduced risk rating at the end of March 2020			
1338 (reduced from 16 to 12)	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 24 months) b) integrated THRIVE approach (a way of working with children and young people that supports optimal social and emotional development) not fully developed across the system to support those 'at risk' and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	- A CYPs Health System Leaders' Group has been convened following the Action on Autism Summit. The first meeting is scheduled for 24 May 2019. -Waiting list initiative in place to bring the waiting list to 12 months by Jan/Feb 2020. - Media and communications being provided externally - Report to Safeguarding Steering Group to provide assurance on the next steps - Additional funding identified by CCG and CMBC to manage the increased backlog. CCG working with existing providers to develop a plan and agree proposal	- A CYP Health System Leaders' has been implemented following the system leaders' summit - A waiting list trajectory for ASD has been implemented and is being monitored by the Open Minds Data and Monitoring Group. - Implementation of a screening tool - Training packages have been commissioned from Unique Ways to support, train and raise awareness with education, parents/carers around supporting/managing CYP with autism - A therapeutic practitioner has been commissioned to support CYP and their families who are currently on the waiting list for an assessment to diagnose for ASD and to provide support/advice to those who are not diagnosed

1316 (reduced from 16 to 12)	The CCG fails to manage running cost spend within the ring fenced allocation of £4.6m which means we will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG. There are a number of risks within the principal risk which contribute to the overall score which include the increased risk of annual pay award. The CCG has a target to reduce running costs by 20% in real terms by 2020/21.	- The CCG has set a target to underspend by £0.6m in 2019/20 in preparation for the reduction in 2020/21 and included within annual budget approved by Governing Body in April 2019. - Plan presented to Finance & Performance Committee demonstrating challenge and the key actions these include - Vacancy control process in place - authorisation required by Senior Management Team for any changes. - Budgetary control processes in place, budget holders nominated. - Full budget review process instigated with Chief Financial Officer's budget holder meetings to assess risks and savings for 2019/20 onwards.	- Monthly financial reporting systems. - Internal Audit reviews on financial systems and processes. - Regular budget holder meetings to review running cost budgets - Discussion of risk and position in monthly Finance and Performance paper.

1292 (reduced from 16 to xxx)	The APMS (Alternative Provider Medical Services) contracts which are due to expire on the 30th September 2019 may not be extended due to affordability and provider willingness which may result in the need to find alternative service provision for the registered patients of each of the practices.	- Negotiations with current providers be led by the Head of Contracting and Procurement - Paper to Commissioning of Primary Medical Services Committee (CPMSC) meeting in March 2019 about provider proposals and affordability - Paper to CPMSC in May 2019 regarding further proposals and pre-consultation engagement	Private committee paper - 7th March 2019 Private Committee paper - 2nd May 2019 Private update to CPMSC - July 2019
202 (reduced from 15 to 12)	The West Yorkshire Urgent Care (WYUC) service does not meet the service standards set out within the contract and financial settlement for 2019/20 due to increased demand and the inability of the services to meet that demand. Therefore creating additional pressures on other urgent care services, and providing an unacceptable level of service provision for patients.	- Robust WYUC Contract and Quality Governance arrangements in place where regular monitoring of the service takes place. - Daily routine SITREP reports received and where required escalation process in place (and teleconferences, where required) where WYUC performance is reviewed. - High level local involvement from Greater Huddersfield CCG as Lead Commissioner - Greater Huddersfield CCG	- Contract Management Board receive regular updates - led by Greater Huddersfield CCG - Sub-Regional WYUC contract management and clinical governance arrangements in place. - Local contingency plan held by the A&E Delivery Board for times of increased pressure e.g. bank holidays - Escalation in relation to service through Greater Huddersfield & Calderdale CCG on-call arrangements

		hosting contract management on behalf of the West Yorkshire CCGs. - Contract performance reviewed at Finance and Performance Committee; quality performance reviewed by Quality & Safety	then to NHS England
Major risks that closed in 2019-20			
1292	The APMS (Alternative Provider Medical Services) contracts which are due to expire on the 30th September 2019 may not be extended due to affordability and provider willingness which may result in the need to find alternative service provision for the registered patients of each of the practices.	- Negotiations with current providers be led by the Head of Contracting and Procurement - Paper to Commissioning of Primary Medical Services Committee (CPMSC) meeting in March 2019 about provider proposals and affordability - Paper to CPMSC in May 2019 regarding further proposals and pre-consultation engagement	Private committee paper - 7th March 2019 Private Committee paper - 2nd May 2019 Private update to CPMSC - July 2019

Governance Statement Appendix 3

Governing Body Assurance Framework: principal risks to the achievement of the strategic objectives and compliance with the CCG's licence and actions identified to mitigate these risks in 2020-21

Strategic Objective		Summary of Principal Risks	Mitigation
1.	**Achieving the agreed strategic direction for Calderdale**	We do not deliver our strategic outcomes because we have not integrated our commissioning activities with Calderdale Council.	▪ Chief Officer, Chair and Assistant Clinical Chair members of the Health and Wellbeing Board supporting effective partnership working. ▪ Single Plan for Calderdale (SPFC) - a single strategic direction.
		We do not deliver our strategic outcomes because we have not tackled the wider determinants of health.	▪ Partnership working via Calderdale Council senior staff including Directors of Public Health and Adult Health and Social Care. ▪ SPFC provides single strategic direction for Calderdale Council and CCG.
		We do not deliver our strategic outcomes because we have not implemented new models of primary care and community services	▪ Wellbeing Strategy sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. ▪ CCG one year operational plan sets the strategic direction aligned to the Wellbeing Strategy and Calderdale Cares. ▪ Partnership working through the Health and Wellbeing Board to develop an integrated model of primary and community services, physical and mental health.
		We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint.	▪ Work plan agreed by the West Yorkshire & Harrogate Joint Committee and approved by CCG member practices.

		We do not deliver our strategic outcomes because we have not delivered the proposed clinical model of hospital and community services as set out in the response to the Secretary of State in August 2018.	▪ Process developed between CCG and CHFT in regards to managing interim service changes. ▪ We completed consultation on 21st June 2016 on proposed future arrangements for hospital and community health services. ▪ Interim service changes to cardiology, respiratory and frail elderly services have been put in place. ▪ Regular reporting to the Secretary of State for Health & Social Care ▪ Regular reporting through the Clinical Quality Board to Quality Finance and Performance Committee.
		We do not deliver our strategic outcomes because we have not fully developed and optimised system working on enabling functions, such as workforce, estates, digitisation and communications.	▪ **Workforce:** System forum to understand and develop workforce plans to deliver new models of care. ▪ **Estates:** System forum to understand and develop plans to digitise in order to deliver new models of care, recognise one public estate strategy and Calderdale development plans. ▪ **Digitisation:** System forum to understand and develop Estate plans to deliver new models of care. ▪ **Communications:** Clear integrated plans to ensure high quality communications in order to share the CCG narrative with stakeholders and the public.
		We are unable to deliver our strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.	▪ Engagement of practices through the Commissioning Engagement Scheme. ▪ Practice Managers' Action Group inputs to clinical commissioning and shares information with member practices on behalf of the CCG.

2.	Improving Quality	We do not improve patient experience in line with our plans due to a failure to use appropriate patient and public engagement intelligence to support service improvement and plans to change service models	▪ Patient and Public Engagement and Experience Strategy (2013-20) and annual improvement plan (2019-20) in place. ▪ Patient and Public Experience and Engagement Steering Group (including partners) and Patient Experience Group. ▪ Patient and Public Engagement and Experience Group and terms of reference. ▪ Engagement and Equality and Diversity Assurance Process.
		We are unable to commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans – thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire & Harrogate Partnership Plan	
		We do not maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients	▪ Quality outcome standards, quality schedule, patient safety and relevant targets within service specifications ▪ Quality and Safety Dashboard (information at CCG level and by main providers).
		We are unable to provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding arrangements, resulting in harm to children and adults.	▪ Safeguarding policies and procedures in place. ▪ Annual section 11 audits scrutinise provider safeguarding arrangements. ▪ Collaborative working through provider safeguarding committees.

3.	Improving value	We do not deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable.	▪ Annual review of financial controls arrangements by Internal/External audit. ▪ 5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting planned community services, reducing financial risk. ▪ Development of Care Closer to Home model to reduce increasing demand on acute services (CC2H).
4	Improving governance	We don't comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.	▪ Compliance with the provisions of the CCG's Constitution which has been approved by the membership and NHS England. ▪ Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework
		We don't release capacity and enable the development of new integrated commissioning, Primary Care Networks and provider alliance arrangements due to low risk appetite and not having the right CCG Governance form and membership.	▪ Robust governance structure, integrated risk management framework and systems of internal control in place. ▪ Annual Governing Body and committee performance assessment – identifying development needs and action plans.

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

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Roles and Responsibilities

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

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

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

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

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

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

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS.

My opinion is set out as follows:

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

My **overall opinion** is that

- **Significant assurance** is given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

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

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

2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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

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

The design and operation of the Assurance Framework and associated processes.

NHS Calderdale CCG was found to have robust governance and risk management arrangements in place. The Governing Body is collectively responsible and accountable for setting the strategic direction for risk and ensuring that integrated risk management arrangements are in place across the organisation. The Governing Body monitors and reports on its risks through the Corporate Risk Register and Governing Body Assurance Framework.

An Integrated Risk Management Framework (IRMF) has been documented which outlines how the CCG manages the risks and how risks are scored and categorised in line with the defined process. This framework is reviewed and approved by the Governing Body annually.

The Governing Body reviews the Assurance Framework bi-annually, where any gaps in assurances and controls are considered. The Governing Body is well sighted on the risks facing the organisation. A review of the Assurance Framework to review the emphasis on the effectiveness of assurance and controls will be undertaken later in the year at the next Governing Body Development Session.

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

The 2019/20 Internal Audit Plan was approved by the Audit Committee on 16 May 2019. The work of Internal Audit continues to focus on the design and embedding of core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

- Governance
- Information and Performance Management

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- Quality
- Integration and Business Development
- Commissioning and Contract Management
- Financial Assurance

Where variances from the plan have occurred these have been undertaken with the approval of the Chief Financial Officer and the Audit Committee. No departures from the plan that are material for the purposes of this opinion have occurred.

Following the completion of an audit, an audit report is issued and an assurance level awarded. The following assurance levels are used:

Opinion Level	Opinion Definition
HIGH (STRONG)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
SIGNIFICANT (GOOD)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
LIMITED (IMPROVEMENT REQUIRED)	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.
LOW (WEAK)	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives.

An action plan is agreed with management. In order to ensure significant progress is being made in the implementation of agreed actions an Audit Recommendations Status Report is presented to every Audit Committee.

The outcome of the audit reports from the 2019/20 audit plan are summarised below.

Audit Area	Assurance Level
Collaboration	High
Conflicts of Interest	High
Continuing Healthcare	N/A – Control Improvement Audit
Core Financial Systems	Significant
Data Security and Protection Toolkit: Stage One	N/A – Advisory Report
Data Security and Protection Toolkit: Stage Two	High
Governance and Risk Management	High
Primary Care Co-Commissioning	High
Quality Innovation Productivity and Prevention (QIPP)	Significant
Safeguarding	High

Taking into account the Internal Audit work completed, all of my findings and the CCG's actions to date in response to my recommendations to date, I believe that no areas of significant risk exist.

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Looking Ahead

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

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

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

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

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

DRAFT

The Accountability Report – Remuneration and Staff Report

This section of the Annual Report sets out the CCG's remuneration policy for Governing Body and Very Senior Managers, reports on how that policy has been implemented. The report also sets out information about staff numbers and costs, policies, activities, relations and our approaches to engagement.

Remuneration Report

Remuneration and Nomination Committee

The bellow provides the composition of the Remuneration and Nomination Committee throughout the financial year and up to the signing of the ARA on 23 June 2020 and attendance for 2019/20 financial year.

Remuneration and Nomination Committee (As at 23 June 2020)*		
Member	**Role**	**Attendance**
John Mallalieu	Chair of the Committee and Lay Member (Finance and Performance);	3/4*
Alison MacDonald	Vice Chair of the Committee and Lay Member (Patient and Public Engagement) (from 1 December 2020)	1/1
Dr Rob Atkinson	Secondary Care Specialist	3/4
Professor Rob McSherry	Register Nurse (Deputy to Secondary Care Specialist)	1/1
Dr Steven Cleasby	GP Member and Governing Body Chair (Member for Nomination Items Only)	3/4*
Dr Farrukh Javid	GP Member (from 10 October 2019)	3/4

** The committee meeting on 14 October 2020 was a single item agenda concerning a matter of remuneration. The Chair of the Committee was not required to attend due to a conflict of interest. The CCG Chair was not required to attend as they are a committee member for nomination business only.*

The Remuneration and Nomination Committee is supported in its considerations by Human Resources Managers.. The CCG's HR, Learning and Development and OD service is commissioned from the North of England Commissioning Support unit (NESC) which commenced as the CCG provider from the 1 August 2019. Prior to this the Committee the CCG's HR and Learning and Development service was

commissioned from Calderdale and Huddersfield Foundation Trust. Up until the 31 December 2019, the committee was supported by the Head of Corporate Affairs and Governance who has now left the CCG. The committee is now supported by the Chief Finance Officer/Deputy Chief Officer (Interim Accountable Officer from 16th April 2020).

The Governance Statement contains further details about the role and work of the Remuneration Committee in 2019-20.

Policy on the remuneration of senior managers
For the purpose of this report, the senior managers of Calderdale CCG are defined as:

- Very Senior Managers (VSMs), i.e. the Accountable Officer and the Chief Finance Officer/Deputy Chief Officer;
- GPs on the Governing Body – including the Chair of the CCG;
- Registered Nurse and Secondary Care Specialist;
- Lay Members;
- Chief Quality and Nursing Officer.

The post of Chief Quality and Nursing Officer is shared with Greater Huddersfield and North Kirklees CCGs, and the post-holder is engaged by Greater Huddersfield CCG under a contract of employment. The arrangement is governed by a Memorandum of Understanding between the CCGs.

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above, with the exception of the Chief Quality and Nursing Officer, who is engaged under the Agenda for Change framework. There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement. These, together with a review of comparative data across CCGs, any recommended rates of remuneration for Very Senior Managers and legal advice, are used to inform the determinations of the Remuneration Committee.

Hutton Review Fair Pay Principles (2011):

- Remuneration should fairly reward each individual’s contribution to their organisation’s success and should be sufficient to recruit, retain and motivate executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;

- Remuneration must be set through a process that is based on a consistent framework and independent decision making based on accurate assessments of the weight of roles and individuals' performance in them;

- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay are being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay;

- Remuneration must be based on the principle of equal pay for work of equal value.

GP Members of the Governing Body

For GP Governing Body members (including the Chair of the Governing Body) remuneration should be either:

- At a reasonable rate, in line with practice earnings; or
- At a rate commensurate with allowing backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary;
- In line with any local sessional rate.

Registered Nurse and Secondary Care Specialist

For the Registered Nurse and Secondary Care Specialist posts on the Governing Body, remuneration should be:

- If still in NHS employment, at a rate commensurate with their salary or as needed for replacement costs; or at a rate commensurate with the average rate for their profession and level of seniority;
- If retired/not working, at the same rate as lay members;
- If self-employed, in line with earnings.

Lay Members

For Lay Members, remuneration is based on benchmarking with other CCGs.

Remuneration of Very Senior Managers (VSMs)

No senior managers are paid more than £150,000 per annum pro rata. There are two posts which are subject to VSM terms and conditions at Calderdale CCG. These are the Accountable Officer and the Chief Finance Officer/Deputy Chief Officer. In

considering the remuneration for these posts the committee takes account of the following factors:

- Pay guidance provided by NHS England;
- Benchmarking with other CCGs
- Complexity factors;
- Availability of guidance on recruitment and retention premiums;
- Prevailing economic climate and local market conditions;
- Any joint management arrangements;
- Public and internal perception to others in the CCG;
- Performance of the individuals and the CCG.

This approach has been applied for 2019/20 and will also be applied for future years.

Senior manager remuneration (including salary and pension entitlements)

Name & Title	2019/20					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total
Dr.Steven Cleasby, Chair	55-60	0	0	0	0	55-60
Dr.Majid Azeb	40-45	0	0	0	0	40-45
Dr.Nigel Taylor	10-15	0	0	0	0	10-15
Dr.Caroline Taylor	45-50	0	0	0	0	45-50
DR Farrukh Javid	30-35	0	0	0	0	30-35
Helen Davies	45-50	0	0	0	0	45-50
Dr Rob Atkinson, Secondary Care Clinician	15-20	0	0	0	0	15-20
Dr. James Gray	35-40	0	0	0	0	35-40
Rob McSherry, Registered Nurse	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	5-10	0	0	0	0	5-10
Denise Cheng Carter, Lay Advisor	0-5	0	0	0	0	0-5
Peter Roberts, Lay Member	0-5	0	0	0	0	0-5
Alison McDonald, Lay Member	0-5	0	0	0	0	0-5
Penny Woodhead	30-35	0	0	0	22.5-25	55-60
Matt Walsh - Accountable Officer	135-140	0	0	0	0	135-140
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	105-110	0	0	0	30.0 - 32.5	140-145

Note 1: The information in Table 1 above is subject to audit by our external auditors, KPMG

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k; however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 3 David Longstaff left the Governing Body on 29th February 2020

Note 4 Peter Roberts joined the Governing Body on 1st December 2019

Note 5 Denise Cheng Carter joined the Governing Body on 1st December 2019

Note 6 Alison Macdonald joined the Governing Body on 1st December 2019

Note 7 Dr Nigel Taylor left the Governing Body on 30th June 2019

Name & Title	2018/19					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total
Dr.Alan Brook, Chair	5-10	0	0	0	0	5-10
Dr.Steven Cleasby, Chair	65-70	0	0	0	0	65-70
Dr.Majid Azeb	45-50	0	0	0	0	45-50
Dr.Nigel Taylor	45-50	0	0	0	0	45-50
Dr.Caroline Taylor	55-60	0	0	0	0	55-60
DR Farrukh Javid	30-35	0	0	0	0	30-35
Helen Davies	40-45	0	0	0	0	40-45
Dr Rob Atkinson - Secondary Care Clinician	15-20	0	0	0	0	15-20
Dr. James Gray	20-25	0	0	0	0	20-25
Rob McSherry Registered Nurse	5-10	0	0	0	0	5-10
Kate Smyth, Lay Member	5-10	0	0	0	0	5-10
John Mallalieu, Lay Advisor	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	5-10	0	0	0	0	5-10
Penny Woodhead	30-35	0	0	0	20.0 - 22.5	50-55
Matt Walsh - Accountable Officer	135-140	0	0	0	10-12.5	145-150
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	105-110	0	0	0	22.5-25	125-130

Note 1: The information in Table 1 above is subject to audit by our external auditors, KPMG

Note 2: Dr A Brook, was Chair of the Governing Body until 30 April 2018

Note 3: Dr S Cleasby became Chair of the Governing Body, 1 May 2018. He was the Assistant Clinical Chair prior to that.

Note 4: Dr J Gray joined the Governing Body, 28 June 2018

Note 5: Rob McSherry joined the Governing Body, 1 August 2018

Note 6: Kate Smyth left the Governing Body, 31st January 2019

Note 7: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £90k - 95k; however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Pension benefits as at 31 March 2020

Name & Title	Real increase in pension at pension age 60. (Bands of £2,500) £000's	Real increase in lump sum at age 60. (Bands of £2,500) £000's	Total accrued pension at age 60 as at 31/03/20. (Bands of £5,000) £000's	Lump sum at age 60 related to accrued pension as at 31/03/20. (Bands of £5,000) £000's	CETV at 1 April 2019 £000's	CETV at 31 March 2020 £000's	Real Increase in CETV £000's	Employers Contribution to Stakeholders Pension
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	**0 - 2.5**	**0 - 2.5**	**20 - 25**	**0 - 5**	**217**	**249**	**32**	**0**
Penny Woodhead - Chief Quality & Nursing Officer	**0 - 2.5**	**0 - 2.5**	**0 - 5**	**0 - 5**	**36**	**11**	**60**	**0**

Note 1: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore not included in the table.

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k, however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Cash equivalent transfer values

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

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

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

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

Remuneration of Very Senior Managers
This is covered in the previous section.

Compensation on early retirement or for loss of office
No payment has been made in compensation for loss of office or early retirement during 2019-20.

Payments to past members
No payment has been made to past senior managers.

Pay multiples
Note1: The information in this section is subject to audit by our external auditors, KPMG.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director/Member in their organisation and the median remuneration of the organisation's workforce. The rationale for the remuneration of Governing Body members including the clinical Chair is set out in section 2 above.

The banded remuneration of the highest paid Director/Member in NHS Calderdale CCG in the financial year 2019-20 was £155-160K (2018-19: £155-160k) this is after pro rata'ing part time employees. This was 4.24 times (2018-19: 4.3) the median remuneration of the workforce, which was £37,598 (2018-19: £36,644). The small

reduction in pay multiple between the two years is in the main due to the differences between Agenda for Change and senior manager pay inflationary uplifts in 2019/20

In 2019-20, 0 (2018-19, 0) employees received remuneration in excess of the highest-paid Director/Member. Remuneration ranged from £17k - £159k (2018-19: £14k to £157k).

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

The CCG does not offer any performance-related pay, including non-consolidated performance-related pay.

Staff Report

The CCG's workforce profile is shown below and the information is based on the directly employed staff of the CCG as at 31st March 2020. Information relating to the Governing Body is reported separately.

Number of senior managers
Information relating to individuals classed as senior managers for the purposes of this annual report can be found in section xx.

Staff numbers and costs
Average number of people employed and engaged as per table below:

	31-Mar-20			31-Mar-19		
	Permanent employees	Other	Total	Permanent employees	Other	Total
	Number	Number	Number	Number	Number	Number
Total CCG	61	16	77	67	16	83

The staff costs and employee benefits as at 31st March 2020 are set out below

2019-2020 Staff Costs & Employee Benefits	2019-2020								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,566	3,330	236	2,233	2,187	46	1,333	1,143	190
Social security costs	351	351	0	235	235	0	117	117	0
Employer contributions to the NHS Pension Scheme	569	569	0	431	431	0	138	138	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	3	3	0	3	3	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**4,490**	**4,254**	**236**	**2,902**	**2,856**	**46**	**1,588**	**1,398**	**190**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(26)	(26)	0	(26)	(26)	0	0	0	0
Net employee benefits expenditure including capitalised costs	**(26)**	**(26)**	**0**	**(26)**	**(26)**	**0**	**0**	**0**	**0**
Less: Employee costs capitalised				0	0	0		0	0
Net employee benefits expenditure excluding capitalised costs	**4,464**	**4,228**	**236**	**2,876**	**2,830**	**46**	**1,588**	**1,398**	**190**

The staff costs and employee benefits as at 31st March 2019 are set out below for comparison.

2018-2019 Staff Costs & Employee Benefits	2018-2019								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,585	2,973	612	2,164	2,051	75	1,459	922	537
Social security costs	320	319	1	225	224	1	95	95	0
Employer contributions to the NHS Pension Scheme	433	432	1	274	311	1	121	121	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	6	6	0	6	6	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**4,344**	**3,730**	**614**	**2,669**	**2,592**	**77**	**1,675**	**1,138**	**537**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(24)	(24)	0	(24)	(24)	0	0	0	0
Net employee benefits expenditure including capitalised costs	**4,320**	**3,706**	**614**	**2,645**	**2,568**	**77**	**1,675**	**1,138**	**537**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**4,320**	**3,706**	**614**	**2,645**	**2,568**	**77**	**1,675**	**1,138**	**537**

Staff composition

As at 31st March 2020, the CCG directly employed 82 staff (excluding Governing Body, but including the two Very Senior Managers (VSM)). This equates to 75.15 whole time equivalent (WTE).

Gender profile of the organisation

The following table sets out the gender profile of the organisation as at 31 March 2020.

	Governing Body (excl. Very Senior Managers)	Very Senior Managers (VSM)	Staff Excl. Governing Body and VSMs	Total
Female	**4**		**66**	**70**
Male	**7**	**2**	**14**	**23**
Total	**11**	**2**	**80**	**93**

Note 1: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay report.

Sickness absence data

The yearly average sickness figures for the CCG between 1st April 2019 and 31st March 2020:

Total FTE Days lost:	1,101.69
Total FTE Staff	**28,504.14**
Rolling 12 month period average	**2.72%**

The CCG recognises the importance of balancing the health needs of employees with the needs of the CCG, and it is the considered view of the management team of the CCG that the overarching strategic priority pertinent is to create the kind of organisational culture within which people can be the best that they can possibly be.

As such the CCG has policies and procedures in place to support employees with sickness absence and continues to develop a positive and pro-active approach in supporting employees through sickness absence or difficult periods in their lives. This has recently been evidenced by reviewing the Managing Sickness Absence Policy in not only aiming to reduce the levels of sickness through improvement plans but providing supporting mechanisms to employees during periods of short and long term sickness.

During 2015, the CCG introduced an Employee Assistance Programme (EAP) to further support the needs of the workforce and this service has been recently renewed for a further two years. The aim of EAP is to help employees deal with personal problems that might adversely impact their work performance, health and well-being. This service provides confidential advice and counselling support to employees which makes available an early source of practical and emotional support for employees facing issues in their home or work life. This is viewed by the CCG as being important in supporting the health and wellbeing of employees.

Throughout the winter period of 2019, the CCG offered workplace vaccinations to all its employees, in order to support the resilience of the workforce and the community. The winter flu campaign raised awareness of the benefits of the flu vaccination. The final uptake was 66%. The CCG also commissions a comprehensive Occupational Health service, providing expert advice on the management of health conditions at work.

The CCG is committed to the health and wellbeing of its staff and works hard to promote a healthy working environment. The Staff Forum has been proactive throughout the year in carrying out a number of initiatives. Some of its activities are described on page 28.

The CCG engages with its staff through a variety of mechanisms, including an active staff forum, weekly updates with the Chief Officer/Deputy Chief Officer, monthly staff workshops, and through a staff intranet, which includes discussion forums and regular news. The CCG also participates annually in the national NHS Staff Survey in order to gain staff feedback and understand how the CCG benchmarks against other NHS organisations. 77.1% of staff responded to the survey in 2019. Overall, the CCG's results were positive, with the engagement index score being higher than average when benchmarked against other CCGs.

Particular highlights related to the organisation taking positive action on health and wellbeing, communication between senior managers and staff, clarity of responsibilities, and a focus on organisational values in appraisal conversations. The results will be discussed with staff in order to build on the CCG's ongoing staff engagement plan, focusing on strengths and areas for improvement.

Staff policies

The CCG has a suite of staff policies providing clarity on the CCG's vision, values and expectations. These include policies on health and safety, trade union recognition and time off for representation, whistleblowing and flexible working. All the CCG's policies can be found on our website at the link below.
https://www.calderdaleccg.nhs.uk/key-documents/

The CCG's commitment to recruitment, continuing employment, training and career development of disabled people is set out in a number of policies and procedures. These include:

Requirement	Policy or procedure
Giving full and fair consideration to applications for employment by the CCG made by disabled persons, having regard to their particular aptitudes and abilities.	• Equality and Diversity Policy; • Recruitment and Selection Policy.

Continuing the employment of, and arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company.	• Equality and Diversity Policy; • Managing Sickness Absence Policy; • Flexible Working Policy; • Learning and Development Policy.
Training, career development and promotion of disabled people employed by the company.	• Equality and Diversity Policy; • Recruitment and Selection Policy; • Learning and Development Policy; • Pay Progression Policy; • Appraisal Paperwork.

Policy review

The CCG has a rolling programme of policy review and awareness raising, as well as the appraisal procedure to further improve the focus on the quality of conversations taking place. The implementation of these policies together with occupational health input supports the continuation of employment and provision of appropriate training to any employee who becomes disabled and ensures access for all CCG employees, including disabled staff members to training, career development and promotion opportunities.

Equality impact assessments have been carried out on all the above policies. Over the past 12 months monitoring has taken place to ensure there has been no detrimental effect with regard to implementation of these workforce policies on CCG staff and to ensure that the CCG have proactively identified and addressed any inequalities.

Disability Confident Employer

In 2016, the government made a commitment to halve the employment gap for disabled people and in order to achieve this it introduced a new Disability Confident scheme. We are extremely proud to say that our CCG was awarded the level 2 Disability Confident Employer badge for 2 years from August 2019. The award is based on us being able to demonstrate that we:

- Have undertaken and successfully completed the Disability Confident self-assessment;
- Are taking all of the core actions to be a Disability Confident employer;
- Are offering at least one activity to get the right people for the business and at least one activity to keeping and developing employees.

As a Disability Confident Employer, we are able to use the logo which lets people know that we have made a commitment regarding recruitment, training, and retention of people with disabilities and the promotion of disability awareness across the organisation. We will continue to work to make this a welcoming and accessible place for people with a disability.

Trade Union relations and representation

Having good working relationships with trade union representatives is important to us.

HR representatives and CCG senior managers from Calderdale, Greater Huddersfield and North Kirklees CCGs meet with the relevant trade union representatives at the Joint Partnership Forum to discuss any staff issues or test proposals that might have a direct impact on staff.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974. During 2019-20, there were three members of staff, who were accredited Trade Union representatives. These representatives provided a service across the three CCGs - Calderdale, Greater Huddersfield and North Kirklees. One of these representatives is employed by Calderdale CCG.

Relevant union officials during 2019/20

Total number of employees who were relevant union officials during the period of 1st April 2018 to 31st March 2019 (note1) (FTE)	3

Note1: One of the representatives is employed by NHS Calderdale CCG.

The table below contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Percentage time spent on facility time

Percentage of time spent	No. of Employees
0%	
1-50%	3
51-99%	
100%	

Percentage of pay bill spent on facility time

	£
Total cost of facility time (note1)	£4370
Total pay bill (note2)	£14,263,536
% of total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.03%

Note1: This is based on actual salary of the 3 trade union representatives
Note 2: This is the combined total pay bill for Calderdale, Greater Huddersfield and North Kirklees CCGs

The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2019-20, on paid trade union activities.

Paid Trade Union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100	100%

Other employee matters

The CCG works closely with partners in health and social care, and is a leader in a number of initiatives to develop the current and future workforce of Calderdale and beyond. The CCG has recently secured funding, in partnership with Calderdale College, to develop the Care 21 programme on behalf of employers across West Yorkshire and Harrogate. Care 21 involves collaboration between the College and employers, to understand the skills and behaviours needed in the future health and care workforce. A curriculum programme is being designed and delivered with employer involvement, to support students to be work-ready and to develop a cross-organisational mind-set.

The CCG is also instrumental in leading other pieces of system-wide work. For instance, providing leadership to work which will support the development of relationships across multi-disciplinary teams, and forming part of a group to bring stakeholders to discuss and agree actions in relation to workforce.

The CCG's approach to human capital management is supported by a robust set of policies and procedures, which underpin the full employee cycle. This includes a fair and transparent approach to recruitment and learning, and a well-embedded appraisal process, to assist individuals and teams with career management in support of the strategic aims of the CCG and the health and care system.

The CCG is an active participant in a Calderdale-wide Future Leaders programme. This is a new venture in partnership with public and private sector employers across Calderdale. It provides existing managers with the opportunity to develop leadership skills and gain a qualification, and contributes to human capital management and employability across the CCG's local area.

The CCG's approach to pay is included in the remuneration report. With the exception of Very Senior Managers, all staff are engaged under Agenda for Change terms and conditions. There is a clear pay progression policy, ensuring that employees are performing to the standards required in their role, in order to progress up the pay scale.

Employee consultation

The CCG recognises the benefits of joint partnership working through the Social Partnership Forum across Calderdale, Greater Huddersfield and North Kirklees CCGs. The purpose of this forum is to allow a mechanism to formally consult and negotiate on a range of CCG business that directly impact on staff.

Expenditure on consultancy

Expenditure on consultancy (2019-20)

Description	Costs(£)
No expenditure on consultancy in 2019-20	0
TOTAL	0

External Audit

NHS Calderdale CCG appointed KPMG as their external auditor from 1st April 2017. The cost of the work performed by the auditor in respect of the reporting period 2019-20 is £57,800 (including VAT).

Services from KPMG (2019-20)

Services from KPMG	£
Audit Services	
Statutory audit and services carried out in relation to the statutory audit, e.g. reports to the Secretary of State	**49,200**
Further assurance services - Compliance with the requirements of the Mental Health Investment Standard.	**8,600**
Other Services	**0**
TOTAL	**57,800**

Before agreeing to carry out any non-audit work, KPMG's risk and quality policies require all independence issues to be considered and reviewed by senior partner to ensure that the non-audit work is in line with ethical standards/AGN01.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months are as follows:

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

We 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 where necessary that assurance has been sought.

New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and March 2020, for more than £245 per day and that last for longer than six months are as follows:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Governing Body member/senior official engagements

For any off-payroll engagements of Governing Body members and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

	Number
Number of off-payroll engagements of Governing Body members, and/or senior officials with significant financial responsibility, during the financial year (Note1).	1
Total number of individuals on payroll and off-payroll that have been deemed "Governing Body members and/or senior officials with significant financial responsibility", during the financial year (this figure must include both on-payroll and off-payroll engagements).	16

Note1: This off payroll engagement relates to the Secondary Care Specialist on the CCG Governing Body, Dr Rob Atkinson, who is employed by Barnsley Hospital NHS Foundation Trust and his costs are recharged to the CCG under a three year secondment agreement and as such he does not sit on the CCG payroll.

Exit packages, including special (non-contractual) payments

There has been no exit package or other departure, requiring exit packages or severance payments during 2019-20.

Exit Packages including special (non-contractual) payments (2019-20)

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

Exit Packages including special (non-contractual) payments (2018-19)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	1	13,500	1	13,500	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where NHS Calderdale CCG has agreed early retirements, the additional costs are met by NHS Calderdale CCG and not by the NHS Pensions Scheme. Ill- health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

	Agreements 2019/20	Total Value of agreements 2019/20
	Number	**£000s**
Voluntary redundancies including early retirement contractual costs	0	Not applicable
Mutually agreed resignations (MARS) contractual costs	0	Not applicable
Early retirements in the efficiency of the service contractual costs	0	Not applicable
Contractual payments in lieu of notice*	0	Not applicable
Exit payments following Employment Tribunals or court orders	0	Not applicable
Non-contractual payments requiring HMT approval**	0	Not applicable
TOTAL		

Parliamentary Accountability and Audit Report

NHS Calderdale CCG is not required to produce a Parliamentary Accountability and Audit Report. For disclosures on remote contingent liabilities see Financial Statements note 31 and for losses and special payments, gifts, and fees and charges see Financial Statements note 40. An audit certificate and report is also included in this Annual Report at page 151.

NHS
Calderdale
Clinical Commissioning Group

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2019-2020

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2020 have been prepared by
Calderdale CCG under the Health and Social Care Act 2012
in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(2,360)	(1,208)
Other operating income	2	-	-
Total operating income		**(2,360)**	**(1,208)**
Staff costs	4	4,490	4,344
Purchase of goods and services	5	334,716	317,603
Depreciation and impairment charges	5	1	424
Provision expense	5	-	-
Other Operating Expenditure	5	392	455
Total operating expenditure		**339,599**	**322,825**
Net Operating Expenditure		**337,239**	**321,617**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**337,239**	**321,617**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**337,239**	**321,617**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**337,239**	**321,617**

Statement of Financial Position as at 31 March 2020

	Note	2019-20	2018-19
		£'000	£'000
Non-current assets:			
Property, plant and equipment	13	45	-
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		45	-
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	310	595
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	5	1
Total current assets		**315**	596
Non-current assets held for sale	21	-	-
Total current assets		**315**	596
Total assets		**360**	596
Current liabilities			
Trade and other payables	23	(27,065)	(27,700)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total current liabilities		**(27,065)**	(27,700)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(26,705)**	(27,104)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(26,705)**	(27,104)
Financed by Taxpayers' Equity			
General fund		(26,706)	(27,104)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(26,706)**	(27,104)

The notes on pages 121 to 150 form part of this statement

The financial statements on pages 117 to 120 were approved by the Audit Committee on 18th of June 2020 under delegated authority from the Governing Body and signed on its behalf by

Chief Finance Officer/ Interim Accountable Officer
Neil Smurthwaite

Calderdale Clinical Commissioning Group - Annual Accounts 2019-20

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

Changes in taxpayers' equity for 2019-20	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2019	(27,104)	0	0	**(27,104)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(27,104)**	**0**	**0**	**(27,104)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(337,239)	0	0	**(337,239)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(337,239)**	**0**	**0**	**(337,239)**
Net funding	337,637	0	0	**337,637**
Balance at 31 March 2020	**(26,706)**	**0**	**0**	**(26,706)**

Changes in taxpayers' equity for 2018-19	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2018	(21,785)	0	0	**(21,785)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(21,785)**	**0**	**0**	**(21,785)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Impact of applying IFRS 9 to Opening Balances	0	0	0	0
Impact of applying IFRS 15 to Opening Balances	0	0	0	0
Net operating costs for the financial year	(321,617)			(321,617)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(321,617)**	**0**	**0**	**(321,617)**
Net funding	316,298	0	0	316,298
Balance at 31 March 2019	**(27,104)**	**0**	**0**	**(27,104)**

The notes on pages 121 to 150 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	**2019-20**	2018-19
		£'000	£'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(337,239)	(321,617)
Depreciation and amortisation	5	1	76
Impairments and reversals	5	0	348
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	286	904
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(635)	3,909
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(337,587)**	(316,380)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(46)	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(46)**	0
Net Cash Inflow (Outflow) before Financing		**(337,633)**	(316,380)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		337,637	316,298
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**337,637**	316,298
Net Increase (Decrease) in Cash & Cash Equivalents	20	**4**	(82)
Cash & Cash Equivalents at the Beginning of the Financial Year		**1**	83
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**5**	1

The notes on pages 121 to 150 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

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

In 2020/21, in response to the Covid-19 pandemic, all detailed financial planning was suspended and the requirement for CCGs to agree annual contracts with providers was removed. Instead, all CCGs are currently making regular 'block' payments to NHS providers in line with guidance. This mechanism is currently confirmed to the end of July 2020. The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. DHSC guidance confirms that it is reasonable to assume funding will continue to flow on the same basis for 2021/22.

Based on this position, the CCG believes that it remains appropriate to prepare the accounts on a going concern basis.

1.2

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities. The accounts for 2019-20 have been calculated under a net accounting 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 Gorup are outside the scope of IFRS 3 BusinessCombinations. Where fundtions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of apsorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Subsidiaries**

The clinical commissioning group has no subsidiaries.

1.5 **Associates**

The clinical commissioning group has no associates.

1.6 **Joint arrangements**

The clinical commissioning group has no joint arrangements other than one pooled budget see note 1.7.

1.7 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
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.

1.8 **Operating Segments**

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

1.9 **Revenue**

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

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

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

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

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.10.2 **Retirement Benefit Costs**

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

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

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

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within finance income. Re-measurements of the defined benefit plan are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive [income / net expenditure].

1.11 **Other Expenses**

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

1.12 **Grants Payable**

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

1.13 **Property, Plant & Equipment**

1.13.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.13.2 **Measurement**

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

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

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

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

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

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

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

1.13.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.14 Intangible Assets

1.14.1 Recognition

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

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

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

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

1.14.2 Measurement

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

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

1.14.3 Depreciation, Amortisation & Impairments

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

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

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

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

1.15 Donated Assets

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

1.16 Government grant funded assets

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

1.17 Non-current Assets Held For Sale

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

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

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.18.1 The Clinical Commissioning Group as Lessee

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18.2 The Clinical Commissioning Group as Lessor

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

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

1.19 Private Finance Initiative Transactions

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

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

- payment for the fair value of services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 Services Received

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

1.19.2 PFI Asset

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

1.19.3 PFI Liability

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

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

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

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

1.19.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.
Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

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

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

1.20 **Inventories**

Inventories are valued at the lower of cost and net realisable value, using the ***first-in first-out*** cost formula.

1.21 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.22 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive x.xx% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.23 **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.

1.24 **Non-clinical Risk Pooling**

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

1.25 Carbon Reduction Commitment Scheme

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

1.26 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 Financial Assets

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

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.27.1 Financial Assets at Amortised cost

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

1.27.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.27.3 Financial assets at fair value through profit and loss

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.27.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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

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

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

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

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

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

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

1.32 Losses & Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.33.2 Sources of estimation uncertainty
The Clinical Commissioning Group has made an estimate fro the prescribing accrual based on the latest intelligence available from NHS Business Services Authority and Presquipp.

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

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

The Clinical Commissioing Group has commenced the assessment of the application of IFRS 16 to its financial statements. This commenced with work to identify leases which are currently operating leases and should be reclassified as finance leases as well as a broader review of recurring expenditure streams where right to use assets may be embedded in contracting arrangements. The work has progressed to March 2020, when the CCG revised it operational priorities and working patterns to deal with the COVID19 pandemic and combined with the decision to deter the implementation of IFRS16 in the NHS to 1 April 2021 means that it has not been practical to complete this work or present it for audit. The work to identify the impact of this standard is expected to recommence in Autumn 2020.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**2,148**	1,047
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**186**	137
Recoveries in respect of employee benefits	**26**	24
Total Income from sale of goods and services	**2,360**	**1,208**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**-**	-
Total Other operating income	**-**	**-**
Total Operating Income	**2,360**	**1,208**

Other operating revenue is revenue received that is not directly attributable to the provisiuon of healthcare or healthcare services. Revenue in this note does not include revenue received from NHS England which is drawn directly into the bank account of the clinical commissioning group and credited to the General Fund.

A change in accounting policy of gross to net staff recharges between neighbouring Clinical Commissioning Group has resulted in a reduction of operating income in 2018-19.

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	1,674	-	-	-	-	113	26
Non NHS	-	474	-	-	-	-	73	0
Total	**-**	**2,148**	**-**	**-**	**-**	**-**	**186**	**26**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	2,148	-	-	-	-	186	26
Over time	-	-	-	-	-	-	-	-
Total	**-**	**2,148**	**-**	**-**	**-**	**-**	**186**	**26**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to

	2019-20 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2019-20
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**3,330**	**236**	**3,566**
Social security costs	**352**	**-**	**352**
Employer Contributions to NHS Pension scheme	**569**	**-**	**569**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**3**	**-**	**3**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	4,254	236	4,490
Less recoveries in respect of employee benefits (note 4.1.2)	**(26)**	**-**	**(26)**
Total - Net admin employee benefits including capitalised costs	4,228	236	4,464
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,228	236	4,464

4.1.1 Employee benefits

	Total		2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**2,973**	**612**	**3,585**
Social security costs	**319**	**1**	**320**
Employer Contributions to NHS Pension scheme	**432**	**1**	**433**
Other pension costs	**-**	**-**	**-**
Apprenticeship Levy	**6**	**-**	**6**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	3,730	614	4,344
Less recoveries in respect of employee benefits (note 4.1.2)	**(24)**	**-**	**(24)**
Total - Net admin employee benefits including capitalised costs	3,706	614	4,320
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	3,706	614	4,320

4.1.2 Recoveries in respect of employee benefits

			2019-20	2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Total £'000**
Employee Benefits - Revenue				
Salaries and wages	**(21)**	**-**	**(21)**	**(18)**
Social security costs	**(2)**	**-**	**(2)**	**(3)**
Employer contributions to the NHS Pension Scheme	**(3)**	**-**	**(3)**	**(3)**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(26)	-	(26)	(24)

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**61.29**	**16.39**	**77.68**	**67.00**	**16.00**	**83.00**
Of the above: **Number of whole time equivalent people engaged on capital projects**	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		**2019-20 Other agreed departures**		**2019-20 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	1	13,500	1	13,500
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**13,500**	**1**	**13,500**

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

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	13,500
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**13,500**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change).

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

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

Where **entities** has agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.5 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

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

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

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

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

4.5.1 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 2019, is based on valuation data as 31 March 2018 updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant

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

4.5.2 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.

31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Admin £'000	2019-20 Programme £'000	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	114	488	602	407
Services from foundation trusts *(1)	-	180,739	180,739	169,026
Services from other NHS trusts	-	21,445	21,445	21,694
Provider Sustainability Fund	-	-	-	-
Services from Other WGA bodies	-	-	-	0
Purchase of healthcare from non-NHS bodies	-	58,866	58,866	58,732
Purchase of social care	-	-	-	-
General Dental services and personal dental services	-	-	-	-
Prescribing costs	-	37,584	37,584	34,246
Pharmaceutical services	-	-	-	-
General Ophthalmic services	-	206	206	231
GPMS/APMS and PCTMS *(2)	-	30,750	30,750	29,719
Supplies and services – clinical	-	17	17	42
Supplies and services – general	163	513	676	553
Consultancy services	-	-	-	-
Establishment	223	797	1,020	1,038
Transport	2	1	3	3
Premises	243	2,253	2,496	1,720
Audit fees	49	-	49	49
Other non statutory audit expenditure				
· Internal audit services	-	-	-	-
· Other services *(3)	10	-	10	10
Other professional fees	45	153	198	79
Legal fees	42	3	45	33
Education, training and conferences	9	1	10	20
Funding to group bodies	-	-	-	-
CHC Risk Pool contributions	-	-	-	-
Non cash apprenticeship training grants	-	-	-	-
Total Purchase of goods and services	**900**	**333,816**	**334,716**	**317,603**
Depreciation and impairment charges				
Depreciation	-	-	-	-
Amortisation	1	-	1	76
Impairments and reversals of property, plant and equipment	-	-	-	-
Impairments and reversals of intangible assets	-	-	-	348
Impairments and reversals of financial assets				
· Assets carried at amortised cost	-	-	-	-
· Assets carried at cost	-	-	-	-
· Available for sale financial assets	-	-	-	-
Impairments and reversals of non-current assets held for sale	-	-	-	-
Impairments and reversals of investment properties	-	-	-	-
Total Depreciation and impairment charges	**1**	**-**	**1**	**424**
Provision expense				
Change in discount rate	-	-	-	-
Provisions	-	-	-	-
Total Provision expense	**-**	**-**	**-**	**-**
Other Operating Expenditure				
Chair and Non Executive Members	-	-	-	-
Grants to Other bodies	392	-	392	455
Clinical negligence	-	-	-	-
Research and development (excluding staff costs)	-	-	-	-
Expected credit loss on receivables	-	-	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-	-	-
Inventories written down	-	-	-	-
Inventories consumed	-	-	-	-
Other expenditure	-	-	-	-
Total Other Operating Expenditure	**392**	**-**	**392**	**455**
Total operating expenditure	**1,293**	**333,816**	**335,109**	**318,482**

Admin Expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

***1** Internal Audit Fee's of £35K 2019-20 (2018-19 £39k) are included in Services from Foundation Trusts.

***2** GPMS/APMS and PCTMS included £29.558m for delegated responsibility for commissioning Primary Medical Services for 2019/20 (£28.073m in 2018/19).

***3** Fee relates to compliance work in realtion to the Mental Health Investment Standard.

6.1 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	2018-19 **Number**	2018-19 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,782	94,751	9,748	90,988
Total Non-NHS Trade Invoices paid within target	9,586	92,228	9,619	88,191
Percentage of Non-NHS Trade invoices paid within target	**98.00%**	**97.34%**	**98.68%**	**96.93%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,888	207,431	2,525	192,179
Total NHS Trade Invoices Paid within target	2,792	206,389	2,417	190,806
Percentage of NHS Trade Invoices paid within target	**96.68%**	**99.50%**	**95.72%**	**99.29%**

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

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.

8. Investment revenue

The Clinical Commissioning Group does not have any investment revenue.

9. Other gains and losses

The Clinical Commissioning Group has no other gains and losses during the period.

10. Finance costs

The Clinical Commissioning Group has no finance costs during the period.

11. Net gain/(loss) on transfer by absorption

The Clinical Commissioning Group has no net gain / (loss) during the period.

12. Operating Leases

12.1 As lessee
[Where the NHS clinical commissioning group is a lessee, include a general description of significant leasing arrangements, including:
(a) *basis on which contingent rent is determined*
(b) *terms of renewal, purchase options or escalation clauses and*
(c) *restrictions imposed by lease arrangements*

12.1.1 Payments recognised as an Expense				2019-20				2018-19
	Land	Buildings	Other	Total	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	1,071	-	**1,071**	-	1,085	0	**1,085**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**1,071**	**-**	**1,071**	**-**	**1,085**	**0**	**1,085**

12.1.2 Future minimum lease payments				2019-20				2018-19
	Land	Buildings	Other	Total	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	963	-	**963**	-	737	-	**737**
Between one and five years	-	3,191	-	**3,191**	-	2,947	-	**2,947**
After five years	-	3,615	-	**3,615**	-	4,183	-	**4,183**
Total	**-**	**7,769**	**-**	**7,769**	**-**	**7,867**	**-**	**7,867**

The CCG occupies property owned and managed by NHS Property Services. From 2013-14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 12.1.1

Whilst our arrangements with NHS Property Services fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note includes only the known future minimum lease payments from other rental arrangements.

12.2 As lessor
12.2.1 Rental revenue

The Clinical Commissioning Group has no rental revenue during the period.

12.2.2 Future minimum rental value

The Clinical Commissioning Group has no future minimum rental value during the period.

13 Property, plant and equipment

2019-20	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	-	-	-	-	-	-	138	700	838
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-	46	-	46
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**184**	**700**	**884**
Depreciation 01 April 2019	-	-	-	-	-	-	139	700	838
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	1	-	1
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**140**	**700**	**840**
Net Book Value at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**44**	**-**	**44**
Purchased	-	-	-	-	-	-	45	-	45
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**45**	**-**	**45**
Asset financing:									
Owned	-	-	-	-	-	-	45	-	45
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**45**	**-**	**45**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2019	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

2018-19	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2018	-	-	-	-	-	-	138	700	837
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**138**	**700**	**837**
Depreciation 01 April 2018	-	-	-	-	-	-	110	305	414
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	11	337	348
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	18	57	75
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**138**	**700**	**837**
Net Book Value at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**0**	**(0)**
Purchased	-	-	-	-	-	-	0	0	0
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**0**	**0**
Asset financing:									
Owned	-	-	-	-	-	-	0	0	0
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**0**	**0**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2018	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group do not have any assets under construction.

13.2 Donated assets

The Clinical Commissioning Group do not have donated assets.

13.3 Government granted assets

The Clinical Commissioning Group do not have government granted assets.

13.4 Property revaluation

The Clinical Commissioning Group do not have any properties.

13.5 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

13.6 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

13.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

13.8 Cost or valuation of fully depreciated assets

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

	2019-20 £'000	2018-19 £'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	139	139
Furniture & fittings	700	700
Total	**839**	**839**

13.9 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	1	3
Furniture & fittings	3	15

14 Intangible non-current assets

The Clinical Commissioning Group has no intangible non-current assets during the period.

14.1 Donated assets

The Clinical Commissioning Group do not have any donated assets.

14.2 Government granted assets

The Clinical Commissioning Group do not have any government granted assets.

14.3 Revaluation

The Clinical Commissioning Group do not have any properties.

14.4 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

14.5 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

14.6 Non-capitalised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

14.8 Cost or valuation of fully amortised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.9 Economic lives

Not applicable to Calderdale Clinical Commissioning Group.

15 Investment property

The Clinical Commissioning Group has no investment property at 31st March 2020.

16 Inventories

The Clinical Commissioning Group has no inventories at 31st March 2020.

17.1 Trade and other receivables

	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	3	-	399	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	-	-	-	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	152	-	157	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	115	-	-	-
Non-NHS and Other WGA accrued income	-	-	-	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	40	-	39	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**310**	**-**	**595**	**-**
Total current and non current	**310**		**595**	
Included above:				
Prepaid pensions contributions	-		-	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

17.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000
By up to three months	94	12	394	149
By three to six months	-	-	6	40
By more than six months	-	-	-	7
Total	**94**	**12**	**400**	**196**

£106k of the amount above has subsequently been recovered post the statement of financial position as at 04 June 2020.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2020.

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

18 Other financial assets
18.1 Current
The Clinical Commissioning Group has no current assets as at 31st March 2020.

18.2 Non-current
The Clinical Commissioning Group has no non-current assets as at 31st March 2020.

18.3 Non-current: capital analysis
The Clinical Commissioning Group has no non-current capital as at 31st March 2020.

19 Other Current assets
The Clinical Commissioning Group have no other current assets as at 31st March 2020.

20 Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	1	83
Net change in year	4	(82)
Balance at 31 March 2020	**5**	**1**
Made up of:		
Cash with the Government Banking Service	5	1
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**5**	**1**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**5**	**1**
Patients' money held by the clinical commissioning group, not included above	-	-

The Clinical Commissioning Group have no bank overdraft as at 31 March 2020.

21 Non-current assets held for sale
The Clinical Commissioning Group does not have any non current assets held for sale during the period.

22 Analysis of impairments and reversals

22.1 Analysis of impairments and reversals: property, plant and equipment

	2019-20 £'000	2018-19 £'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Loss or damage resulting from normal operations	-	-
Over-specification of assets	-	-
Abandonment of assets in the course of construction	-	-
Total charged to departmental expenditure limit	**-**	**-**
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Other	-	(348)
Change in market price	-	-
Total charged to annually managed expenditure	**-**	**(348)**
Total impairments and reversals charged to the statement of comprehensive net expenditure	**-**	**(348)**
Impairments and Reversals charged to the revaluation reserve		
Loss or damage resulting from normal operations	-	-
Over-specification of assets	-	-
Abandonment of assets in the course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Other	-	-
Change in market price	-	-
Total Impairments and reversals charged to the revaluation reserve	**-**	**-**
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	**-**	**-**
Total impairments and reversals of property, plant and equipment	**-**	**(348)**

The Clinical Commissioning Group does not has had no imapirments of intangible fixed assets..

22 Analysis of impairments and reversals cont'd

22.7 Analysis of impairments and reversals: totals

	2019-20	2018-19
	£'000	£'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Departmental expenditure limit	-	-
Annually managed expenditure	-	(348)
Total impairments and reversals charged to the statement of comprehensive net expenditure	**-**	**(348)**
Impairments and reversals charged to the revaluation reserve	-	-
Total impairments	**-**	**(348)**
Of the above:		
Impairment on revaluation to "modern equivalent asset" basis	-	-
Impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure included above:		
Property, plant & equipment charged to departmental expenditure limit	-	-
Intangible assets charged to departmental expenditure limit	-	-
Total charged to departmental expenditure limit	-	-
Property, plant & equipment charged to annually managed expenditure	-	-
Intangible assets charged to annually managed expenditure	-	-
Total charged to annually managed expenditure	-	-
Total impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure	**-**	**-**

23 Trade and other payables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	1,651	-	3,126	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,368	-	1,454	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	13,751	-	14,258	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	9,563	-	8,572	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	56	-	58	-
VAT	-	-	-	-
Tax	45	-	46	-
Payments received on account	-	-	-	-
Other payables and accruals	631	-	186	-
Total Trade & Other Payables	**27,065**	**-**	**27,700**	**-**
Total current and non-current	**27,065**		**27,700**	

The CCG has no liabilities for early retirement.

Other payables include £67k outstanding pension contributions at 31 March 2020

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31st March 2020.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31st March 2020.

26 Borrowings

The Clinical Commissioning Group has no borrowings as at 31st March 2020.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group has no private finance initiative, LIFT or other service concession arrangements as at 31st March 2020.

28 Finance lease obligations

The Clinical Commissioning Group has no financial lease obligations as at 31st March 2020.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31st March 2020.

30 Provisions

	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	-	-
Other	-	-	-	-
Total	**-**	**-**	**-**	**-**
Total current and non-current	**-**		**-**	

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However , the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2020 is £51,001. (2018/19 £99,615).

The clinical commissioning group has no provisions balances transferred to it as a result of the 1st April 2013 transition and has no provisions arising during the period.

31 Contingent Liabilities

	2019-20 £'000	2018-19 £'000
Contingent liabilities		
Equal Pay	-	-
NHS Resolution Legal Claims	-	-
Employment Tribunal	-	-
NHS Resolution employee liability claim	-	-
Redundancy	-	-
Continuing Healthcare	-	-
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	**0**	**0**
Contingent assets		
Amount Payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

	2019-20	2018-19
	£'000	£'000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

32.2 Other financial commitments

The NHS clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2019-20	2018-19
	£'000	£'000
In not more than one year	-	-
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**-**	**-**

33 Financial instruments

33.1 Financial risk management

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

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

33.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

33.1.5 Financial Instruments

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

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Equity Instruments designated at FVOCI 2019-20 £'000	Total 2019-20 £'000
Equity investment in group bodies	-	-	-
Equity investment in external bodies	-	-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	-	-	-
Trade and other receivables with NHSE bodies	3	-	3
Trade and other receivables with other DHSC group bodies	-	-	-
Trade and other receivables with external bodies	151	-	151
Other financial assets	-	-	-
Cash and cash equivalents	5	-	5
Total at 31 March 2020	**159**	**-**	**159**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	528	-	**528**
Trade and other payables with other DHSC group bodies	11,253	-	**11,253**
Trade and other payables with external bodies	15,183	-	**15,183**
Other financial liabilities	-	-	**-**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 31 March 2020	**26,964**	**-**	**26,964**

34 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2019-20 £'000	2018-19 £'000
Total net expenditure reported for operating segments	337,239	321,617
Reconciling items:		
Total net expenditure per the Statement of Comprehensive Net Expenditure	337,239	321,617

34.2 Reconciliation between Operating Assets and SoFP

	2019-20 £'000	2019-20 £'000
Total assets reported for operating segments	359	596
Reconciling items:		
Total assets per the Statement of Financial Position	359	596

34.3 Reconciliation between Operating Liabilities and SoFP

	2019-20 £'000	2019-20 £'000
Total liabilities reported for operating segments	(27,065)	(27,700)
Reconciling items:		
Total liabilities per Statement of Financial Position	(27,065)	(27,700)

35 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2019-20				Amounts recognised in Entities books ONLY 2018-19			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund	NHS calderdale CCG & CMBC	Reduction of DTOC and Emergancy Re admissions	0	0	0	14,732	0	0	0	14,239

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Metropolitan Borough Council in relation to the Better Care Fund.

The Better Care Fund (BCF) is a mandatory policy to facilitate integration of service provision between Health and Social Care.

The schemes managed through the BCF include: Disabled Facilities Grants, carers services, supporting social care, reablement and recovery services. Under the policy we have to report on a number of metrics which include delayed discharges from hospital and levels of emergency admissions.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budget is jointly controlled between the CCG and Calderdale Metropolitan Borough Council.

The NHS Clinical Commissioning Group has £119k of payables relating to the Better Care Fund as at 31st March 2020.

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

Name of entity	Description of principal activities	Basis for treatment eg materiality

The CCG has no interests not accounted for under IFRS 10 or IFRS 11.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health.
During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practise for which Governing Body members have a relationship have been below. In 2019/20 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

	2019-20				2018-19			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Longroyde Surgery (Dr Alan Brook)	N/A	N/A	N/A	N/A	450	0	0	0
Spring Hall Group Practice (Dr Steven Cleasby)	1,310	0	0	0	1,119	0	0	0
Southowram Surgery (Dr Majid Azeb)	359	0	0	0	364	0	0	0
Hebden Bridge Group Practice (Dr Nigel Taylor)	2,896	0	0	0	2,577	0	0	0
Beechwood Medical Centre (Dr Caroline Taylor)	1,126	0	0	0	1,114	0	0	0
Rastrick Health centre (Dr F Javid)	646	0	0	0	593	0	0	0
Bankfield Surgery (Dr J Gray)	1,230	0	0	0	700	0	0	0
Rosegarth (Dr H Davies moved from Hebden Bridge Practice 2019-20)	1,283	0	0	0	N/A	N/A	N/A	N/A

CCG Chief Officer, spouse is an Employee of Calderdale and Huddersfield NHSFT and material transactions are detailed below.

CCG Chair, spouse is an employee of Insight.

David Longstaff was the audit lay member for Calderdale CCG, Greater Huddersfield CCG and North Kirklees CCG , but had no material transactions.

In addition the executive Governing Body members have relatives or interests with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Bradford Teaching Hospitals NHS FT
Leeds Teaching Hospitals NHS Trust
Rosegarth Surgery
Overgate
Local Care Direct
Locala
Pennine GP Alliance
West Yorkshire and Harrogate Health Care Partnership.

One Governing Body member also has material transactions with :
Barnsley Hospital NHS FT

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

	2019/20 £000	2018/19 £000
Calderdale and Huddersfield NHSFT	149,752	142,081
South West Yorkshire Partnership NHSFT	24,010	21,793
Yorkshire Ambulance NHS Trust	11,815	12,438
Leeds Teachings Hospitals NHST	7,252	6,842
Bradford Teachings Hospitals NHSFT	4,166	3,706
NHS Greater Huddersfield CCG	0	0
Pennine Acute NHST	n/a	418
East Lancashire Hospital NHS Trust	n/a	695
Mid Yorkshire Hospitals NHS Trust	n/a	759
Central Manchester University NHS FT	536	510
CSU	225	225
The Christie NHS FT	53	53
Calderdale Local Medical Committee	0	69
NHS North Kirklees CCG	0	0

In addition the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies.

	2019/20 £000	2018/19 £000
Calderdale Metropolitan Borough Council	19,911	18,512

38 Events after the end of the reporting period

The Clinical Commissioning Group has no post balance sheet events which will have a material effect on the financial statements.

39 Third party assets

The Clinical Commissioning Group held no cash and cash equivalents which relate to monies held by the Clinical Commissioning Group.

40 Losses and special payments

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 2019-20 Number	**Total Value of Cases 2019-20 £'000**	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000
Administrative write-offs **(1)**	- -	- -	1 -	348
Fruitless payments	- -	- -	- -	-
Store losses	- -	- -	- -	-
Book Keeping Losses	- -	- -	- -	-
	- -	- -	- -	-
Constructive loss	- -	- -	- -	-
Cash losses	- -	- -	- -	-
Claims abandoned	- -	- -	- -	-
Total	**-**	**-**	**1**	**348**

(1) The Administrative write off in 2018-19 related to impairment of CCGs fixtures and fittings and IT assets which were recognised and accounted for in 2018-19.

Special payments
The CCG has had no special payments during the period.

41 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2019-20 Target £'000	**2019-20 Performance £'000**	**2019-20 Duty Achieved**	2018-19 Target £'000	2018-19 Performance £'000	2018-19 Duty Achieved
Expenditure not to exceed income	340,616	339,599	Yes	322,825	322,825	Yes
Capital resource use does not exceed the amount specified in Directions	50	45	Yes	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	338,256	337,239	Yes	321,617	321,617	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	50	45	Yes	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,850	4,138	Yes	4,697	4,677	Yes

The CCG received total revenue resource allocation of £338,256 and had net expenditure of £337,239k delivering an in year surplus of £1,017k.

42 Analysis of charitable reserves

Not applicable to Calderdale Clinical Commissioning Group.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS CALDERDALE CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group ("the CCG") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2019/20.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or

inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 50, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 50, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act

2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in December 2019 and updated in April 2020 as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Calderdale 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, as a body, 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 Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Calderdale CCG for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler
Statutory auditor, for and on behalf of KPMG LLP
Chartered Accountants
1 St. Peter's Square
Manchester
M2 3AE

23 June 2020