NHS
Calderdale
Clinical Commissioning Group

Annual Report 2016 - 17

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OUR LOGO EMBRACES ALL OUR VALUES

LONG LIFE
Preventing people from dying prematurely

QUALITY OF LIFE
Enhancing the quality of life for people with a long-term condition

INDEPENDENCE
Helping people to recover and maintain their independence

CARE
Ensuring people have a positive experience of care

PROTECTION
Ensuring a safe environment and protecting people from harm

EQUALITY
Reducing inequalities

The NHS Act 2006 (as amended) requires Clinical Commissioning Groups to prepare an Annual Report and Accounts.

The Annual Report and Accounts consists of four sections:

1) The Performance Report

2) The Accountability Report, which consists of:

- A Corporate Governance Report
  - Members' Report
  - Statement of Accountable Officer's Responsibilities
  - Governance Statement
- A Remuneration and Staff Report
  - Remuneration Report
  - Staff Report

3) Parliamentary Accountability and Audit Report

4) Annual Accounts

The Annual Report and Accounts 2016-17 for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on 18 May 2017 under delegated authority from the Governing Body.

Version: FINAL

Contents

Glossary

A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
AQP	Any Qualified Provider
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Service
CC2H	Care Closer to Home
CCG	Clinical Commissioning Group
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CIP	Cost Improvement Plan
CPMSC	Commissioning Primary Medical Services Committee
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
DoLS	Deprivation of Liberty Safeguards
FFT	Friends and Family Test
GMS	General Medical Services
GH CCG	NHS Greater Huddersfield Clinical Commissioning Group
HCAI	Health Care Associated Infection
HMRC	Her Majesty's Revenue and Customs
HPMO	High Performing Membership Organisation
HWB	Health and Wellbeing Board
LTC	Long Term Condition
MCA	Mental Capacity Act
NHSE	NHS England
NK CCG	North Kirklees Clinical Commissioning Group
NICE	National Institute of Clinical Excellence
PDR	Performance and Development Review
PMS	Primary Medical Services
PPEE	Patient and Public Engagement and Experience
PPI	Patient and Public Involvement
QIPP	Quality, Innovation, Productivity and Prevention
RCRTRP	Right Care, Right Time, Right Place
SCR	Serious Case Review
SDMP	Sustainable Development Management Plan
SI	Serious Incident
SMT	Senior Management Team
STP	Sustainability and Transformation Plan
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
VCSE	Voluntary, Community and Social Enterprise organisations
VSM	Very Senior Manager
VAC	Voluntary Action Calderdale
W CCG	NHS Wakefield Clinical Commissioning Group
WYSTP	West Yorkshire Sustainability and Transformation Plan

Introduction to the Annual Report

If you believe everything that you read in the papers and hear on the news, you would think that the year 2016-17 was the year that the NHS finally imploded. There has been much talk of crisis and every day, where there used to be, dependably, one main story on health and care in a news bulletin, now there are three. Most of those stories are laden with a sense of doom and foreboding. It is as if there is collusion afoot to talk down the ability of the NHS and of public services more generally to deliver what people actually require of them. It is as if there was a plot to undermine faith and belief in this greatest of constructs and most noble of causes; to provide the best possible care, free at the point of need, for all who require it, regardless of their wealth and funded through general taxation.

We have been thinking a lot about the basis upon which the NHS was established so many years ago, and its ability to flex and change with the times; how different the service is now, in many respects, to the service that was established in 1948 and how similar in other respects. Changes resulting from advances in technology and medicines, massive changes in expectation, changes in the nature of the population that is served and the increasing complexity of care required for a population that is aging (one of the successes that has been delivered in part as a consequence of better access to healthcare and better understanding of the impact of lifestyle choices) all have had an impact on the way in which the service is delivered. We are, in a sense, the victim of our own success.

So what has really happened in this past year in the Calderdale health and care system? This past year has seen the conclusion of our consultation on care in hospitals and in a community setting. We have set a course for the future. The process of moving through to final decisions has been a complicated business. There have been all sorts of obstacles and challenges along the way and there will be more to come. But we believe that we have established, with our colleagues in Greater Huddersfield CCG and in Calderdale and Huddersfield Hospital Foundation Trust that we are determined to surmount each and every obstacle that is put in our way. Witnesses and participants in our dialogue across the local system and regionally and nationally are in no doubt about our commitment to purpose and our commitment to the people that we serve and with whom we wish to create a service that is fit for the future. We would like to take this opportunity to recognise the passion that local people have about this NHS and thank them for their valuable input into the consultation process.

This year has seen a ramping up of expectation nationally in relation to the need for change. We are now part of a Sustainability and Transformation Partnership which spans West Yorkshire and Harrogate and the CCG has a significant input into the leadership and content of the programmes of work emerging from that. Calderdale continues to punch above its weight in these conversations. We are proud of that.

Our financial position becomes ever more challenging. Changes to the national allocation formula have resulted in Calderdale receiving the lowest level of growth possible. Money is being redistributed across the wider NHS. Some say that money is moving south. The crisis in hospital funding and cost control is accentuated by decisions made in relation to social care allocations. In the middle of all of that are people. We have worked hard this year to drive a conversation about how we manage the movement of people into, through and out of our hospital so that they get the care they need and we minimise the harm that can result from long and unnecessary stays in a hospital bed. We are proud of the fact that wherever we discuss these difficult issues we take a first view from the experience of the people that we serve. Our governing body meetings have featured stories like these many times and every time, we can feel the difference that it makes to the tone and purpose of our conversations. We are using the same approach in the Health and Wellbeing Board and at the Accident & Emergency Delivery Board.

Finally, we want to pay tribute to the people who work with us and for us in the CCG. Any success that we have enjoyed, any change that we have delivered, any difference that we are making is down to the hard work and dedication of the people who work with us. Their effort this year has been immense. We are privileged to be part of an organisation made up of people who have such commitment to working in the service of Calderdale residents. We recognise their commitment, are really so very proud of it, and do not take it for granted.

Our purpose is to create a movement for change. We are confident that the work that the CCG has been doing over the past 12 months is beginning to deliver this. Our system is ready for change. We are delivering change. We are expecting that our financial challenge will add to our momentum and purpose. There is hope. Whilst others around us are beginning to panic, we will not. We will focus resolutely upon the job that we are here to do, and we will continue to do our utmost to do it in the right kind of way.

Dr Alan Brook,
Chair

Dr Matt Walsh,
Chief Officer

Performance Report

Dr Matt Walsh

Accountable Officer

24 May 2017

Performance Overview

1. Performance of the CCG during 2016-17

This overview section provides a summary of the purpose and activities of the CCG, how it has performed during the year and any key risks to the achievement of its strategic objectives. Despite the challenges that have been faced by the local health and care system, the CCG has performed well over the past year. We have worked hard with partners to ensure urgent and emergency care resilience and manage the financial challenges. We have also maintained a close grip on performance against the NHS Constitution Standards and ensuring that quality and safety is maintained in the services that we commission. This activity is reflected in the overall achievement of the NHS Constitution Standards and the achievement of our statutory financial targets. We do not underestimate the financial challenges going forward and the performance analysis section of this report contains further detail of our financial position and recovery plan for 2017-18. In all this, we have maintained our focus on our public and patient engagement and in continuing to build partnership working.

2. Calderdale CCG

NHS Calderdale CCG is a membership organisation consisting of 26 general practices that look after the health needs of the estimated 219,500 people who live in Calderdale and/or are registered with a Calderdale GP. This means that local clinicians have a lead role in commissioning the health services used by local people.

3. Purpose of the CCG

The purpose of the CCG is to improve the health and lives of people living in Calderdale and/or registered with a Calderdale GP practice. This is achieved by working with partners to ensure that healthcare is available for anyone who needs it, ensuring good quality care and keeping people safe, helping people to maintain a healthy lifestyle and working with the local authority to address health inequalities locally. Our overall budget allocation was £312m in 2016-17 which we use to commission health and care services such as planned hospital care, urgent and emergency care, rehabilitation care, community health services, mental health and learning disability services on behalf of the people of Calderdale.

Growing demand for health and care services, price inflation and the costs of new drugs and treatments mean that we need to look at how we spend our budget to get maximum benefit for everyone. As a CCG we must live within our means and unless we change the way that

services are delivered we will not have enough money to fund them. We have a statutory duty to balance our books.

4. Activities of the CCG in 2016-17

The following section sets out a summary of the activity carried out in 2016-17 to:

- Transform the way that healthcare is provided for local people;
- Sustain quality and keep people safe;
- Ensure system resilience;
- Ensure a clear focus on financial recovery;
- Invest time in partnership working.

4.1 Transform the way that Healthcare is Provided for Local People

The CCG has worked hard this year with partners across the health and socal care system and through the Health and Wellbeing Board to develop a Single Strategic Plan for Calderdale. The plan consolidates and builds on the aims set out in the CCG's 5 Year Strategic Plan and Two Year Operational Plan. It takes forward our plans for; integrated commissioning, tackling the wider determinants of health, and delivering new models of primary and community services. It takes into account our proposals for the new clinical model of hospital services and sets out the benefits of working at scale across the West Yorkshire and Harrogate footprint on certain specialties such as stroke services (West Yorkshire and Harrogate Sustainability and Transformation Plan).

Care closer to home for diabetes

Our local specialist diabetes team has been working with our GP practices to increase their knowledge, skills and experience in that area. Most adults with diabetes stabilised on injectable therapies now receive their routine care from their GP practice rather than from the hospital.

It also identifies the work needed to develop an integrated approach to the key enabling functions of workforce, digitisation, estates, data quality and analysis and communication.

➢ **Sustainability and Transformation Plans**

Our Single Strategic Plan for Calderdale was submitted to NHS England as part of the submission of the West Yorkshire and Harrogate STP.

Strategic direction: Single Plan for Calderdale

Integrating Commissioning:

- Health & Social care working jointly
- Sharing budgets
- Defining outcomes, measuring performance
- Agreeing longer-term contracts
- Capitated budgets
- Larger geographies payment, procurement and statutory duties
- Encouraging and supporting providers to work in a more integrated way

Tackling the Wider Determinants of Health:

- Inequalities
- Economy
- Education
- Environment
- Employment
- Housing
- Prevention at Scale

Delivering new models of primary and Community Services:

- Collaboration and integration
- New 'Integrated Care' organisation
- Delivering integrated primary and community services, physical and mental health, in partnership with statutory and third sector
- Prevention, self-care, independence, personalisation

Working on a West Yorkshire Footprint:

- Oversight by Healthy Futures Programme
- Includes acute reconfiguration locally and across West Yorkshire
- 9 priorities – delivery at scale (critical mass, doing things once)

Enablers: digitisation, workforce, estate, data quality and analysis, communication

➢ **West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)**

Working with partners, the CCG has played an active role in the development of the West Yorkshire and Harrogate STP and identifying those areas that would benefit from taking a collaborative approach across a wider footprint:

- Cancer services
- Urgent and emergency care
- Specialist services
- Hyper acute stroke

Achieves the critical mass needed

- Standardisation of commissioning policies
- Acute collaboration
- Primary and community services

Do the work once and share best practice

- Mental health
- Prevention

Achieves greater benefits

In February 2017, the CCG member practices approved the establishment of the 'Healthy Futures' joint committee to oversee the work plan being taken forward across the West Yorkshire and Harrogate area. This builds on the work that has been carried out across the West Yorkshire and Harrogate CCGs in previous years.

- **General Practice Forward View**

We believe that the general practices that are providing services to our registered population are central to achieving our strategic direction. The continuity of care provided to patients by general practice, together with the ability of general practice to provide a universal core service whilst simultaneously responding and adapting to the needs of diverse population groups, is unique within the NHS.

The CCG's Strategic Intent for Primary Care, developed in 2016, sets out our ambition and vision for primary medical services in Calderdale to 2020:

> *Wherever you go in Calderdale to receive your primary medical services you can be guaranteed that your experience will be excellent and your outcomes from treatment will be as good as the best. This will be delivered by a model for general practice that is sustainable and responds to the needs of the system and is regarded as fantastic by the people who work in it and the people who use it.*

The *General Practice Forward View*, published by NHS England, sets out a plan, supported by a multi-billion pound investment, to stabilise and transform general practice in England. Our strategic intent was further developed in December 2016 to include our high level plans for the implementation of the General Practice Forward View in Calderdale.

Our plans are set in the context of our local and West Yorkshire and Harrogate STP, are based around our ambition for Care Closer to Home and our Primary Care Strategic Intent and identify how we intend to invest resources to transform general practice - ensuring it is sustainable in the future.

Good Access to General Practice

Good, effective access to general practice is the key platform for our strategy. Access is important for patients and is an area currently where there is variation across practices. Waiting times to access general practice services is important to patients and it is becoming increasingly important when managing system-wide resilience. During the year we have worked with our member practices to develop standards of good access which are in line with the Calderdale vision for Primary Medical Services. We also invested in extra capacity within general practice providing an additional 14,920 appointments for patients between December 2016 and April 2017.

The CCG has worked closely with the Pennine GP Alliance to develop plans for improving access further in 2017, which will see the development of locality based services and progress towards the aspirations of the GP Forward View.

Developing Estates and Infrastructure

The CCG commissioned Community Ventures to develop an Estates Feasibility Study to support the emerging vision for primary and community based services, the future needs of the population and the potential optimal configuration of the estate to maintain and sustain services over the longer-term using national policy and service planning (designed around "Clinical Hubs") over the medium and longer term. The Feasibility Study provides an outline estate infrastructure/vision that supports the *Five Year Forward View* in becoming a reality and supports our bids to the national estates and technology transformation fund. The CCG will continue to develop and implement its plans for the delivery of its vision for general practice to ensure that the services it commissions are sustainable.

Medicines Management

The Medicines Management team continues to influence prescribing across the health economy through membership of the South West Yorkshire Area Prescribing Committee, the primary care antimicrobial stewardship subcommittee, the wound formulary group, and the medicines safety group. Medicines safety continues to be a priority for the team who provide feedback on medication incidents reported to the CCG by member practices and who have developed some updates for practices on medicines safety issues. A number of safety initiatives have been implemented in practices in the last year by the external medicines optimisation team to improve the safety of high risk medicines such as anticoagulants, HIV drugs and methotrexate.

➢ Care in Hospital

RIGHT CARE | RIGHT TIME | RIGHT PLACE

In June 2016, the CCG completed the consultation on proposed future arrangements for hospital and community health services. The consultation process received independent assurance from the Consultation Institute and met the Institute's best practice standards.

Following the consultation, we entered a post-consultation deliberation phase during which we considered the responses received in the context of the CCG's duties and obligations, including those in relation to Equality and Health Inequalities. The post-consultation deliberation phase was informed by:

- The Independent Report of Findings from the consultation, which was shared with the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC) and published on the CCG's website;

- The independent Equality and Health Inequality Impact Assessment of the consultation, which was also published on the CCG's website;
- The issues and concerns raised in the response to the consultation from JHOSC which included the response from Calderdale and Kirklees Healthwatch.

In October 2016, the CCG agreed to proceed to explore implementation of the proposed changes as part of a Full Business Case. The CCG together with Greater Huddersfield CCG and Calderdale and Huddersfield Foundation Trust are now producing the Full Business Case and associated documents. This will form one of our key activities in 2017-18.

Formal Consultation

The formal consultation on the future of hospital and community services included proposals for care in hospital and community services in both Calderdale and Greater Huddersfield. The consultation lasted 14 weeks and included a range of events and activities to gather the views of local people.

These activities included 3 public meetings, 17 information sessions, a survey included in *Calderdale Talkback*, targeted work with Children and Young People and conversations with a range of staff, partner organisations and through local community and voluntary sector organisations.

We are hugely grateful to everyone who took the time to share their views and feedback during the consultation. Over 7,500 people replied to the survey and in addition we received over 500 phone calls, letters, documents, texts and emails and 8 petitions. The feedback from the consultation was independently analysed and the resultant report highlighted six key themes:

1. Travel and Transport	4. The consultation process
2. Clinical safety and capacity	5. Understanding the proposal
3. Rationale for change	6. The need for change

The findings from the consultation were deliberated by both Calderdale and NHS Greater Huddersfield CCGs; in addition there were responses from organisations such as Healthwatch and the local authority to consider.

4.2 Sustain Quality and Keep People Safe

Ensuring that services are safe, deliver high quality outcomes and improve patient experience is fundamental to everything we do. Over the past year we have:

- Maintained our close working relationships with all providers to ensure delivery of high quality care;
- Revised the Quality and Safety Dashboard to ensure any areas of support are identified in a timely manner;
- Developed the use of Quality Impact Assessments to ensure that we understand the impact of any commissioning decisions on quality;
- Promoted a culture of excellence within the CCG by involving patients, their carers, staff and key stakeholders.

Practice Research

The West Yorkshire Research and Development team works hard to ensure that general practice research activity takes place in line with regulatory requirements and good governance. The research projects contribute to continued improvement in patient safety and care. In 2016-17, 66 participants were recruited to ongoing research studies by 14 member practices. This is a marked increase on 2015-16, when 13 participants were recruited from 2 practices.

➢ Safeguarding

Safeguarding activity, both nationally and locally, continues to grow and now includes Modern Slavery and Human Trafficking, Female Genital Mutilation (FGM), Prevent (part of the government's anti-terrorism strategy) and the Mental Capacity and Deprivation of Liberty Safeguards. The safeguarding philosophy has moved to become more person focused, empowering people to decide what support and outcomes they require to maintain their wellbeing and a move away from professional-led decision making.

During 2016-17, the safeguarding team has worked more closely with GP practices by developing a network of GP leads to enhance the quality of safeguarding provision in primary care. We have provided significant input to the Calderdale Safeguarding Boards including the development of a toolkit for conducting Safeguarding Adults Reviews which help all agencies learn from incidents to improve service responses. We have developed and implemented a series of policies and guidance for CCG and primary care staff. We have received highly favourable feedback from NHS England who came to audit our safeguarding structures. Working closely with our Continuing Health Care team we have implemented a system to make applications to the Court of Protection for Deprivation of Liberty authorisations and supported individuals to appeal to the court to ensure their human rights are upheld.

The team continues to work closely with colleagues on a local, regional and national basis sharing approaches to new safeguarding initiatives.

- **Patient and Public Engagement and Experience**

The Patient and Public Engagement and Experience Team works with colleagues across Calderdale, Greater Huddersfield and North Kirklees CCGs to ensure that learning from patient experience and patient and public engagement is at the heart of everything we do.

This year, we established a Patient Experience Group across Calderdale, Greater Huddersfield, North Kirklees and Wakefield CCGs with the remit of sharing good practice to improve patient experience across the main providers. The group has an agreed work plan and reports to the Quality Committee on a quarterly basis.

The team have also undertaken a number of patient and public engagement projects during the year. Some examples of these are included below:

- **Care Closer to Home:** Engagement on a single point of access to services and the development of a website for families and carers of children aged 0-5 years. Ongoing work to develop a range of services based at Todmorden Health Centre has included the voice of local people and a community panel.

- **Mental Health services including Child and Adolescent Mental Health Services (CAMHS) and Learning Disability services:** A transformation of local mental services has involved engagement with the public in service areas including rehabilitation and recovery services and a My Health Day for people with a learning disability.

- **Assistive Technology:** We continue to work with service users when procuring local services. Local people tested and provided feedback on equipment to support long-term conditions. This information was used to support commissioners in the procurement of a new provider.

A Vision for Care Homes in Calderdale

The CCG has been working with colleagues and partners across health and social care to develop a vision for care home provision in Calderdale for the future. The vision is that care homes will be an integral part of the community providing access to different types of care and support in partnership with many different people young and old. This vision with public engagement feedback was shared by the CCG and local authority at an event in March which was attended by many care home providers, engagement champions, the voluntary sector and CHFT. It was inspiring to see such a 'buzz' in the room as people came alive thinking of new ways of working together and leading change in communities. Feedback from the day was very positive with comments such as:

"*I found the event totally refreshing and inspirational, the dream is a great concept and indicates your forward thinking and understanding and importance of the working relationship between providers and local authorities*."

The CCG and Calderdale Council will now work with others to turn this vision into reality and to make Calderdale a 'great place to grow old'.

Patient Stories

Patient stories can reveal a great deal about the quality of services, the culture of an organisation, and the effectiveness of mechanisms to manage, improve and assure quality. They also serve as a powerful reminder to organisational leaders of their accountability for quality. This year the Patient Experience team have:

- Mapped and streamlined the process for delivering patient stories across Calderdale, Greater Huddersfield and North Kirklees CCGs;
- Developed a toolkit to support staff in gathering, recording and sharing patient stories;
- Designed training and support packages for staff and patients/carers;
- Developed creative solutions for sharing stories across the CCGs; and
- Produced a central storage hub/library that meets all governance requirements under the direction and support of the Quality Committee.

4.3 Ensure System Resilience

In our summary of performance later in this report we highlight the continued pressure on our local urgent care system. The Accident & Emergency Delivery Board (previously the System Resilience Group) has been proactively leading the system to ensure high quality care and system resilience. The Board is chaired by the CCG's Chief Officer and includes clinicians from both primary and secondary care. Meeting monthly, the Board:

- Reviews system performance and identifies mitigating actions;
- Drives the system to identify system risk and develop responses within the context of financial and workforce constraints;
- Develops thinking on any pilots or new initiatives in response to the needs of the local system;
- Seeks to ensure alignment with the work of the West Yorkshire Urgent & Emergency Care Network and the work of the Healthy Futures programme;
- Is developing a view of the Board's 'common purpose' in order to drive forward future plans;
- Ensures opportunity for partners to come together in development mode to build relationships and nurture innovation.

4.4 Ensure a Clear Focus on Financial Recovery

The CCG has had a challenging financial year in 2016-17 and has responded by developing a financial recovery plan to take us forward into 2017-18. Further detail of our financial performance and recovery plans are set out later in the performance analysis of this report.

4.5 Partnership Working

The CCG continues to be committed to partnership working across a number of footprints. During 2016-17 the main strands of this work have been:

- The proactive work undertaken with the Health & Wellbeing Board to develop a Single Strategic Plan for Calderdale;
- Proactive work undertaken with Calderdale Local Medical Committee on developing resilient and sustainable primary care, focus on our shared priorities and making effective use of available resources;
- The continued leadership of the work of the Vanguard Board which has been pivotal in developing thinking on new accountable care models;
- Active participation on the Accident & Emergency Delivery Board;
- Our focus on work to reduce delays in transferring patients across care settings, and reducing harm associated with delays and de-conditioning;
- Our focus on work to bring together partners, in the form of the Elective Care Board. This supports our work to strengthen our elective care QIPP (Quality, Innovation,

Productivity and Prevention) plans and brings together both NHS and independent sector providers in order to innovate and improve care;

- The collaboration with our partners in Greater Huddersfield CCG, CHFT and Locala CIC in the form of a Transformation Group which is working to align improvement activities and create efficiency;
- The creation of a new Integrated Commissioning Executive between the CCG and Calderdale Council to drive forward integrated commissioning activities;
- Our proactive involvement in the development of the West Yorkshire Healthy Futures programme at both an executive and programme level – ensuring Calderdale has a strong voice in leading and shaping initiatives.

Partnership working: falls prevention through early identification

In 2016, the CCG led a multi-stakeholder team to review the approach to early identification and prevention of falls for frail elderly people who live in their own homes. The project included the Fire & Rescue Service (FRS), Calderdale Council, CHFT community falls team, AgeUK and Community Transport. The project aimed to enhance the FRS Home Hazard Risk Assessments by including health and social care to deliver a more holistic assessment – the *Safe and Well Check*. Part of the work included identifying people for onward referral and appropriate signposting. Since the pilot started, the FRS in Todmorden and the Upper Valley Staying Well Team, have completed 61 visits with one third of individuals being referred to partner agencies. This has resulted in individuals being supported earlier, enabling them to maintain their independence for longer. This approach is now being rolled out across Calderdale. The aim is to roll out this approach across all West Yorkshire Fire Services.

The commitment that the CCG has shown to partnership working and to raising the visibility of our clinical leaders in particular, is reflected in the current performance rating for the CCG on *My NHS* (www.nhs.uk/mynhs) which rates the CCG as GREEN on the quality of its leadership. Our focus on building and sustaining relationships is also reflected in the welcome results of this year's 360 degree stakeholder survey in which 85% of respondents said that they felt that there were good working relationships in place, and 79% said we had clear and visible leadership. We also welcomed the fact that 79% of respondents had confidence in our ability to deliver our strategic plans.

The 2016-17 year-end assessment for our CCG will be available from July 2017 on www.nhs.uk/service-search/Performance/Search

5 Summary of Performance

Our areas of challenge on performance relate to the financial position across the system and the resilience of our urgent care system. This is reflected in the three critical risks for 2016-17; the risk that patients who are medically fit to be discharged from hospital are subject to delays in their transfer of care; and the risk that the CCG fails to deliver its 2016-17

planned financial surplus; the risk that the system will not deliver the NHS Constitution 4-hour Accident & Emergency target due to pressures associated with demand, capacity and flow. Our other major risks also reflect the pressure on the system and our ability to mitigate against this through our QIPP programme (further information is contained in the Governance Report on page 37).

The performance of our system however, whilst suffering exactly the same stresses as the wider NHS, is better than most. That, at least in some part, is a function of the commissioner grip on the things that matter and the Finance and Performance Committee has played an important role in this regard. The Committee has continued to maintain grip, and the flow of information has enabled monitoring of the position and the committee to ascertain the impact of key initiatives through QIPP and through regular reports on the contract position and progress with the process of contract challenge. We have also worked with health and social care partners on the Accident and Emergency Delivery Board to monitor and respond to the pressures on the urgent care system.

6 Key Issues and Risks

The issues and risks for the CCG reflect our ability to work with partners across the system to respond and transform the way that health and social care is delivered across Calderdale and across West Yorkshire at a time of increasing pressures on our urgent care system and financial position. In responding to these challenges we are committed to sustaining the quality of services being provided and working with local authority public health colleagues on the prevention and supported self-care agenda. (See Appendix 1: The Governance Statement for a summary of the in-year risks classed as 'serious' on our Corporate Risk Register, i.e. with a score of 15 or above).

The risks to the delivery of our strategic objectives and compliance to the CCG's licence are set out in Appendix 3 of the Governance Statement.

Performance Analysis

1. Key Performance Indicators used by NHS Calderdale CCG

Delivery against the CCG mandate is measured by using the indicators set out in the NHS Constitution. This ensures a consistent approach which can be assessed against explicit standards and benchmarked across the local healthcare system, regionally and nationally.

- **NHS Constitution standards:**

- Referral to treatment times (maximum waiting times from referral to treatment for patients on incomplete non-emergency pathways);
- Waiting times for diagnostic tests;
- Accident and Emergency waiting time to be admitted, transferred or discharged;
- Cancer waiting times;
- Ambulance response times for category A calls;
- Mixed Sex Accommodation;
- Incidence of Health Care Acquired Infections (HCAIs);
- Cancellation of operations;
- Care Programme Approach (CPA) for mental health patients.

Performance against the standards of the NHS Constitution has been strong throughout the year with the majority of the constitutional standards being achieved (See Appendix 1: Performance Report, page 34). Good progress has been made in:

- Referral to treatment times for patients on incomplete non-emergency pathways;
- Diagnostic waiting times – less than six weeks from referral;
- Cancer waiting times – 2 week wait following GP referral;
- Cancer waiting times – 31 days from diagnosis to treatment.

Sustaining the 4-hour target in Accident & Emergency has proved difficult with periods of underperformance during 2016-17. Achieving and sustaining this target remains a priority for the local health and care economy.

Overall performance has been good against the cancer target of 62 day wait from urgent GP referral to first definitive treatment. However the standard has been breached over the past few months. Any breaches are reviewed initially by the Calderdale and Greater Huddersfield Cancer Network to identify the cause and impact and are discussed as appropriate at the Clinical Quality Board. The CCG receives internal assurance through the Quality and Finance and Performance Committees.

- **Quality Premiums**

The Quality Premium is a NHS England scheme to reward CCGs for improvements in the quality of services they commission. The Quality Premium paid to CCGs in 2016-17 reflects the quality of the health services commissioned in the previous year.

The table below summarises the measures that cover a combination of national and local priorities, the financial reward available and the achievement made in Calderdale.

Theme	Measure	Percentage of the Quality Premium	Potential Value (£000's)	Achievement (Y/N)	Eligible Funding (£000's)
Urgent and Emergency Care	Reduction in avoidable emergency admissions	16.7%	£175	N	£0
	Increase in the number of patients admitted for non-elective reasons, discharged at weekends or bank holidays	16.7%	£175	Y	£175
Mental Health	Reduction in waiting times for mental health patients in A&E departments	33.3%	£350	N	£0
Prescribing	Improved antibiotic prescribing in primary and secondary care	11.1%	£115	Y	£115
Local	Reduction in readmissions for mental health patients	11.1%	£115	Y	£115
	Increase in the number of patients discharged with a joint health and social care plan	11.1%	£115	Y	£115
TOTAL		100%	£1045		£520

The total reward available to the CCG was £1,045m. Due to challenges associated with urgent and emergency care, the eligible reward was £520k. These pressures also had an adverse impact on the delivery of the constitutional standards for Accident & Emergency waits and ambulance response times. This reduced the overall Quality Premium available to the CCG by 50%. As a consequence, Calderdale received £260k for the Quality Premium. For the purposes of clarity, this had no impact on the CCG's underlying financial position as the CCG had not made an assumption about the award of the quality premium in its financial plans for 2016-17.

➢ Better Care Fund

The Better Care Fund (BCF) is a national initiative to promote integrated out of hospital care and is seen as an important enabler for system transformation and integrated commissioning. Two new national conditions were added in 2016-17 focused on the delivery of out of hospital services and reductions in delayed transfers of care, both of which had clear alignment with delivery of the CCG's Plans. Throughout the year, we have continued to work closely with Calderdale Council, ensuring that the BCF Plan for 2016-17 was fully aligned with the Care Closer to Home Programme. The Plan included schemes aimed at reducing the growth in avoidable emergency admissions to hospital and permanent admissions to residential care. The plan also aimed to reduce delayed transfers of care (DTOC) and achieve improvements in rehabilitation outcomes.

The BCF has six metrics against which our performance is measured:

- Non-elective admissions in hospital (general and acute), all age;
- Delayed transfers of care (delayed days) from hospital (age 18+);
- 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 re-ablement/rehabilitation services;
- Effectiveness of re-ablement services;
- Patient/service users experience.

Performance against the Better Care Fund metrics is reported to the Better Care Fund Programme Board and quarterly to the CCG's Finance and Performance Committee and the Health and Wellbeing Board. It is also reported to NHS England on a quarterly basis (See appendix 2: Performance Report, page 35).

➢ **Quality, Innovation, Productivity and Prevention (QIPP)**

Throughout 2016-17 the CCG continued to work on a set of initiatives which sought to improve patient care and reduce inefficiencies. The approach to the work was to:

- Build on work carried out over the past 2 years;
- Focus on initiatives that delivered our strategic intentions, particularly Care Closer to Home;
- Ensure alignment between QIPP initiatives and primary care initiatives – particularly the Commissioning Engagement Scheme (see Members Report);
- Maximise the use of joint staff working across Calderdale and Greater Huddersfield CCGs in order to ensure consistency and learning wherever possible;
- Develop further joint working between the CCG, Greater Huddersfield CCG, CHFT and Locala CIC – to ensure that schemes are aligned and visible;
- Continue to work with Right Care as part of the first wave of CCGs, to maximise delivery of Right Care opportunities in our current and future plans;
- Strengthen our focus on elective care work through the Elective Care Improvement Board;
- Develop recovery proposals for 2017-18 to 2020-21.

In 2016-17 the medicines management team delivered estimated savings from the prescribing budget of £840k through implementation of the CCG prescribing action plan. This included cost effective changes to patients medication in line with local and national guidelines to maximise the benefit from the prescribing budget for Calderdale patients.

A key focus during the last quarter of the year was to develop plans aimed at delivering the planned £11.6m QIPP target for 2017-18 as part of financial recovery.

➢ **Friends and Family Test**

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service they receive, or where improvements are needed. Results are published nationally on NHS Choices.

The CCG's Quality Team reviews the information on a monthly basis, monitoring response rates as well as the percentage of patients who are or are not likely to recommend a service.

The Quality Team reviews the statistics for all providers in relation to inpatient care, outpatients, emergency care, community services and maternity. The data is displayed on the Quality and Safety Dashboard received by the Quality Committee. The Primary Care Quality and Improvement team also reviews the FFT data for primary medical services.

2. Financial Performance

The CCG has had a challenging financial year in 2016-17. We have experienced unprecedented increases in spend on acute hospital activity, specifically with our local hospital, which combined with the CCG receiving the lowest levels in growth in allocations across the region has meant that the CCG has not achieved its financial plan for the year. The CCG had planned to deliver a reported surplus of £6.4m and in addition the CCG was required to maintain an unspent £3.1m risk reserve as a contribution to the NHS England national position to manage risk across the NHS (a reported surplus would have been £9.5m). However during the year, due to significant financial challenges the CCG was not able to deliver the planned level of surplus; its reported surplus position is £2.7m, a reduction on its plan of £3.7m. The CCG has managed to retain the national risk reserve and has therefore delivered a surplus of £5.8m. This failure to achieve our reported plan will impact on the CCGs eligibility for Quality Premium payments as our underlying surplus was less than 1% of our allocation.

The CCG has a number of statutory financial duties and targets against which our performance is monitored. Although the CCG has experienced significant financial challenges and has not achieved its financial plan, 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 CCGs performance against these targets in 2016-17:

Financial Duty	Achieved/Not Achieved	Performance in 2016/17
Achieve operational financial balance	**Achieved**	Delivered surplus of £5,783k
Revenue administration resource use does not exceed the amount specified in Directions	**Achieved**	The CCG underspent on its administration by £548k
Maintain capital expenditure within Capital Resources		Utilised capital resource of £32k
Manage cash within the CCG's Cash Limit	**Achieved**	Cash balance of £45k
Public Sector Payment Policy - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty)	**Achieved**	Non-NHS invoices 99.6% volume, 99.7% value. NHS Invoices 95.6% volume, 99.7% value.

➢ Investments in Services

During 2016-17 we invested over £312m to improve the health and care of local people through the commissioning of high quality services. The net investments in the different sectors as well as the proportion of spend against the CCG's management cost allowance is set out in the diagram on page 26.

As a result of the financial pressures the CCG has not been able to utilise non-recurrent budgets to invest in specific services as in previous years. However we have maintained investments in priority areas.

Specific investments during the year have been in the following new services for people in Calderdale:

- **Quest for Quality Service** – continued funding for care homes in Calderdale to improve the quality of the care they provide through new technology and a new community-based multi-disciplinary team.

- **End of Life Care** – continued funding for the programme aimed at educating health professionals around good palliative care provision and also providing dedicated out of hours crisis intervention/community nursing service.

- **Mental Health** – continued funding for Crisis Resolution Team to support 24/7 service.

- **Child and Adolescent Mental Health Service (CAMHS)** – additional investment to support the service and Autism Spectrum Disorder backlog.

- **Respiratory** – investment of six specialist respiratory nurses in the community as part of Care Closer to Home.

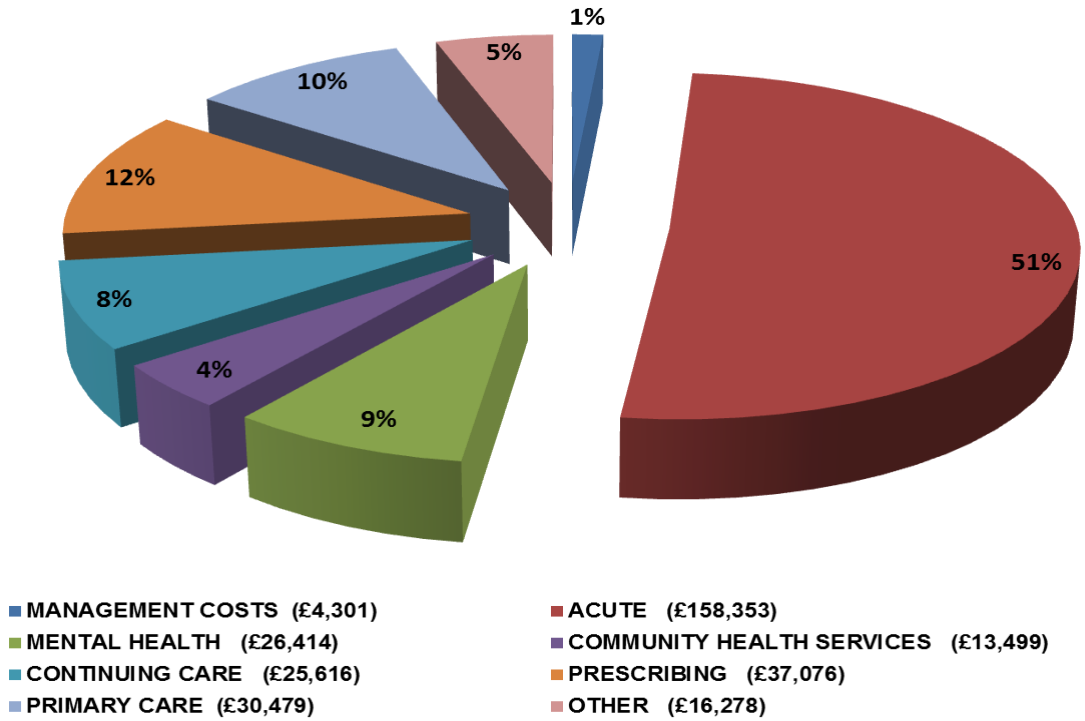
- **Musculo-skeletal services (MSK)** – investment in new upper limb service in the community.

- Attracted national funding for Improving Access to Psychological Therapies (IAPT).

A copy of the contracts register can be found on the CCG's website:
https://www.calderdaleccg.nhs.uk/wp-content/uploads/2016/06/NHS-Calderdale-CCG-Contract-Register-January-2017.pdf

The CCG has underspent against its management cost allowance by £548k.

Net investment by the CCG (£000)



➢ Financial planning for 2017-18

In order that we continue to deliver the transformation and service change set out in our strategic plan, following NHS England guidance a number of reserves have been created within our financial plan for 2017/18, these include:

- Better Care Fund;
- 0.5% Contingency reserve;
- GP Forward View investment;
- Five Year Forward View Mental Health;
- Children and Young People and Eating Disorders.

The plan for 2017-18 is extremely challenging and relies on the CCG being able to make significant levels of QIPP savings of £11.5m. Even with this level of savings the CCG is planning a small deficit of £400k in 2017-18. As part of our recovery programme, the CCG will be reviewing all its previous investment and contracts to ensure value for money and that expected outcomes are being delivered. In addition, the CCG has identified five key areas to focus resource whilst in financial recovery. These are:

- Eliminating Waste;
- Ensuring services are performing as expected;
- Transactional work;
- New models of funding and financial flows;

- Stopping things.

The Governing Body has agreed the financial plan for 2017-18 and recognises that the level of savings required to meet our plan is challenging. As part of any investment recognised above the Governing Body has clear expectations of how they will aid our recovery and financial sustainability as well as deliver clear outcomes for patients.

➢ **Financial Risk**

As part of our planning process the CCG has identified a number of risks that threaten delivery of our 2017-18 financial plan which are reflected on our Corporate Risk Register (See Appendix 1: Governance Statement: risks to the CCG). These include:

- That acute spend increases above that currently forecast;
- That prescribing spend is higher than that forecast in plan;
- That continuing care spend continued to grow above the level that we have forecasted in plan; and
- 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.

Antimicrobial stewardship continues to be a priority to safeguard these vital medicines for future use by reducing the growth of antimicrobial resistance. Our CCG is on track to achieve the 2016-17 Quality Premium. This is for maintaining the prescribing of broad spectrum antibiotics below the England median level. An antibiotic campaign ran in Calderdale practices and community pharmacies in 2016 with the following key messages:

1) Become an antibiotic guardian;
2) Don't prescribe for self-limiting illnesses;
3) Promote self-care.

3. 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 spending public money well, the smart and efficient

use of natural resources and building healthy, resilient communities. 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 acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

In order to fulfil our responsibilities we produced a Sustainable Development Management Plan (SDMP) in 2015. This is due for revision in 2017-18 in the light of the changing context in which the CCG is now operating.

3.1 Good Corporate Citizenship Tool

The CCG, as a commissioning organisation and employer, continues to carry out activities in a number of areas included in the Good Corporate Citizenship Tool. These demonstrate our commitment to fulfilling our corporate social responsibility. A number of these areas are covered elsewhere in this annual report and include:

- *Community engagement policies and performance* (ref: the work of our patient and public engagement and experience team);
- *Partnership and planning policies and performance* (ref: our work with the Health and Wellbeing Board, the Transformation Board and through the West Yorkshire and Harrogate STP);
- *Emergency Preparedness* (ref: the focus on the Accident and Emergency Delivery Board on Urgent Care Resilience and our continued emergency planning work with partners across Calderdale and West Yorkshire as a category 2 responder);
- *Models of Care* (ref: our continued focus on integrated commissioning and Care Closer to Home as part of the Single Strategic Plan for Calderdale and the BCF Plan);
- *Healthy Lifestyles* (ref: our continued commitment to staff health and wellbeing with our focus on mental wellbeing this year and continued support for the Food for Life Programme).

3.2 Encouraging a Healthy Workforce

The issue of workforce health and wellbeing is of great importance to the CCG. We have engaged in a range of initiatives to support the physical and psychological wellbeing of our staff. This has strong sponsorship from the Governing Body and the SMT, and is managed through the Staff Forum.

Some examples are:

- Participation in the Global Corporate Challenge. This 100 day challenge is aimed at increasing physical activity and improving nutrition, sleep quality and psychological resilience. Key outcomes were that 72% of participants exceeded the national guidance for physical activity of 10,000 steps per day, 74% reported feeling less stressed and 78% said they felt more productive;
- A regular informal "tea and talk" session to encourage positive relationships across the organisation, with a quarterly focus on promoting positive mental health;

- The introduction of a Wellbeing Half Hour, which provides staff with a weekly opportunity to undertake activities, with an overall aim of contributing to overall wellbeing and benefitting productivity;
- Training for managers in how to manage sickness absence, including the promotion of positive health and wellbeing;
- The establishment of a "walk and talk" walking group, to encourage staff to take a break, participate in physical activity, and build relationships;
- A programme of activities to promote World Mental Health day, including the introduction of a mental health pledge wall;
- The introduction of mindfulness sessions;
- The development of an approach to staff volunteering, to benefit the local community.

The CCG is also an active participant in a Calderdale-wide workforce wellbeing group, working with other local public sector organisations to develop a joined-up approach to the wellbeing of the people of Calderdale.

3.3 Reducing our Carbon Footprint

Whilst we recognise that reducing our carbon footprint continues to be a challenge for the CCG, we are committed to rolling out a number of initiatives specifically:

➢ **Focus on Reducing Car Journeys**

In 2016-17 we increased our staff base by just over one third as a result of the closure of the Commissioning Support Unit and the transfer or appointment of staff to fulfil these roles.

A number of these staff are in shared roles, increasing the pressure to make regular car journeys between CCGs. We used the sustainability day in March to launch our focus on

reducing the number of car journeys and miles travelled. Staff can monitor the miles saved on the CCG's intranet.

We now have video and teleconferencing equipment at the CCG. This contributes to the reduction of our carbon footprint, releases staff capacity and energy which otherwise would be spent travelling and makes an important contribution to our financial sustainability.

- **Focus on Effective Meetings**

Following our external governance review in 2015-16 we re-evaluated all of our committee meetings to identify whether we were working as effectively as we could. We reduced the number of required meetings or re-focussed the agendas of others (see the Governance Statement). This has resulted in a release of staff and Governing Body member capacity and reduced printing costs.

- **Focus on a Reduction in Printing**

On the 23rd March 2017, as part of the sustainability day we launched the challenge of reducing our printing by 20% over the next three months. We will continue to monitor our progress against this into 2017-18.

- **Resource Usage in 2016-17**

Our resource usage in 2016-17 is set out in the table below:

Resource	**Quantity (kWh)**		**tCO2 emissions**		**Cost (Inc. VAT) (£)**	
	2015-16	**2016-17**	**2015-16**	**2016-17**	**2015-16**	**2016-17**
Gas **note1**	49,662	37,600	10.4	8	13,648	1,828
Electricity **note4**	281,132	51,652	161.6	27	45,052	7,265
General waste **note2**	--	--	--	--	---	----
Recycling (including confidential waste)	--	--	--	--	2,451	2,364
Water **note3**	--	--	--	--	--	--
	Miles				**Miles**	
Business Travel **(miles) note4**	35,418	56,732	12.8	20.5	20,367	33,844

Note1: Part way through 2015-16 new meters were fitted by the landlords which allow for individual meter reading rather than being required to pay a proportion of total costs. This accounts for the reduction in reported usage and cost

Note2: General waste disposal forms part of the cleaning contract and is not separated out

Note3: The charge for water usage is contained within the general service charge and is not separated out

Note4: Staff numbers for Calderdale CCG increased by just over one third in 2016-17 with an increased number of staff working in shared roles across more than one CCG. This is reflected in part in the increase in business travel figures.

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4. Meeting our Statutory Duties

Whilst the CCG is compliant with its statutory duties overall, we have summarised our activities in four of the areas below:

4.1 **Ensuring the Continuous Improvement in Quality** (Section 14R, NHS Act 2006 as amended)

Ensuring patient safety and improving quality is core to our business. We work hard to maintain strong relationships with our providers and this enables us to take forward the learning from reviews from the National Quality Board such as *Shared Commitment to Quality*, which is a new framework that will promote improved quality criteria across all national health organisations, and the recent findings of the Care Quality Commission report *Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.*

Our focus on reducing harm, improving effectiveness and experience includes:

- Local CQuIN (Commissioning for Quality and Innovation) targets;
- Supporting incident reporting and sharing lessons learned particularly across the whole system;
- Participation in campaigns such as *National Kitchen Table Week* (where staff and colleagues are invited to visit to it and have a conversation about what they know about keeping people safer);
- Embedding the use of quality impact assessments in all commissioning decisions to ensure we understand and mitigate any impacts on quality;
- Using patient experience data collected through our patient story process and Patient Experience Group, to help inform commissioning decisions and make improvements in partnership with our providers.

4.2 **Public and Patient Involvement** (Section 14Z2 NHS Act 2006 as amended)

The CCG aims to involve people as early as possible in the development of services and to have a voice in commissioning decisions. As part of our duty to involve local people we have a strategy which sets out our approach to engagement and patient experience. This has been published on the CCG's website.

As part of our approach we want to involve those who will be most affected including local people who represent the voice of our most vulnerable and protected groups. By ensuring local people have a voice and are involved in any service change, plan or proposal, we can ensure services meet the needs of the people who use them now and in the future.

Our aim is to involve local people through a range of methods either individually or through partners such as the voluntary and community sector, patient reference groups and organisations such as Healthwatch. This year we have involved people in a number of

service areas and projects. Examples of services and projects undertaken in 2016-17 are provided earlier in this report.

4.3 **Reducing Health Inequality** (Section 14T NHS Act 2006 as amended)

Throughout 2016-17 the CCG has continued its strong relationship with the Public Health Team at Calderdale Council. The CCG and the Public Health Team have developed a number of opportunities to ensure that there is a clear focus on the wider determinants of health and proactive work on reducing health inequalities. During 2016-17 this has included:

- Stronger collaboration on the content of the Calderdale Joint Strategic Needs Assessment;
- The Director of Public Health attending the CCG's Governing Body;
- The Public Health Team being part of our Commissioning Development Forum where we develop our thinking together;
- A Public Health Consultant being a 'virtual' member of the Service Improvement Team to ensure that the importance of public health is visible in our plans;
- The development of a key strand in the Single Strategic Plan for Calderdale on wider determinants which has also served as our STP submission to West Yorkshire and Harrogate – demonstrating the commitment of our system to this work;
- The development of an early version of a Joint Prevention Strategy across the two organisations which provides a single basis from which to develop and deliver new initiatives;
- A number of joint improvement activities led by the Vanguard programme, for example the *Staying Well* initiative, which focused on reducing the negative impact of social isolation in older people, and supported self-care schemes for people with a long-term conditions.

➢ **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. In doing this, we are guided by our Equality and Diversity Strategy to ensure that all activity puts equality at the centre of all we do as both commissioners and employers:

- All staff and Governing Body members are required to complete their statutory and mandatory training, which includes equality and diversity elements;
- Establishment of the Calderdale Equality Panel (membership is drawn from a range of community and voluntary sector organisations representing each of the protected characteristics);

- The panel graded the CCG and participating NHS organisations against a set of Equality Delivery System (EDS2) outcomes to inform the Equality Objectives for 2017-18
- Performance against the delivery of our equality and diversity duties is reported into the Quality Committee on a quarterly basis and an Annual Report submitted to the Governing Body.

4.4 Contribution to the Delivery of the Joint Wellbeing Strategy (Section.116B (1)(b) Local Government and Public Involvement in Health Act 2007)

The CCG has worked proactively with the Calderdale Health and Wellbeing Board in the development of a Single Strategic Plan for Calderdale. In 2012 the Health and Wellbeing Board agreed a 10 Year Strategy.

Five years into the lifetime of the original strategy, six Health and Wellbeing Board development sessions were held throughout the year to build on the content of the strategy and develop an updated plan – the Single Strategic Plan for Calderdale. This was formally agreed by the Health and Wellbeing Board in January 2017. The Board also agreed an approach to take the work forward, which was to:

- Develop an implementation plan for the remaining actions from the Joint Wellbeing Strategy and the Single Strategic Plan confirming a single approach to delivery;
- Strengthen partnership working and joint implementation of actions within the first 18 months;
- Identify a set of priority areas, by which the Health and Wellbeing Board could demonstrate the value of a strengthened partnership approach;
- Adopt the recommendations proposed in the Director of Public Health Report 2016 to promote health in the first 1000 days;
- Identify the key enabling work which would need to be taken forward in order to deliver the strategic direction;
- Become the basis for the national imperative to integrated health and social care in the next 1,000 days – providing clarity on what it means to integrate and the outcomes that need to be achieved;
- Provide the basis for dialogue on developing an Accountable Care Organisation to deliver community services in Calderdale – focused on the principles of prevention, supported self-care, independence and personalisation;
- Provide the opportunity to embed and deliver on priorities developed at the State of Calderdale and Economic Resilience events held in February 2017 – including a focus on youth, and closer working with local education providers.

Work is ongoing to develop and agree a timeline for delivery of key priorities to be overseen by the Health and Wellbeing Board.

Performance against NHS Constitution Rights and Pledges (please see page 21 for further information)

Appendix 1

Reporting Period Mar 2016/17

NHS Constitution Rights and Pledges 2016/17

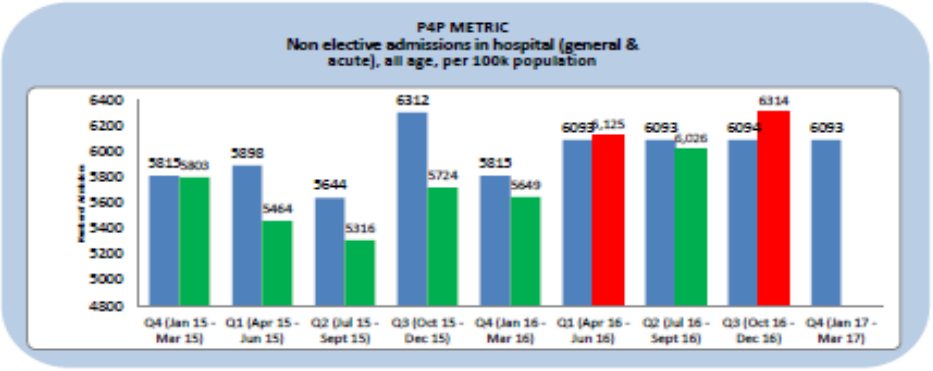
Outcome/Measure		Target/ Baseline	Period Actual	Period RAGS	YTD	YTD RAG	Direction of Travel
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	82.3%	-	84.1%	-	↑
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	97.2%	-	97.2%	-	↑
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	94.7%	●	94.8%	●	↑
	Number of patients waiting more than 52 weeks	0	0	●	0	●	↔
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	93.8%	●	99.0%	●	↓
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	97.4%	●	94.2%	●	↑
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0	●	0	●	↔
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	99.0%	●	97.7%	●	↑
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	97.3%	●	96.1%	●	↑
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	100.0%	●	98.4%	●	↔
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%	●	98.4%	●	↔
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	●	100.0%	●	↔
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	●	100.0%	●	↔
Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	89.8%	●	86.4%	●	↑
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	100.0%	90.1%	●	↑
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	tba		tba	100.0%	tba	
Category A Ambulance Calls	Red/Category1 calls resulting in an emergency response arriving within 8 minutes **	75%	73.3%	●	70.0%	●	↑
	Amber/Category 2R calls resulting in an emergency response arriving within 19 minutes **		82.1%	-	73.3%	-	↑
	Amber/Category 2T calls resulting in an emergency response arriving within 19 minutes **		69.6%	-	66.8%	-	↓
	All handovers between ambulance and A&E must take place within 15 minutes *	95%	70.9%	●	72.3%	●	↑
	All crews should be ready to accept new calls within a further 15 minutes *	95%	69.7%	●	73.0%	●	↓
Mixed Sex Accommodation	Minimise breaches	0	0	●	0	●	↔
MRSA	Number of MRSA reported infections	0	0	●	1	●	↓
C_Diff	Number of C-Diff blood stream infections	39	7	●	51	●	↑

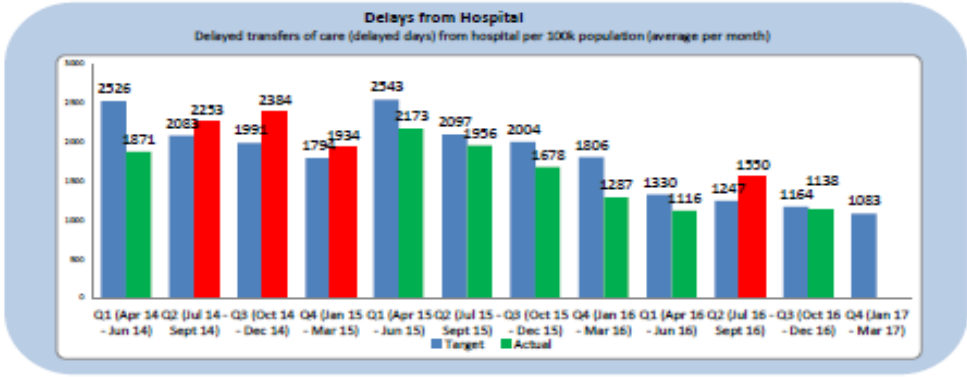
* = main provider level

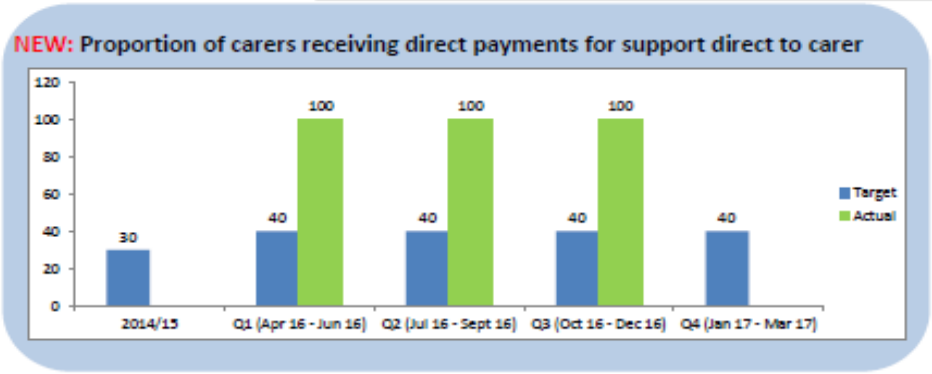
** YAS have been participating in a pilot which has involved new call categories. The initial pilot ran from 21st April 2016 until 19th October 2016 and the second phase began on 20th October 2016. Due to the changes in categories direct comparison between the different phases cannot be done because they don't necessarily represent the same activity

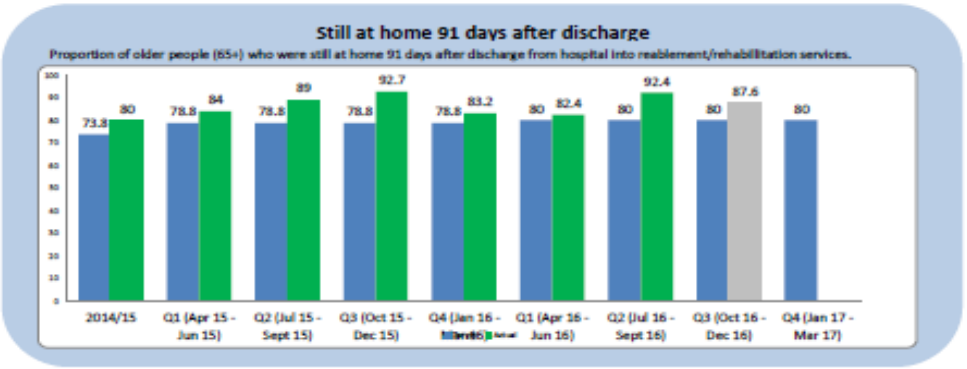
Appendix 2

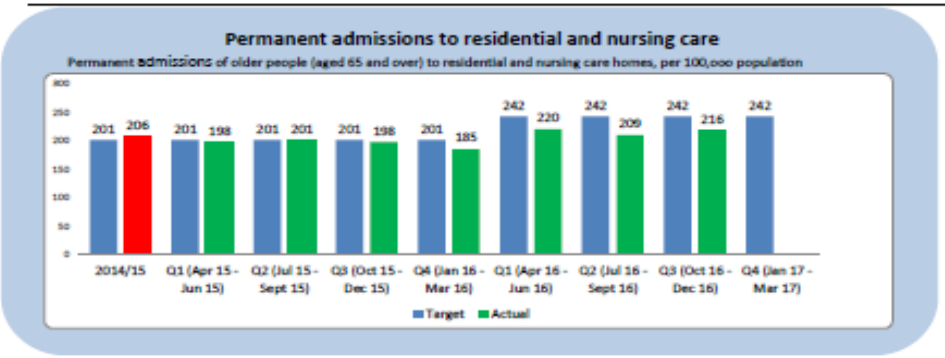
Performance against the Better Care Fund Metrics (please see page 22 for further information)

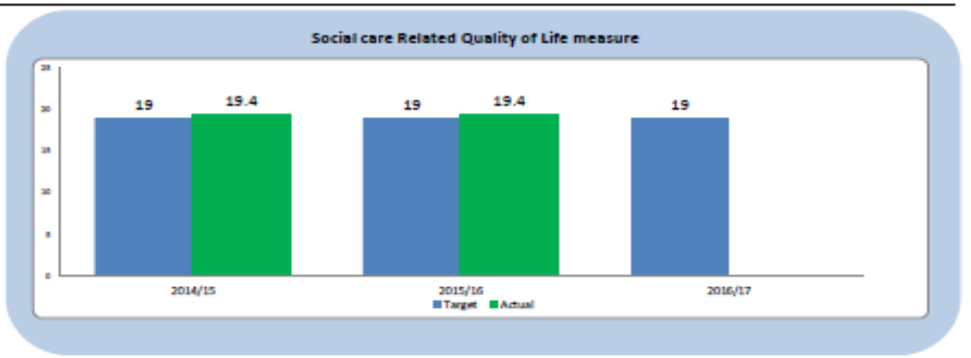












Accountability Report

1. Corporate Governance Report

    - Members Report
    - Statement of Accountable Officer's responsibilities
    - Governance statement

2. Remuneration and Staff Report

3. Parliamentary Accountability and Audit Report

Dr Matt Walsh

Accountable Officer,

24 May 2017

CORPORATE GOVERNANCE REPORT

Members Report

1. The CCG as a Membership Organisation

The CCG is made up of the 26 practices based in Calderdale (see Appendix 1 to this Members Report). The CCG engages with the member practices and primary care clinicians in a number of ways; through the Practice Commissioning Leads, the Commissioning Team meetings, Clinical and Lay Associates, the Medicines Advisory Group and the Practice Managers Advisory Group.

Commissioning Engagement Scheme

The mechanism for engaging with the practices is set out in the commissioning engagement scheme which is approved on an annual basis. In 2016-17, work continued to develop strong clinical engagement in the commissioning process, as well as addressing local needs. Building on the work undertaken in the previous years, the scheme involved the CCG membership working together to:

- Improve the quality of patient care;
- Improve access to services;
- Support each other in identifying and sharing of best practice;
- Promote continuous improvement of services;
- Enable the review of existing services and service redesign.

In 2016-17, the outcomes of the scheme which were aligned with the CCG's strategic priorities, were:

- An improvement in quality and safety – Services and Medicines;
- Improved patient experience – Access and Quality;
- A reduction in unwarranted variation between practices in both service delivery and usage of secondary care services;
- A contribution towards QIPP delivery across the healthcare system;
- Supporting shift from unplanned to planned care.

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

- **Practice Commissioning Leads**

Each practice has nominated a Practice Commissioning Lead, the role of which is 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 shaping the priorities of the CCG, testing plans and proposals and taking forward projects aligned to the priorities of the CCG.

In 2016-17, the CCG held six Practice Commissioning Leads meetings which are attended by the Practice Commissioning Lead and Practice Manager from each of the member practices.

The Practice Commissioning Leads also vote on behalf of their practices and during the year voted on the amendments to the CCG's Constitution and the establishment of the Healthy Futures Joint Committee as a Committee of the CCG.

Work with the member practices is steered by the CCG's Clinical Development Forum (CDF).

- **Commissioning Teams**

The member practices are funded by the CCG to meet together in one of five commissioning teams to work collaboratively on a project relating to one of the CCG priorities. This approach over past few years has promoted a culture of partnership working, sharing good practice and facilitated a collective approach to problem solving. Last year each of the teams undertook a project relating to one of the CCG priorities:

- Frailty – can admissions for Cellulitis or Urinary Tract Infections (UTIs) be avoided?
- Respiratory – early intervention to prevent lower respiratory tract infection, reducing need for hospital admission;
- Cardiovascular Disease – Heart Failure/Cardiac Rehabilitation;
- Mental Health – improving communications.

In order to take this work forward, the teams met at least four times during the year and were supported by representatives from the CCG's Finance, Medicines Management, Contracting and Data Quality/Information Teams and lead programme manager and the attendance at one of the meetings by a Governing Body clinician. The findings from the projects were presented at the Practice Leads meeting in March 2017. The commissioning teams submitted a final report at the end of April 2017which includes a summary of areas of shared of good practice, an outline of commissioning issues identified and areas for potential QIPP Initiatives, the learning from the projects together with any recommendations and any learning from participation in the scheme to enable a review of performance and identification of areas for future development.

Highlights from the Commissioning Team work

Heart Failure
We have worked with Calderdale and Huddersfield Foundation Trust to improve the quality and ease of GP referrals to the heart failure.

Cellulitis
We reviewed the possible obstacles to the use of intravenous antibiotics for treating cellulitis in the community. This will inform future commissioning decisions.

Urinary Tract Infections
Working with clinicians at CHFT, we designed and implemented a training event for all GP practices on improving the identification of UTIs leading to more effective treatment and referrals into the continence service.

Respiratory
We know that patients who attend the community respiratory clinic have fewer emergency admissions. As well as promoting GP referrals to the clinic, we audited the pre-admission care of our patients. As a result we will be working with the Respiratory Team to develop a consistent approach to care of people with pneumonia.

Quality of Information
We worked with clinicians and staff at South West Yorkshire Partnership Foundation Trust to improve the way that GPs and the Trust work together to ensure transfer of timely and high quality patient information.

Performance of the membership

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

- Attendance at practice leads meetings - There has been excellent attendance at the practice leads meetings with all the practices represented at each meeting;
- The presentations of commissioning team project findings at the practice leads meeting in March 2017;
- Evaluation of the effectiveness and value of each practice leads meeting carried out to inform future planning;
- The submission of the final commissioning team reports at the end of April 2017, which the CCG uses to identify any service redesign or QIPP` recommendations as well as assessing the effectiveness of the commissioning engagement scheme;
- Visits to practices carried out by a member of the Governing Body and SMT between September and November 2016.

2. The Governing Body and its Committees

The CCG's membership have delegated authority to the Governing Body to oversee the work of the organisation and make decisions on their behalf as set out in the scheme of reservation and delegation incorporated in the CCG's Constitution (see Governance Statement). The members of the CCG's Governing Body as at 18th May 2017 are set out below.

Details of the Governing Body and committee membership and attendance throughout the year can be found in Appendix 1 of the Governance Statement and in the Remuneration and Staff Report.

The CCG's Governing Body throughout the year

Dr Alan Brook	Chair and GP Member
David Longstaff	Deputy Chair/Lay Member (Audit)
Dr Matt Walsh	Chief Officer
Julie Lawreniuk	Chief Finance Officer (until 30th April 2016)
Lesley Stokey	Interim Chief Finance Officer (1st May 2016 -31st August 2016)
Neil Smurthwaite	Chief Finance Officer and Deputy Chief Officer (from 1st September 2016)
Dr Steven Cleasby	Assistant Clinical Chair and GP member
Dr Majid Azeb	GP Member
Jackie Bird	Registered Nurse
Dr Helen Davies	GP member (from 1st April 2017)
Dr Farrukh Javid	GP Member (from 1st April 2017)
Dr Rajesh Phatak	Secondary Care Specialist (until 28th February 2017)
Dr Lubna Saghir	GP Member (1st August 2016 – 31st March 2017)
Kate Smyth	Lay Member (Patient and Public Involvement)
Dr Caroline Taylor	GP Member
Dr Nigel Taylor	GP Member
Dr John Taylor	GP Member (until 31st January 2017)
Advisors to the Governing Body	
John Mallalieu	Lay Advisor (Finance, Performance and External Relations)
Penny Woodhead	Head of Quality
Stuart Smith	Director of Adults and Children's Health and Social Care Services (Calderdale Metropolitan Borough Council)
Paul Butcher	Director of Public Health (Calderdale Metropolitan Borough Council)

3. Register of Interests

CCGs 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[1].

The CCG has a number of systems and processes in place to manage conflicts of interests – both real and perceived. These are set out in the CCG's Constitution, CCG Standards of Business Conduct and our Policy on the Management of Conflicts of Interest. They include registers of interest for our Governing Body and Committees, Associates and Subject Specialists, staff and CCG members. The register of interests for the Governing Body 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.

4. Personal Data Related Incidents

Details of any incidents involving data loss or confidentiality breaches are contained in the Governance Statement.

5. Statement of Disclosure to Auditors

Each individual 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.**

6. Modern Slavery Act

The Modern Slavery Act 2015[2] establishes a duty for commercial organisations with an annual turnover in excess of £36m to prepare an annual slavery and human trafficking statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its business. Income earned by NHS bodies from government sources, including CCGs, is

[1] Section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act; CCG Constitution (as revised May 2017)
[2] http://www.legislation.gov.uk/uppga/2015/30/contents

considered to be publicly funded and is therefore outside the scope of these reporting requirements. Where NHS bodies engage in profit-making activities, these may still be sufficient to trigger the reporting requirements.

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.

However, during the past year, the CCG has demonstrated its commitment through our membership of the West Yorkshire and local 'Human Trafficking & Modern Slavery' Groups. The aim of the groups is to work in partnership to combat modern day slavery by developing preventative approaches; strengthening support and protection of victims; and improving the identification, disruption and prosecution of offenders. Modern Slavery is also included in training that the safeguarding team delivers to GP practices and CCG staff which aims to improve identification of issues and ensure appropriate referrals are made.

Appendix 1

List of Member Practices and Practice Commissioning Leads

Practice Name	Location	Practice Lead
Bankfield Surgery	Huddersfield Road, Elland	Dr J L Gray
Beechwood Medical Centre	Keighley Road, Ovenden	Dr L King
Boulevard Medical Practice	Savile Park Road, Halifax	Dr P Rajeswari
Burley Street Surgery	Burley Street, Elland	Dr F Naz
Brig Royd Surgery	Hirstwood, Ripponden	Dr B Wyatt
Caritas Group Practice	▪ Woodside Surgery Boothtown ▪ Mixenden Stones Surgery ▪ Shelf Health Centre	Wendy Iles
Locala Community Partnerships CIC	▪ Calder Community Practice, Todmorden ▪ Park Community Practice, Horne Street, Halifax	Dr Susi Harris
Church Lane Surgery	Church Lane, Brighouse	Dr J Crossland
Hebden Bridge Group Practice	▪ Valley Medical Centre, Hebden Bridge, ▪ Grange Dene Medical Centre, Mytholmroyd ▪ Kershaw Drive, Luddenden Foot	Dr K Moore
Horne Street Surgery	Horne Street Health Centre, Halifax	Dr M Niazi
Keighley Road Surgery	Keighley Road, Illingworth	Dr K Simpson
King Cross Practice	King Cross, Halifax	Dr H Bolland
Longroyde Surgery	Castle Avenue, Rastrick	Dr J Grant
Lister Lane Surgery	▪ Lister Lane, Halifax ▪ Boothtown Medical Centre, Boothtown ▪ Nursery Lane, Ovenden, Halifax	Dr S Shetty
Meadow Dale Group Practice	▪ Nursery Lane, Ovenden, Halifax ▪ Rosemount House, Huddersfield Road, Elland ▪ Allan House, Sowerby Bridge	Dr L Weir
Northolme Practice	▪ Kos Clinic, Roydlands Street, Hipperholme ▪ Northowram Surgery, Northowram	Dr Santhanam
Plane Trees Group Practice	Sandbeds Road, Pellon	Dr D Kumar
Queens Road Surgery	Queens Road, Halifax	Dr A Jagota
Rastrick Health Centre	Chapel Croft, Rastrick	Dr D Miller
Rosegarth Practice	▪ Rothwell Mount, Halifax ▪ Siddal, Halifax	Dr P Sawcyzn
Rydings Hall Surgery	Church Lane, Brighouse	Dr A Wilkinson
Southowram Surgery	Law Lane, Southowram	Dr M Azeb
Spring Hall Group Practice	Spring Hall Lane, Halifax	Dr F Price
Stainland Road Medical Centre	Stainland Road, Greetland	Dr S Martin
Station Road Surgery	Station Road, Sowerby Bridge	Dr A Kazi
Todmorden Group Practice	Todmorden	Dr S Vivekanathan

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 Calderdale Clinical Commissioning Group.

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 Section 14R 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements 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 net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and

- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

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

- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Dr Matt Walsh

Accountable Officer

24 May 2017

Governance Statement

By Dr Matt Walsh as Accountable Officer

1. Introduction and Context

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

The CCG'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 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 in my CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG 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 CCG as set out in this governance statement.

3. Governance Arrangements and Effectiveness

The main function of the Governing Body is to ensure that the CCG 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.

The Principles that we abide by are set out in the CCG's Constitution.

3.1 Key Features of the CCG Constitution in relation to Governance

The Governance Framework for Calderdale CCG is clearly set out in our Constitution. It contains the principles of good governance and internal control by which we operate, as well as the governance structure for the organisation. These include:

- The governance structure and decision making;
- Roles and responsibilities of the Governing Body and committees;
- Scheme of reservation and delegation;
- The vision and values of the organisation, the Code of Conduct and adherence to the Nolan principles on Standards in Public Life (1995) 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, including the Policy on the Management of Conflicts of Interest[3].

➢ Split of Responsibilities between the Membership Body and the Governing Body

The CCG's membership body consists of 26 member practices. The decisions reserved to the membership are set out in the CCG's Scheme of Reservation and Delegation. These include 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 and delegation to them the exercise of any functions of the CCG which in its discretion it considers to be appropriate.

They also have responsibility for agreeing the vision and values and overall strategic direction of the CCG.

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

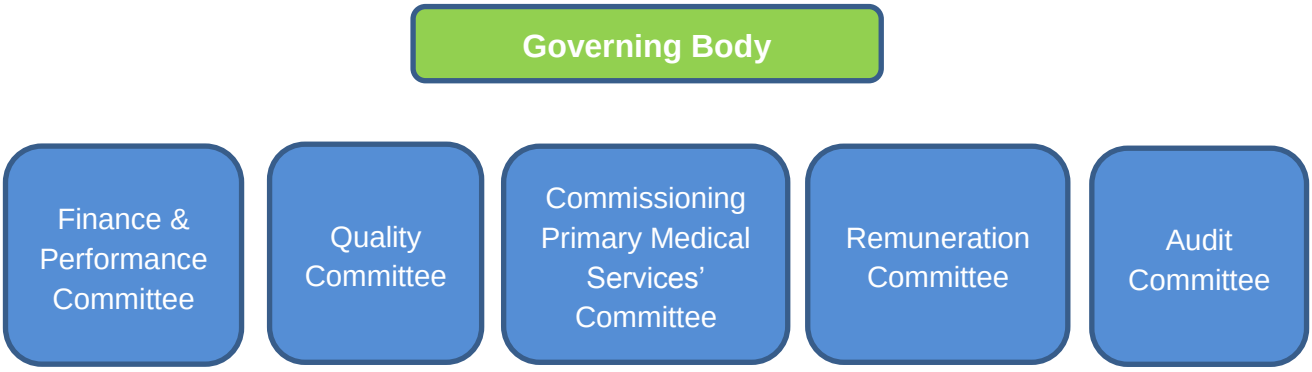
The overarching Scheme of Reservation and Delegation also sets out those decisions that are delegated to the Governing Body and its committees. These include approval of:

- The arrangements for discharging the CCG's statutory duties associated with its commissioning functions;
- The CCG's commissioning plan following engagement with member practices;

[3] NHS Calderdale CCG, Policy on the Management of Conflicts of Interest (revised Feb. 2017)

- 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 local authority, where appropriate;
- Arrangements for any risk sharing or pooled budgets;
- Process for the appointment of the CCG's external auditors.

The governance structure for the CCG comprises the Governing Body and five committees:



Following a change in the legislation[4], the CCG established an Auditor Panel in 2016 to advise the Governing Body on the appointment of the CCG's external auditors (See compliance with the UK Corporate Governance Code on page 57).

The membership of the Governing Body and its Committees, together with the attendance record is set out Appendix 1 at the end of this Governance Statement. Attendance of the Remuneration Committee is set out in the Remuneration Report.

3.2 Work of the Governing Body and Committees

➢ Governing Body

The main function of the Governing Body as set out in the Constitution is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance[5]. What this means in practice is that the Governing Body formulates the strategic direction as well as providing leadership in terms of the vision, values and culture of the organisation. The Governing Body:

[4] Local Audit Accountability Act 2014

[5] Health and Social Care Act 2012

Makes decisions on:

- Strategy;
- Financial spend above £0.5m;
- Certain policies;
- Remuneration of Governing Body members and Very Senior Managers (Chief Officer and Chief Finance Officer/Deputy Chief Officer).

Ensures that the following are being managed appropriately and safely:

- Quality and Safety, Safeguarding, Public and Patient Engagement and Experience, Equality and Diversity;
- Finance;
- Performance;
- Risk management and systems of internal control.

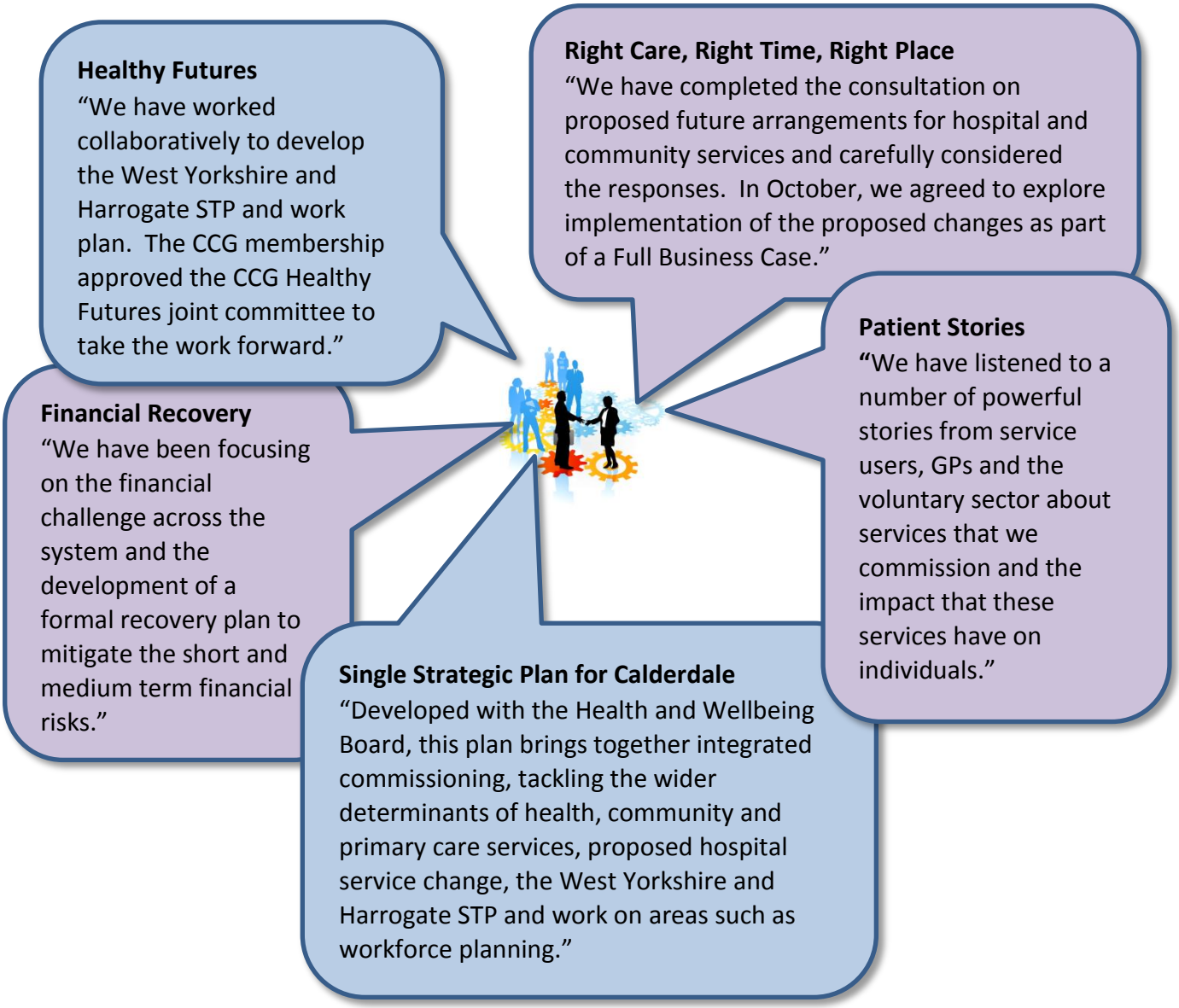
The Governing Body membership comprises the Chair; seven GPs (including the Chair) as elected by the CCG membership, two lay members (one of whom is the Deputy Chair and leads on audit matters and one who leads on public and patient involvement matters); two seconded members (Registered Nurse and the Secondary Care Specialist); the Chief Officer (Accountable Officer) and the Chief Finance Officer.

The Governing Body is supported in carrying out its role by a Lay Advisor (Finance, Performance and External Relations) and by the Head of Quality. The Executive Director of Public Health and the Director of Children's and Adult's Health and Social Care Services at Calderdale Council, also attend the Governing Body as advisors.

➢ Summary of the Work of the Governing Body over the Year

In 2016-17, the Governing Body has had a full agenda, meeting in public on seven occasions (including the Annual General Meeting). In addition we have held one meeting in parallel with Greater Huddersfield CCG. At this meeting the Governing Body unanimously agreed that the findings from the public consultation on the proposed future arrangements for hospital and community services and the subsequent deliberation provided sufficient grounds to proceed to explore implementation of the new model in the Full Business Case.

Governing Body key activities in 2016-17:



➢ Governing Body Performance

The CCG has delivered its statutory financial duties and as set out in the Performance Report, and has achieved, with the support of the system, the majority of the NHS Constitution duties. There has been excellent attendance at meetings by Governing Body members, advisors and officers who have presented high quality papers enabling the right level of scrutiny and discussion in the meetings.

The Governing Body has made a number of difficult decisions over the year and has shown real leadership and commitment to improving services for local people throughout. We continue to develop our leadership skills as part of our organisational development programme.

The committees have provided the right level of assurance to the Governing Body with the Finance and Performance Committee providing the detailed oversight of the management of the financial position ensuring that the Governing Body is fully engaged through formal reports and briefings in development mode. The Quality Committee has presented a clear view of the quality and safety issues that are being addressed by our providers and member practices. 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. The Audit Committee has provided important assurance about the governance, risk management and systems of internal control which is supported by the independent reports produced by Audit Yorkshire. Finally, the Remuneration Committee has ensured that we have a robust process in place for making the right remuneration decisions.

- **Governing Body and Committee Effectiveness**

The KPMG review of our governance arrangements carried out in 2015-16 challenged us to keep under constant review the balance of business between assurance, decision making and allowing space for strategic planning.

Throughout the year the Governing Body and its committees have worked to improve their effectiveness in how they operate and the quality of debate and discussions that they have.

Governing Body Development

We have released more development time to consider some of the strategic areas and challenges in greater detail. Key areas for consideration have been the proposals for hospital and community service change as well as the findings from the public consultation, the development of the Sustainability and Transformation Plans, primary care strategic intentions and draft estates strategy and our response to the system-wide financial challenge.

I strongly believe that we have had a better debate and scrutiny of the proposals as a result of the time put into understanding the proposals, risks and issues associated with them.

We have invested time this year in considering how the changing landscape might impact on the CCG and on the strategic and corporate leadership of the Governing Body and SMT both collectively and individually, how this translates into the culture of the organisation, partnership working and building relationships. We have also taken time to review the way that we manage conflicts of interest and to consider how we respond to the patient stories that are presented at our formal Governing Body meetings.

Review of Roles and Responsibilities of the Committees

Having reviewed the responsibilities and priorities of our committees and the associated time commitment, we have amended the terms of reference and work plans to reduce duplication, identify those items that could be brought to the committees on an exceptions basis and

increase the focus on the priorities. This has facilitated a reduction in frequency of the Audit and Remuneration Committee meetings and reframed the approach of the Finance and Performance Committee to focus more effectively on the issues and risks being considered.

➢ Actions Identified for 2017-18

The self-assessments carried out in 2016-17 have identified some key actions for the next financial year in order to continue to improve our effectiveness:

- Continue to create space for development discussions and consideration of strategic priorities;
- Introduce a systematic programme of induction and training for new Governing Body, committee members and their deputies;
- Continue to focus on the right quality of debate in Governing Body and committee meetings;
- Continue work on system governance arrangements - reviewing individual organisational structures and meetings to avoid duplication and accountability of key individuals to deliver.

The terms of reference for each of the committees can be found on the CCG's website https://www.calderdaleccg.nhs.uk/key-documents/

➢ Finance and Performance Committee

The Finance and Performance Committee advises and supports the Governing Body in scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's strategic and operational plans.

The Committee is supported by the attendance of the Heads of Service and the Performance Manager. The Committee meets monthly and has been quorate on all occasions.

Coverage of Work by the Finance & Performance Committee

The work carried out by the Finance and Performance Committee is contained within its annual work plan and has been delivered in full.

The approach to delivering the business of the Committee has been reframed over the past 12 months to allow a greater focus on financial recovery. In moving to this arrangement, the confidence of the Committee in its discharge of its duties has been maintained, and arrangements have been streamlined to enable reporting on an exceptions basis for the 'recovery' meetings. This has resulted in a more productive and focused approach to the issues and risks.

Finance and Performance Committee Highlights

"There has been a continued focus upon Systems Resilience this year – a key performance challenge for the CCG being the delivery of the 4 hours Accident and Emergency target."

Working to identify:

- New Models of funding & financial flow;
- Ensuring services are performing as expected;
- Transactional work such as coding and counting, contract challenges and CQuIN payments;
- Eliminating waste;
- Stopping things – through QIPP review of schemes and contracts.

"We have also focused hard upon the issue of delayed discharge of patients who are medically fit. The system is actively addressing this issue. We have influenced the thinking in the Accident and Emergency Delivery Board and the Health and Wellbeing Board."

"There is an explicit relationship between our financial recovery and QIPP. This has been further augmented by an alignment with provider CIP (Cost Improvement Programmes), a signal of the start of some better system-working to address system recovery."

➢ Quality Committee

The Quality Committee advises the Governing Body and ensures that effective quality arrangements underpin all services commissioned on behalf of the CCG; that regulatory requirements are met; and patient safety is continually improved to deliver a better patient experience. The Quality Committee submits a comprehensive Quality and Safety report to every meeting of the Governing Body. This updates members on key quality activities related to patient safety, clinical effectiveness and patient experience.

The Committee is supported by the attendance of the Head of Primary Care Quality and Improvement, the Head of Service Improvement and a public health representative from Calderdale Council. The Committee meets on a monthly basis and has been quorate on all occasions.

Coverage of Work by the Quality Committee

The work carried out by the Quality Committee is contained within its annual work plan and has been completed in full. The work plan was reviewed comprehensively following external review of the CCG Governance arrangements. The revised workplan which will be implemented from April 2017 will allow further scrutiny of individual providers on a monthly rotation.

Quality Committee Highlights

"A Primary Care Dashboard has been developed, which provides a high level overview of the 26 practices in Calderdale based on a range of compliance indicators in order to provide assurance about the quality of general practice performance."

"The NHS England safeguarding review (2016) demonstrated CCG compliance with only one action identified: To ensure that safeguarding is referenced in all appropriate CCG policies and communicated within the CCG. This is being implemented."

"A multi-agency experience group been established to use national and local patient experience information to make improvements in partnership with our providers."

"The Quality and Safety Dashboard has been refined to give a clear approach to surveillance levels for each provider and clearly identifies issues for escalation."

➢ **Commissioning Primary Medical Services Committee**

The Commissioning Primary Medical Services Committee (CPMSC) makes corporate decisions on the review, planning and procurement of primary medical care services in Calderdale under delegated authority from NHS England. This includes making decisions in respect of:

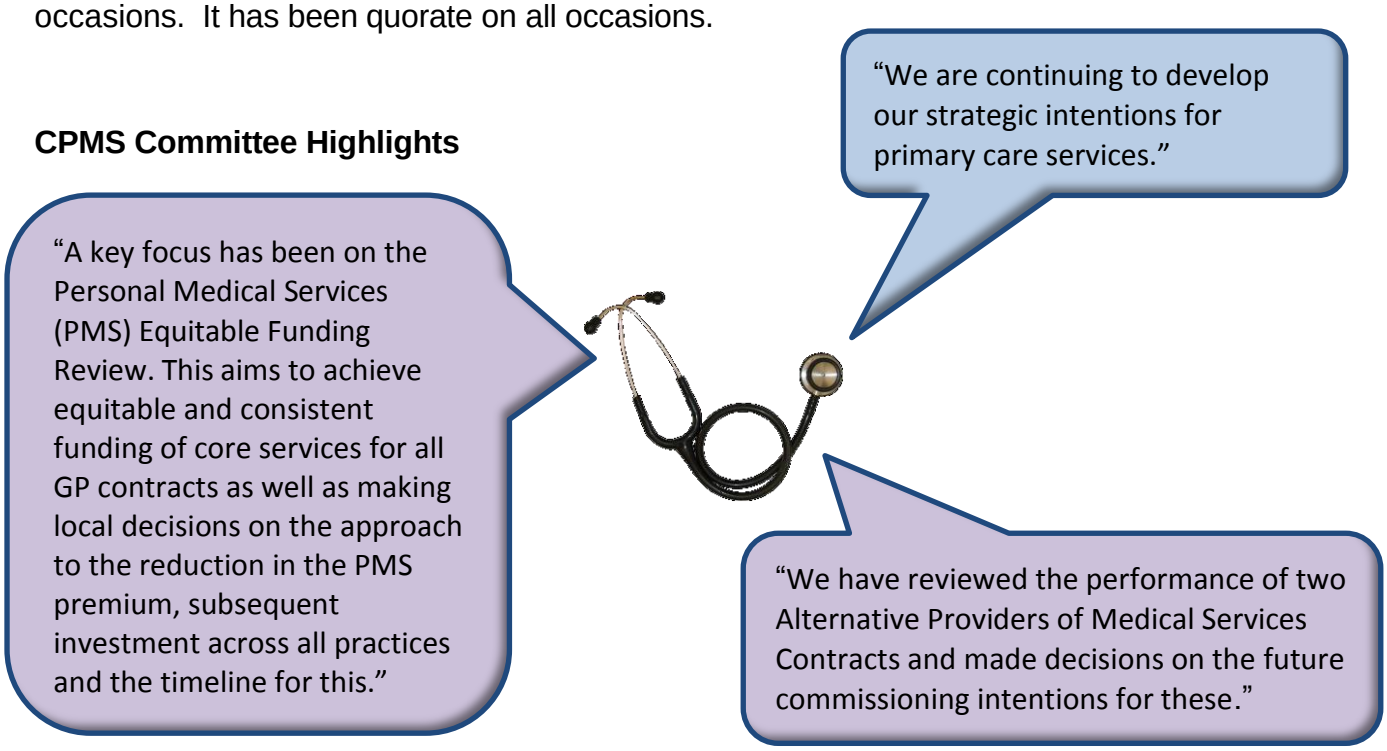
- Contracts for General Medical Services (GMS), Primary Medical Services (PMS) and Alternative Providers of Medical Services (APMS);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Whether to establish new GP practices in an area; approving practice mergers; and on 'discretionary' payments (e.g. returner/retainer schemes).

The Committee operates in accordance with an agreement between NHS England and Calderdale CCG. The functions of the Committee are undertaken in the context of the aim to increase quality, efficiency, productivity and value for money.

The Committee is supported by the attendance of the Heads of Primary Care Quality and Improvement, Finance, Contracting and Procurement and the Corporate and Governance Manager. Representatives from the Calderdale Health and Wellbeing Board, Healthwatch and from NHS England are also invited to attend.

CPMSC meetings are conducted in public and in 2016-17 the Committee met on five occasions. It has been quorate on all occasions.

CPMS Committee Highlights



➢ **Remuneration Committee**

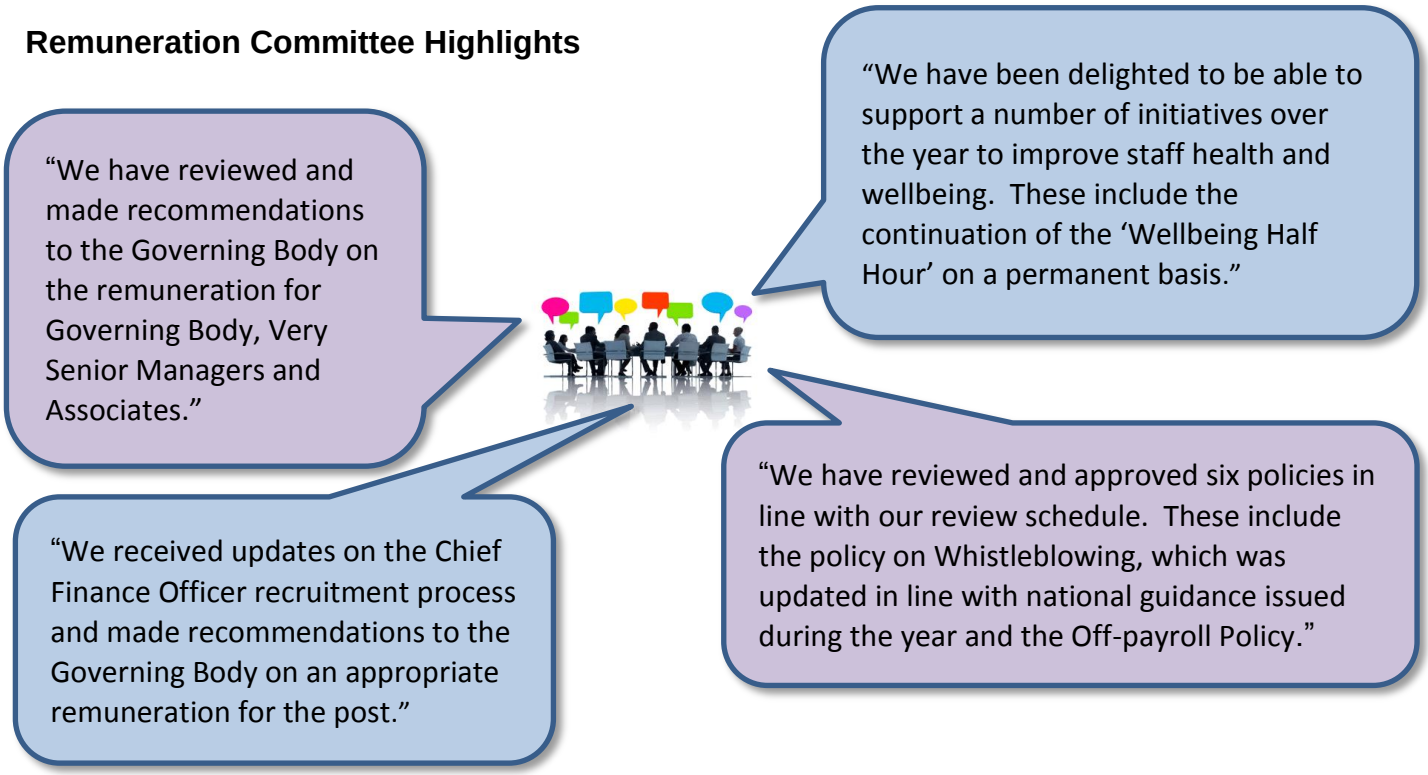
The Remuneration Committee has two key functions:

- It advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; provisions for other benefits and allowances under any pension scheme. It also includes any arrangements for termination of employment of the Chief Officer or the Chief Finance Officer;

- It has responsibility for reviewing and approving Human Resources Policies.

In 2016-17, the Committee was supported by the attendance of the Lay Advisor (Finance, Performance and External Relations), Chief Finance Officer, Human Resources Managers and the Corporate and Governance Manager. The Committee met on a quarterly basis with any additional meetings being held as business requires. One meeting was not quorate. The Committee undertook a review of its roles and responsibilities during the year as part of the CCG's overarching review of its governance arrangements. As a consequence of this and a streamlining of the process for approving HR policies, the number of meetings in 2017-18 will reduce to two whilst retaining the ability to meet on an ad-hoc basis as business dictates.

Remuneration Committee Highlights



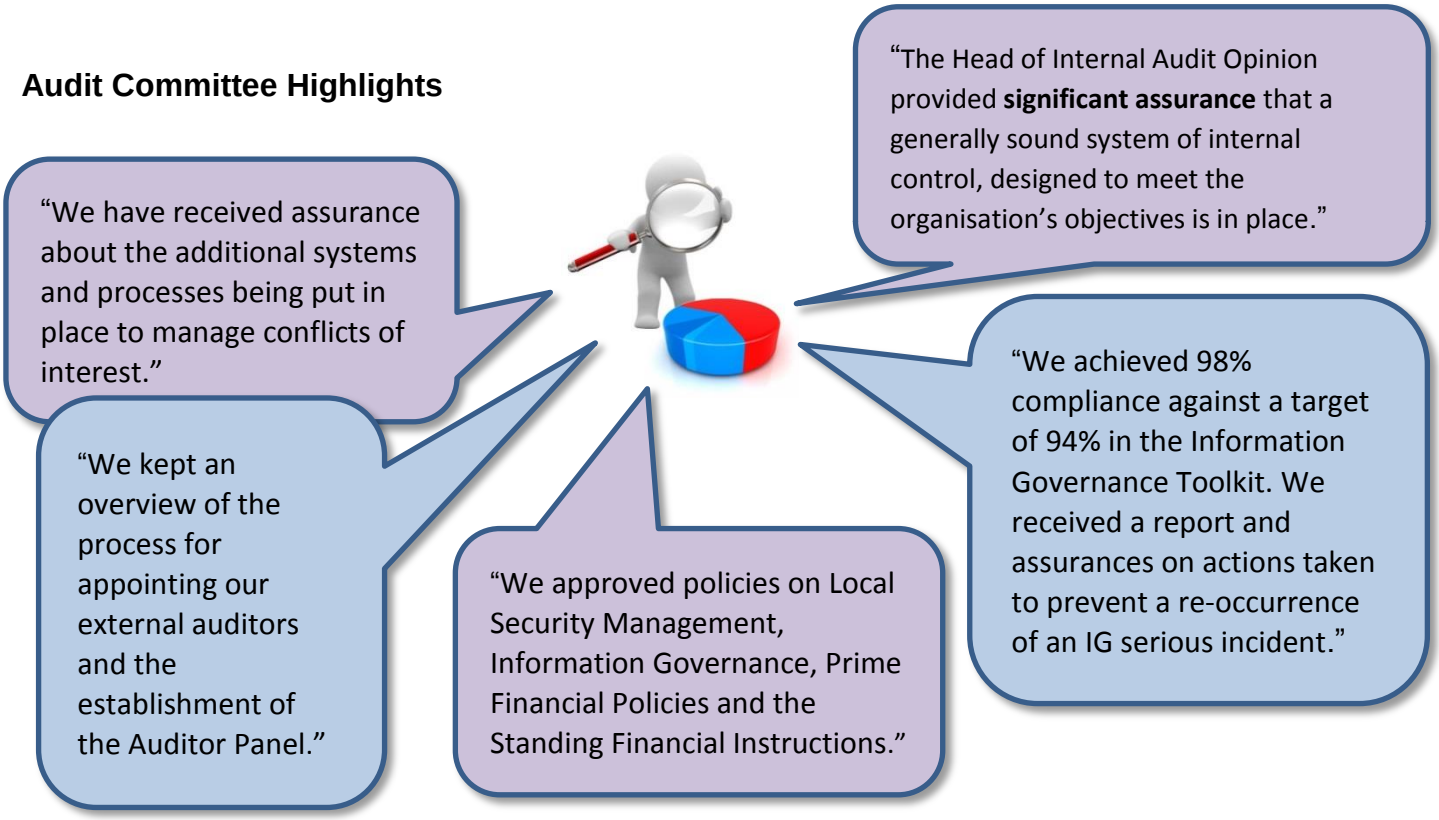
➢ Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions to the CCG in so far as they relate to finance. It also has a role in scrutinising the CCG's risk management arrangements and systems of internal control, emergency preparedness and business continuity.

In 2016-17 the Committee met on five occasions with an additional meeting being held to review the annual report and accounts in detail with all the Governing Body invited. The Committee is supported by the Chief Finance Officer, the Head of Contracting and Procurement, the Corporate and Governance Manager and the external and internal auditors. Attendance at the Committee has been good throughout the year and meetings have been quorate on all occasions.

The terms of reference have been streamlined and work plan refocused, taking a risk based approach to the scrutiny role of the Committee. As a consequence, in 2017-18 the number of meetings will be reduced to four with an additional meeting to review the annual report and accounts.

Audit Committee Highlights



4. Compliance with the UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. 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) we have undertaken a self-assessment of the CCG's systems and processes against those principles of the UK Code that are relevant to the CCG. We have identified three areas where we have developed in 2016-17 and continue to do so into 2017-18.

➢ Self-assessment of our Performance

The UK Code sets out standards **(B4.2, B6)** which focus on the importance of regular self-assessment of the performance of the Governing Body, its committees and individual Governing Body members in order to continually improve its effectiveness. The CCG continually keeps its performance under review with an annual self-assessment and focus on areas for development. The actions taken during 2016-17 and priorities for 2017-18 are covered earlier in this governance statement.

➢ Responsibility for Appointing External Auditors

During 2016-17, following changes to the local external audit arrangements[6] CCGs were required to appoint their own auditors for 2017-18 and future years. In line with national guidance, the CCG established an Auditor Panel in order to advise the Governing Body on

[6] Local Audit Accountability Act 2014,

the appointment of external auditors and entered into a competitive tender process with the Governing Body awarding the contract to KPMG to take effect from 1st April 2017. The UK Code **(standards:C3.2, C3.7, C3.8)** sets out the role and responsibilities of the Auditor Panel, Audit Committee and the Governing Body in relation to external auditors. The CCG will seek to operate in line with principles of the UK Code in this regard.

- **Freedom to Speak Up (Whistle Blowing)**

The UK Code (**standard C3.5**) sets out the expectation that the Audit Committee reviews arrangements by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters. The CCG revised its Whistle Blowing Policy in 2016-17 and appointed the Audit Chair as 'Freedom to Speak Up Guardian' in line with national guidance. The CCG will be rolling out staff and Governing Body awareness sessions in 2017-18.

5. Discharge of Statutory Functions

In light of the 1983 Harris Review, the CCG 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 CCG 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 the appropriate member of the SMT. The Senior Managers have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

6. Risk Management Arrangements and Effectiveness

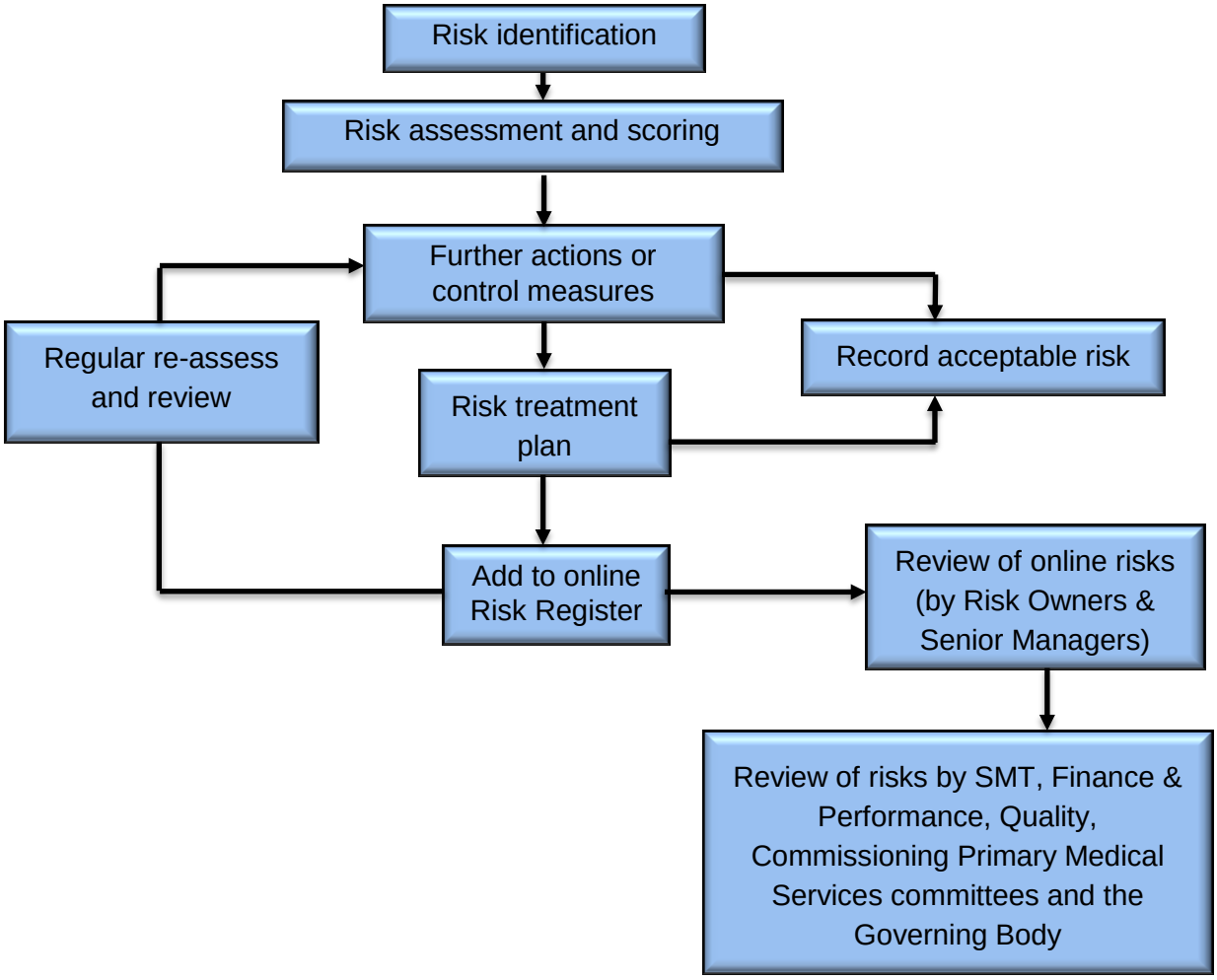
The CCG's comprehensive Integrated Risk Management Framework (IRMF) was revised and approved by the Governing Body during the year. The IRMF describes our approach to managing risk; our risk management objectives, risk appetite and the processes in place to ensure these objectives are not only embedded within the core business of the organisation but also achieved. These are:

RISK MANAGEMENT OBJECTIVES

1. Effectively identify, report and manage risk.
2. Ensure clear accountability for the management and reporting of risk.
3. Effectively capture and learn from mistakes to reduce future risks.
4. Ensure and evidence statutory and regulatory compliance.
5. Effectively manage partnership and project risks

The process that we use to identify, evaluate and control risks is set out in the diagram below:

Effectively identify, report and manage risk



➢ **Risk Identification**

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 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. fire regulations, Care Quality Commission (CQC) standards and reviews, Ofsted reviews, Parliamentary Ombudsmen, professional standards, information governance systems including the IG Toolkit etc.;
- Routine review of serious incidents, incident reports and complaints to identify emerging risks, themes or specific concerns;

- Utilisation of intelligence through partner networks and from stakeholders to encourage the sharing of information to identify potential risks;
- Ensuring contact with regional and national professional associations that provide early warning on serious adverse events;
- Risk review and discussion through operational meetings (team, project or programme management or contract review meetings) and formal governance arrangements, i.e. Governing Body, Quality Committee, Finance & Performance Committee and the Commissioning Primary Medical Services Committee which highlight risks that need to be reflected in the Risk Register.

➢ **Risk Assessment and Scoring**

Risk assessment is a structured process that is used once a risk has been identified to:

- Understand its potential impact and likelihood;
- Examine the control measures that are already in place to manage the risk and evaluate their effectiveness;
- Score the potential of any outstanding risk after considering the effectiveness of existing controls and identify the prioritisation of the risk;
- Identify the target risk score (i.e. the level at which the risk can be accepted, taking into account the CCG's risk appetite);
- Identify any further actions that are necessary to reduce the risk score to the target level.

Risk scores (both current and target) are calculated by multiplying the potential impact or consequence by the potential likelihood or frequency level to provide a risk score using a 5x5 matrix scoring system which produces a range of scores from 1 to 25.

➢ **Risk Recording, Reviewing and Monitoring**

The CCG manages and reports on risk in two ways:

- The Governing Body Assurance Framework (GBAF), which focusses on strategic/long-term risks to the delivery of the CCG's strategic objectives. The GBAF is classed as a 'live' document but is formally reviewed and updated twice per annum.

- The Corporate Risk Register, which focusses on more operational risks that may rise and fall within relatively short time periods. The Corporate Risk Register is formally reviewed on an eight weekly cycle.

More detail regarding the GBAF is provided in the Internal Control Framework section of this report.

- **Corporate Risk Register**

The CCG has an integrated approach to risk, with the recording and monitoring of risks co-ordinated through a single, online risk register. The Risk Register contains records and reports on performance based risks that may rise and fall within relatively short term periods, i.e. operational risks.

The online risk register system allows for an auditable two tiered review process of risks and supports the monitoring and updating of risks within review deadlines. The CCG operates six risk review and reporting cycles per annum.

Once every risk cycle, a corporate "reality check" of the content of the risk registers including a moderation of the scores and actions taken is conducted, through review of the entire risk register by the SMT and a review of relevant risks by the Quality, Finance and Performance and Commissioning Primary Medical Services Committees (as set out in their terms of reference).

The register is archived at the end of each risk cycle, at which point any closed risks from the preceding period are removed from the new live register but remain in the archived record allowing any retrospective review or report to be published.

- **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 Risk Register specify the target risk score (i.e. the level at which the risk can be tolerated). The acceptability of the target risk score is subject to review by the SMT and relevant committee as part of the normal review and reporting process for the Risk Register.

- **Embedding risk management in the CCG's Activity**

The CCG's risk management system is complemented by other control systems and programme management approaches which are designed to deliver assurance on the prevention and/or management of existing risks. Other control systems include our approach to equality impact assessments; counter-fraud, bribery and corruption which is supported by mandatory training for all staff and Governing Body members; briefings on our local security management and information governance policies; and the requirements that all staff, Governing Body members and CCG members register any potential conflicts of interest so that they can be appropriately managed. All these mechanisms put us in a stronger position to prevent/manage risks to the CCG.

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.

All corporate incidents (including IG incidents) together with actions to reduce/prevent re-occurrence are reported to the Audit Committee on a six monthly basis.

An indicator of good staff and patient safety management is the incident reporting culture. 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. Member practices are also requested to report their incidents as soon as reasonably practicable so that any follow up actions can be completed in a timely manner. The CCG is seeing a gradual increase in the number of incidents being reported by practices as a result of more surgeries using DATIX.

"General practice staff are much more enthused about reporting incidents on DATIX and therefore more likely to report in the future as they receive feedback from the ones they have reported and are assured that action is being taken."

Dr Majid Azeb, Chair of Quality Committee

A quarterly GP incident report is provided to the Quality Committee for review and identification of themes and key messages to be fed back to the practices. The report provides data by practice and by type of incident. More detailed data is provided on those themes relating to patient safety and medication incidents. Feedback is provided to member practices in an anonymised form through the CCG's quarterly Safety Bulletin.

- **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 projects.

The CCG has adopted a programme management approach to all major transformation activities. Risk and issues logs are produced for all programmes and are reported to the relevant Programme Board. Risks with a total risk score of 12 or more, or a score of 5 for Consequence/Impact should be escalated from the programme/ project risk register to the Corporate Risk Register.

The key partnerships for the CCG include a number of NHS providers, The GP Alliance, the local authority 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;
- Implementation and maintenance of a scoring system to identify partnerships with high risk scores;
- Prioritised implementation of programme/project risk registers for those areas; categorised as high risk. The risk registers are reviewed though appropriate internal and external governance frameworks.

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

➢ Capacity to Handle Risk

The CCG has a robust and systematic approach to risk management. As Chief Officer I am supported by the SMT in ensuring that we have a positive and open approach to the identification and management of risk.

In 2016-17 we brought the risk management function in-house with staff being supported by the Risk, Health and Safety Manager. The Corporate Risk Register is hosted by Wakefield CCG and allows the CCG to benefit from the sharing of learning across neighbouring CCGs.

➢ Effectiveness of Governance Structures

I receive assurance on the effectiveness of the governance and risk management structures, systems and processes through our internal assurance processes.

The Governing Body is responsible for approving the GBAF and for receiving a report on 'serious' risks (i.e. those rated 15 or above) at each of its formal meetings.

The Audit Committee has the responsibility for providing assurance to the Governing Body on the effectiveness of our governance and risk management systems and processes. It fulfils this responsibility by:

- Ensuring that the Integrated Risk Management Framework is up to date;
- Receiving reports and copies of the GBAF for review twice a year prior to its submission to the Governing Body;

- Receiving six monthly reports on risk management;
- Receiving annual reports from the committees which set out their review of the delivery of their terms of reference, annual work plan and self-assessment of their effectiveness;
- Receipt of reports from Audit Yorkshire on the findings of the annual mandated audit of governance and risk management.

➢ **Responsibilities of the SMT and Committees**

The roles and responsibilities of staff as risk owners, and SMT as reviewers are clearly set out in the Integrated Risk Management Framework. This ensures that there is clarity about the levels of accountability for the management and monitoring of risks. The SMT 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 SMT

The reporting lines and accountabilities are set out in the Integrated Risk Management Framework and reflected in the committee terms of reference. As stated earlier in this report, the SMT 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 relevant governance committee. Each 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 reviewing the principal risks prior to review by the relevant committee and Governing Body.

The Audit Committee reviews the principal risks and mitigating actions as set out in the GBAF prior to submission to the Governing Body.

Timely and Accurate Information to Assess Risks to Compliance with the CCG'S Licence

The assessment of risks is a continuous process informed by:

- SMT identifying new risks or changes to risk profile;
- Financial, contracting, QIPP and performance reports which are submitted on a monthly basis to the Finance and Performance Committee;
- Quality risk reports submitted monthly to the Quality Committee;
- Discussions taking place at the committees and Governing Body on the Risk Register and the GBAF.

Degree and Rigour of Oversight of CCG Performance by the Governing Body

The Governing Body provides challenge and scrutiny of a suite of performance reports which focus on the delivery of the key performance targets, quality, safety, financial and contractual requirements:

- The Finance, QIPP and Contracting Report;
- Quality and Safety Report and Dashboard;
- Performance Report;
- High Level Risk Log and Report.

This level of oversight, which has been supported by the detailed work of the sub-committees, has placed the CCG in a stronger position to deliver its 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 with training being provided to the Contracting and Equality and Diversity teams in 2016-17.

A further Governing Body development session on risk appetite is planned for 2017-18 in response to the ongoing shifts in our operating environment.

➢ **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**, **counter-fraud and local security management** 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, attendance at the Audit Committee review and development session 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 AMT meeting and work taken forward through the different teams within the organisation including primary care, service improvement, continuing health care, quality, finance and contracting. Progress is discussed as part of the financial recovery meetings. The pressures and 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 Finance and Performance Committee maintains a detailed overview of these risks through regular finance and contract reporting 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 and Emergency Delivery Board, The Transformation Board and Contract Partnership meetings.

7. 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 impact should they be realised, and to manage them efficiently, effectively and economically.

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

➢ **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 sub-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 formally reviewed twice per annum and is reviewed by the Audit Committee prior to submission to the Governing Body for approval. In 2016-17 the GBAF has been significantly amended to better reflect the changing landscape with the focus on the delivery of the Single Strategic Plan for Calderdale, work with the West Yorkshire and Harrogate STP and financial recovery.

The GBAF is considered by all the Governing Body committees enabling a detailed conversation about the objectives, risks and the effectiveness of the controls in place.

8. Conflicts of Interest (COI) 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. NHS England has published a template audit framework to ensure consistency of approach.

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

- To take additional measures to publicise the Conflicts of Interest Guardian role and that of the supporting officers, including having a dedicated page on the website;
- To consider whether the Gifts and Hospitality register is expanded to capture details of any previous gifts, the officer reviewing/approving the declaration and the date.

9. Data Quality

Data quality is information of a high standard that has been recorded accurately at the point at which is it collected. For the data to be of a high standard it needs to be complete and consistent. It also needs to be up-to-date, recorded in a timely fashion and relevant. Good quality data:

- Improves patient care with faster diagnoses and better treatment;
- Enhances the clinician's ability to assess quality of care and make informed decisions about the patient's health care;
- Helps the practice to identify target groups of patients and supports clinical audit;
- Effective measurement of clinical achievement;
- Reduces duplication of work and increases efficiency.

The CCG has invested in a Data Quality Team which supports GP practices and the CCGs in Calderdale, Greater Huddersfield, North Kirklees and Wakefield. The role of the team is to promote the correct use of the Electronic Patient Record (EPR), provide training in completing records, offering advice and guidance for data quality queries around QOF (Quality Outcomes Framework), Disease Register Validation, enhanced service recording and reporting, data entry templates, and clinical communications including standardised referral letters and forms. They also provide support with epidemiological data production, clinical audits and records management and data assurance.

In 2016-17 the CCG started to develop a single 'in-consultation' tool. This will provide easy access for GPs to the most up-to-date locally agreed clinical referral pathways (for example, the Musculo-skeletal pathway), guidelines and referral forms. The aim is to save GPs time in consultation and to enable consistently effective referrals.

The work of the Data Quality Team and such initiatives (as well as the new GP dashboard which enables clinicians to see real-time patient data from Calderdale and Huddersfield Foundation Trust) is seen as a real benefit to practices.

The quality of data being presented to the committees and the Governing Body has continued to develop throughout the year. Both the committees and the Governing Body receive reports which provide substantial, informative and detailed analysis across a range of areas within finance, contracting, performance, quality and safety and patient experience. Themed reports and dashboards enable the Governing Body and committees to understand at a much more detailed level some of the areas of challenge on financial recovery and contracting.

I can confirm that the Governing Body is of the opinion that the finance, contracting and performance as well as the Quality and Safety Reports are supported by good quality data enabling the right level of detailed scrutiny in both committee and Governing Body.

There is however, always the opportunity to improve the quality of data and we continue to work with our acute providers and SWYPFT on this and to provide contract challenges on coding.

10. Information Governance

The NHS Information Governance Framework (IGF) sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS IGF is supported by an Information Governance (IG) Toolkit 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.

Information governance compliance is managed and controlled through the implementation of the organisation's IGF and annual IG Action Plan, which includes a programme of work relating to information asset risk management.

This year the CCG continued to demonstrate its commitment to good information governance by setting itself the exacting target of achieving level 3 compliance across 21 target areas within the IG Toolkit. This is a measure of the importance that we place on ensuring that:

- There are robust information governance systems and processes in place to help protect patient and corporate information; and
- Staff and Governing Body members are aware of and comply with those policies, systems and processes.

I am pleased to be able to report that the CCG has achieved level 3 against 22 standards, a level 2 against one standard (with five areas classed as not relevant to the responsibilities of the CCG) in the IG Toolkit, with an overall grade of 'satisfactory'.

The CCG has an active Senior Information Risk Owner (SIRO), Caldicott Guardian and IG lead together with a number of Information Asset Owners who are responsible for information risk within the area of the organisation they manage. Over the year we have been working with our Information Asset Owners to continue to embed effective information risk management arrangements. This has included making sure our transfers of paper and electronic personal information are secure.

The CCG hosts the IG Team on behalf of the CCGs in Calderdale, Greater Huddersfield, North Kirklees and Wakefield. Assurance is provided through the quarterly Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving data security) on a six monthly basis and any actions to mitigate.

We have ensured that all staff undertake annual information governance training and have distributed a staff IG Handbook to ensure that staff are aware of their roles and

responsibilities, including the management of risks in relation to security of person identifiable data. I am pleased to be able to report 100% compliance with the information governance training across both of staff and Governing Body members.

We have an effective system in place for incident capture, reporting and investigation of serious incidents and near misses, including those relating to information governance. Incidents are reported through our online DATIX system and are investigated in line with our incident reporting and investigation policy and procedures. We take all incidents seriously and all are investigated to ensure that we improve our processes to prevent future incidents occurring.

- **Statement in Respect of Information Governance Serious Incidents Requiring Investigation (IG SIRI)**

During 2016-17 there was one personal data-related incident that met the IG SIRI criteria at level 2 severity or above.

Summary of serious incident requiring investigations involving personal data as reported to the information commissioner's office in 2016-17				
Date of incident (month)	**Nature of incident**	**Nature of data involved**	**No. of data subjects potentially affected**	**Notification steps**
October 2016	Uploaded to website in error - A routine review by the CCG of the website identified that some financial transaction spreadsheets containing a limited amount of personal information had been published.	Name; amount funded and an 'expense description'	19	Reported through STEIS and IG Toolkit's Incident Reporting Tool. This notifies NHS Digital, IG Alliance, Department of Health, NHS England and the ICO.
Further action on information risk		An investigation was completed and mitigating actions implemented. Checklist of items to be reviewed and approved prior to publication of the information on the website has been implemented. Learning shared across organisation through the staff workshop.		

In compiling this report, we have considered breach incidents for data for which we were the data controller, as defined by the Data Protection Act (1998).

11. 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.

12. Third Party Assurances

See Review of the Effectiveness of Governance, Risk Management and Internal Control section on page 73.

13. Control Issues

During the year no significant internal control issues or gaps in control were raised with the exception of the serious information governance incident as reported above.

14. Review of Economy, Efficiency & Effectiveness of the Use of Resources

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

The Governing Body receives regular reports from the Finance and Performance, and Quality Committees regarding performance, contractual and financial recovery. In order to provide the necessary level of rigour and governance in support of the CCG's financial recovery plan, an update is also submitted to the Finance and Performance Committee on a monthly basis from the SMT Recovery meeting.

Whilst the Chief Officer and Chief Finance Officer have a combined delegated authority up to £500k; in order to provide additional scrutiny, transparency and assurance, a sub group of the Governing Body has been established to oversee the process in relation to decisions of between £250k - £500k.

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

Further information on our financial planning, in-year performance monitoring and central management costs is included in the Performance Report. We maintain efficiency controls through our recovery processes and through the role of the Finance and Performance Committee (see Performance Report: Financial and QIPP analysis).

Calderdale CCG has a rating of GREEN for the Quality of Leadership indicator on latest available results on *MyNHS* (Quarter 2 2016/17). The year end results for the Quality of Leadership Indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175.

15. Delegation of Functions

In February 2017, the membership of the CCG approved the establishment of the Healthy Futures Committee as a joint committee consisting of the 11 CCGs across West Yorkshire and Harrogate. Currently, no decision making has been delegated in relation to resource allocation. The authority and responsibilities of the committee are set out in a Memorandum of Understanding (MOU), Terms of Reference and annual work plan. The Chief Officer and Chair of the CCG are members of the committee. The minutes from the committee will be received by the Governing Body and CCG membership in accordance with the provisions of the CCG's Constitution.

16. Counter Fraud Arrangements

The CCG commissions 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 Accreditation Board in 2009.

Anti-fraud 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-fraud work plan.

An annual report of fraud, bribery and corruption work is completed and submitted to the Audit Committee for approval. Likewise, the annual assessment (self-review tool – SRT) of the CCG's compliance with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption (SRT) was completed by the LCFS and approved by the Chief Finance Officer. The SRT demonstrates compliance with the NHS Standards for Commissioners. The reports comply with NHS Protect guidelines and provide a summary of the year's activity matched against the standards. There is executive support for anti-fraud work provided by the Chief Finance Officer and members of the Audit Committee. Work plans, proactive work and annual reports are scrutinised and approved by committee members.

All fraud matters are overseen by the Chief Finance Officer who is a member of the Governing Body. The LCFS reports on fraud progress of work to the Chief Finance Officer and the Audit Committee. Should the organisation be subject to a NHS Protect quality assessment, the CCG will take appropriate action as recommended.

17. Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. See Appendix 4: Governance Statement for the full Head of Internal Audit Opinion. The conclusion was 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 weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk."**

During the year the Internal Audit issued no audit reports with a conclusion of 'limited assurance' or 'no assurance'.

18. Review of the Effectiveness of Governance, Risk Management & Internal Control

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

As set out earlier in this Governance Statement, the CCG's formal process for maintaining and reviewing the effectiveness of the system of internal control involves the following:

- The **Governing Body** keeps under review the systems of internal control through reports on risk management and the GBAF as well as the performance, contracting, finance, quality and safety reports. 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;

- At a committee level the **Finance & Performance, Quality and Commissioning Primary Medical Services Committees** are responsible for keeping under review the governance arrangements relating to their remit;

- The **Audit Committee** has oversight of the CCG's financial systems, financial information, risk management and systems of internal control, audit, information governance and business continuity;

- 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 our governance arrangements is commissioned every three years;

- **Third Party Assurance.** Alongside 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 Calderdale & Huddersfield NHS Foundation Trust (provider of payroll services). At the time of writing no significant issues have been reported.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG 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 management letter and other reports.

Conclusion

During the year no significant internal control issues or gaps in control were raised.

Dr Matt Walsh

Accountable Officer

24 May 2017

CCG Governing Body and Committee Membership and Attendance

As at 18th May 2017

Governing Body (includes meetings in parallel with Greater Huddersfield CCG)		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair and GP member [7]	9/9
Dr Matt Walsh	Chief Officer (Accountable Officer)	8/9
Julie Lawreniuk	Chief Finance Officer (until 30th April 2016)	1/1
Lesley Stokey	Interim Chief Finance Officer (1st May 2016 – 31 August 2016)	2/2
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer from 1st September 2016)	6/6
David Longstaff	Lay Member and Deputy Chair	8/9
Dr Steven Cleasby	Assistant Clinical Chair and GP Member	8/9
Dr Majid Azeb	GP Member	8/9
Dr John Taylor	GP Member (until 31st January 2017)	5/7
Dr Nigel Taylor	GP Member	9/9
Dr Caroline Taylor	GP Member	9/9
Dr Lubna Saghir	GP Member (1st August 2016 to 31st March 2017)	5/6
Kate Smyth	Lay Member (patient and public involvement)	9/9
Jackie Bird	Registered Nurse	7/9
Dr Rajesh Phatak	Secondary Care Specialist (until 28th February 2017)	4/8
Dr Helen Davies	GP Member (from 1st April 2017)	1/1
Dr Farrukh Javid	GP Member (from 1st April 2017)	1/1
Advisors to the Governing Body		
John Mallalieu	Lay Advisor (Finance, Performance and External Relations)	9/9
Penny Woodhead	Head of Quality	9/9
Paul Butcher	Director of Public Health (Calderdale Council)	7/9
Bev Maybury	Director of Adult Health and Social Care Services (until 1st Oct 2016)	1/4
Stuart Smith	Director of Adult and Children's Health and Social Care Services (Calderdale Council) (from 20th October 2016)	3/4

[7] All the GP members on the Governing Body also have the statutory title of 'Clinical Leader'.

Finance and Performance Committee (as at 18th May 2017)		
Member	**Role**	**Attendance**
Dr Nigel Taylor	Chair and GP Member	11/13
Dr Matt Walsh	Chief Officer	11/13
Julie Lawreniuk	Chief Finance Officer (until 30th April 2016)	0/1
Lesley Stokey	Interim Chief Finance Officer (1st May 2016 – 31 August 2016)	4/4
Neil Smurthwaite	Chief Finance Officer (from 1st September 2016)	6/8
Dr Steven Cleasby	GP Member (Joined the committee on 1st February 2017)	3/3
John Mallalieu	Lay Advisor (Finance, Performance and External Relations)	12/13
Dr Caroline Taylor	GP Member (stood down from the Committee on 31st January 2017)	7/10
Dr Alan Brook	GP Member deputised for a GP member	1/1
Kate Smyth	Lay Member (PPI) deputised for the Lay Advisor	1/1

Quality Committee (as at 18th May 2017)		
Member	**Role**	**Attendance**
Dr Majid Azeb	Chair and GP Member	13/13
Dr John Taylor	GP Member (until 31st January 2017)	10/10
Dr Caroline Taylor	GP Member and Vice Chair of the Committee (joined the Committee on 1st February 2017)	2/3
Dr Lubna Saghir	GP Member (until 31st March 2017)	2/2
Kate Smyth	Lay Member	12/13
Penny Woodhead	Head of Quality	11/13
David Longstaff	Lay Member and Deputy Chair (acted as a substitute for one meeting)	1/1
Emma Bownas	Quality Manager (designated deputy for Head of Quality)	2/2

Commissioning Primary Medical Services Committee (as at 18 May 2017)		
John Mallalieu	Lay Advisor (Finance, Performance and External Relations) (Chair of the Committee)	5/5
Dr Matt Walsh	Chief Officer	5/5
Kate Smyth	Lay Member (Patient and Public Involvement) (Vice Chair of the Committee)	5/5
Julie Lawreniuk	Chief Finance Officer (until 30th April 2016)	1/1
Lesley Stokey	Interim Chief Finance Officer (1st May 2016 – 31 August 2016)	1/1
Neil Smurthwaite	Chief Finance Officer (from 1st September 2016)	3/3
Jackie Bird	Registered Nurse	4/5
Rajesh Phatak	Secondary Care Specialist (until 28th February 2017)	3/5
Dr Alan Brook	GP Member	4/5
Dr Caroline Taylor	GP Member	4/5

Audit Committee (as at 18th May 2017)		
Member	**Role**	**Attendance**
David Longstaff	Lay Member and Chair	8/8
John Mallalieu (advisor)	Lay Advisor (Finance, Performance and External Relations)	6/8
Kate Smyth	Lay Member	7/8
Jackie Bird	Registered Nurse	4/8
Dr Steven Cleasby	GP Member (stood down from the Committee on 31st January 2017)	6/6
Dr Caroline Taylor	GP Member (joined the Committee on 1st February 2017)	2/2

Summary of major risks to the CCG's governance, risk management and internal control (2016-17)

Appendix 2

Risk No.	Risk Summary	Action to mitigate	Means to assess outcomes
62 Risk rating: 20	Risk that the system will not deliver the NHS Constitution 4-hour Accident & Emergency target due to demand, capacity and patient Flow.	- Use of non-recurrent West Yorkshire A&E Acceleration Zone funding to improve capacity & access; - A&E/primary care streaming services and social work assessment and home-care capacity; - trialing a new primary care service at A&E; - Surge and Escalation and Winter Plans refreshed and learning identified from the pressures experienced during the early part of December.	- The monthly A&E Delivery Board reviews capacity and demand issues from the system and potential solutions. - Continued risks and actions to mitigate identified through the A&E Delivery Board. - Production of Critical Risk Reports.
709 Risk Rating: 20	Risk of delays in patient transfer of care due to (a) a lack of NHS capacity non-NHS services outside hospital, and (b) health and social care systems and processes not currently being optimised.	- A formal Transfer of Care Improvement Plan; visibility and commitment being built within each A&E Delivery Board partner; - Providers share data on delays and mitigating actions; - System engaged in national Ambulatory Care and Frailty programmes (national models of good practice) - Dedicated time to develop new ways of working to improve patient flow and patient experience.	- TOC real-time dashboard provides a system overview of patients who on a discharge pathway. - Commissioners see an aggregated version enabling progress to be assessed. - Finance and Performance Committee review performance against the TOC Improvement Plan.
New in 2016-17			
829 Risk Rating: 20	The CCG fails to deliver the 16/17 planned financial surplus.	- Draft Financial Recovery Plan to be finalised during 2017-18. - Focus on: Eliminating waste; Ensuring services are performing as expected; Transactional work; new models of funding and financial flows; Stopping things. - Recovery Group ensuring recovery and leadership. - CHFT Transformation Group to coordinate and triangulate CCG QIPP schemes and CHFT Cost Improvement Programme. - Development of a system response with shared ownership of recovery (2 CCGs and CHFT) and agreement of Head of Terms.	- SMT reframed on a monthly basis as the Recovery Group monitoring progress and identifying solutions. - Update reports into Finance and Performance Committee and Governing Body

515 (risk rating: 16)	Risk that the Continuing health Care Team may not be able to deliver the level of performance that is expected by the CCG due to the increasing workload and capacity within the current workforce.	- Continue to rationalise workload - identification of key priorities/reallocation of workloads; - Additional capacity agreed by the Senior Management Team	- Weekly review of performance and issues - Appropriate actions to mitigate risk implemented.
826 Risk Rating: 16	Risk that appropriate QIPP schemes may not be in place to ensure the system model is affordable going forward - may result in the non-achievement of control total and/or failure to achieve QIPP targets.	- Clinical engagement in QIPP programmes; - Medium term financial planning process in place; Recovery programme and decision making structure in place.	- Monthly QIPP tracker reporting to QIPP Group; financial and contracting reporting in place through Senior Management Team, Finance and Performance Committee, and Governing Body; - Area Team assurance role with 2016/17 plan approved.
849 Risk rating: 16	Risk that the main acute and community contract with CHFT over-trades significantly by year end due to: increased levels of A&E attendances/emergency admissions; increased GP referrals, outpatient and diagnostic activity, potential to convert into elective activity.	- The contract position discussed at contracting management and QIPP meetings including CHFT Partnership Board. - System pressures discussed at the monthly A&E Delivery Board to identify solutions. - Transformation Group working to better align QIPP and CIP (Cost Improvement Plans) plans. - Contract pressures discussed to ensure alignment with existing QIPP schemes. - Analysis undertaken of key pressure areas, identifying counting and coding issues; - Hypotheses action plan developed and shared.	- Monthly contract position discussed at the Finance and Performance Committee and reported to the Governing Body. - The Transformation Group has a jointly agreed work plan which focusses on addressing issues in key pressure areas.
In-year major risks that have a reduced risk rating at the end of March 2017			
476 (In-year risk rating 16) **Now 9**	Risk that review of working practices within the Calderdale Council Adult Health and Social Care Department could impact upon the delivery of services by the Continuing Health Care (CHC) Team.	- CHC Operations Manager working closely with Local Authority colleagues. - Increased commitment to joint working and evidence of additional social work for CHC processes.	- CCG monitoring the review to identify any impact on CHC team. - Review of practice and issues shared between Head of CHC and Local Authority Heads of Service.

240 (In – year risk rating 15) **Now 9**	The lack of availability of CHFT appointment slots exceeds the agreed 5% threshold. Potentially affecting patient choice of provider, poor patient experience and reputational damage to both provider and commissioner.	- Reviewed at Planned Care Board within CHFT Partnership Arrangements with mitigating actions identified.	- Regular updates on performance against target to Finance and Performance Committee and CHFT/CCGs contract management and Partnership Board.
864 (in-year Risk rating 15) **Now 9**	Risk of harm for patients due to increasing concerns around the assurance of the quality of maternity services, - deteriorating position against performance indicators and CQC (Care Quality Commission) visit in March 2016 which highlighted a number of issues.	- Action plan developed based on external review by Royal College of Nursing carried out in July 2016.	- Maternity services is a key element of the monthly Quality & Safety Dashboard - Maternity Assurance Group monitors progress against the action plans and the 4 indicators requiring monitoring.
865 (in-year Risk rating 15) **Now 9**	Risk that a comprehensive understanding of demand and trading position is not fully supported by data analysis due to a lack of a skilled Business Intelligence (BI) service with capacity - potentially resulting in a lack of understanding of intelligence to manage pressures on key acute and independent sector contracts and to fully support service development.	- Issues escalated to service review meeting for action to mitigate; - Key issues identified as part of the planning round being addressed; - New posts within service provider beginning to become more effective.	- Monthly contract service review meetings in place with the BI service provider.

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 2016-17

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 are members of the Health and Wellbeing (HWB) Board to facilitate effective partnership working. ▪ Single Strategic Plan for Calderdale (SPFC) provides a single strategic direction for Calderdale Council and the CCG.
		We do not deliver our strategic outcomes because we have not tackled the wider determinants of health.	▪ Intelligence Sharing: New Business Intelligence model in place and creating links with health intelligence within the Public Health Team. ▪ HWB SPFC confirms actions to tackle wider determinants of health.
		We do not delivery our strategic outcomes because we have not implemented new models of primary care and community services	▪ SPFC sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. The two year operational plan sets the strategic direction for Calderdale CCG which is aligned to the SPFC.
		We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint.	▪ Draft annual workplan agreed by Health Futures 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 public consultation.	▪ Work plan sets outs the actions required to support the production of the Full Business case and association documentation.
		We do not deliver our strategic outcomes because we have not fully developed and optimised system working on enabling	▪ Work is being taken forward to identify the controls associated with this new principal risk.

		functions, such as workforce, estates and digitisation.	
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 (2013-18) and annual improvement plan (2016-17) in place. ▪ Patient and Public Experience and Engagement Steering Group (including partners) and Patient Experience Group
		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 WY&H STP	
		We are unable to commission high quality and safe services from CHFT due to the Trust not being able to address the service configuration issues, resulting in the need to effect service change on a clinical needs basis in advance of the proposed changes to hospital and community services being implemented.	▪ The CCG use the Quality and Safety Dashboard to identify and track any issues relating to quality and safety ▪ The CCG are working with the provider to plan short/long term solutions to address any issues
		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
		We are unable to provide commissioning arrangements for safeguarding that ensure that smaller 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 (policies, procedures and training)

		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
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.	▪ Development and delivery of short/medium term financial recovery plan ▪ 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 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. right structures, capacity and capability.	▪ Compliance with the provisions of the CCG's Constitution which has been reviewed by NHS England ▪ Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework
		We don't have effective governance and risk management processes in place due to not having the right structures, capacity and capability	▪ Robust governance structure, integrated risk management framework and systems of internal control in place ▪ Process for regular review of governance and risk management part of internal audit annual work plan

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 2017

Roles and responsibilities

On behalf of the Clinical Commissioning Group the 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 Governance Statement is an annual statement by the Accountable Officer, on behalf of the Clinical Commissioning Group and the Governing Body, setting out:

- how the individual responsibilities of the Accountable 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 Governance Statement requirements.

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit 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. As such, it is one component that the Clinical Commissioning Group and Governing Body take into account in making its Governance Statement.

The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer, the Commissioning Clinical Group and Governing Body which underpins the assessment of the effectiveness of the organisation's system of internal control. This opinion will in turn assist the organisation in the completion of its Governance Statement.

My opinion is set out as follows:

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

My **overall opinion** is 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.**

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 the internal audit risk-based plan, 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.

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.

During 2016/2017 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to be embedded.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. The design of the Assurance Framework has been kept under regular review since the creation of the CCG. The Governing Body retains oversight of the design and content the Assurance Framework. The Governing Body reviews the Assurance Framework on a regular basis; it is noted that the design or format of the Assurance Framework has changed during the year and the CCG's have noted increased engagement with the document. The Assurance Framework is subject to regular review by both the CCG's Audit and Quality committees.

The Governing Body has approved a Risk Management Strategy and the CCG's risk management processes have been reviewed during the year. The Governing Body is well sighted on the risks facing the organisation.

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

The 2016/17 Internal Audit Plan was approved by the Audit Committee on 19 May 2016. 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 (incorporating assurance and risk management)
- Securing Improvements in Quality
- Commissioning and Contract Management
- Business Development
- Integration
- Financial Governance
- Information Governance

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

FULL	Full assurance can be given that there is a strong system of internal control which is designed and operating effectively to meet the organisation's objectives.
SIGNIFICANT	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to meet the organisation's objectives and that this is operating in the majority of core areas
LIMITED	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in it's design and/or operation in core areas to effectively meet the organisation's objectives
NO	No assurance can be given if there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the organisation'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.

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level during the development phase. One advisory audit has been completed during 2016/17 to date; this was a review of the evidence submitted by the CCG in its Information Governance Toolkit (V13) from March 2016. The review was carried out to highlight additional evidence requirements to support the CCGs self-assessment score for the Information Governance Toolkit submission in March 2017. Further advisory work has been completed to provide a gap analysis in respect of the evidence that the CCG was planning to submit in its Information Governance Toolkit (V14) on 31 March 2017.

The outcome of the assurance audit reports as at 23 May 2017 from the 2016/2017 audit plan are summarised below. The audits in italics, currently at draft report stage, will be completed by the 31 May 2017.

Audit	**Assurance Level**
Governance & Risk Review	Significant
Conflicts of Interest	Significant
Business Continuity Planning	Significant
Quality, Innovation, Productivity and Prevention (QIPP)	Significant
Business Intelligence	Significant
Continuing Healthcare	Significant
Commissioning (from a Lead Commissioners Perspective)	Significant
Primary Care Co-Commissioning	*Report in Draft (Significant)*
Collaboration	*Report in Draft (Significant)*
Financial Transactions – Part 1	Significant
Financial Transactions – Part 2	Significant
Safeguarding	*Report in Draft (Significant)*

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

Helen Kemp-Taylor, Managing Director and Head of Internal Audit
Audit Yorkshire
23 May 2017

Remuneration and Staff Report

1. Membership of the Remuneration Committee

Details of the members of the Remuneration Committee and their attendance record are set out below.

Remuneration Committee		
Member	**Role**	**Attendance**
Kate Smyth	Lay Member and Chair of the Committee	3/4
Jackie Bird	Registered Nurse	2/4
Dr Alan Brook	Chair of CCG/GP Member	3/4
Dr Nigel Taylor	GP Member	4/4
Advisors to the Remuneration Committee		
John Mallalieu	Lay Advisor (Finance, Performance and External Relations)	4/4

The Remuneration Committee is supported in its determinations by the HR Manager (the HR and Learning and Development service is commissioned from Calderdale and Huddersfield Foundation Trust), the CCG Chief Finance Officer when required, and the Lay Advisor to the Governing Body and the Corporate and Governance Manager.

The Governance Statement contains further details about the role and work of the Remuneration Committee in 2016-17.

2. Policy on Remuneration of Senior Managers

For the purpose of this report, Senior Managers includes:

- Very Senior Managers (VSMs);
- GPs on the Governing Body – including the Chair of the CCG;
- Registered Nurse and Secondary Care Specialist;
- Lay Members;
- Lay Advisor to the Governing Body;
- Head of Quality in her capacity as Advisor to the Governing Body.

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above. 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 provided by DAC Beachcroft LLP, 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 executive 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 CCG) 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 and Lay Advisors

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

3. Remuneration of Very Senior Managers (VSMs)

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

- Pay benchmarking information provided by NHS England;
- 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.

4. Policy on Senior Manager Contracts

The Accountable Officer and Chief Finance Officer have contracts of employment which set out their terms and conditions. These contracts are for permanent positions to ensure business continuity. The notice period is six months.

The CCG currently uses the following terms of engagement for the other Governing Body members; Secondment Agreement (Registered Nurse and Secondary Care Specialist); Contract for Service for GP members (i.e. Clinical Leaders), Lay Members and the Lay Advisor. As set out in the CCG's Standing Orders, the usual term of office for all Governing Body members with the exception of the Accountable Officer and Chief Finance Officer is three years.

The Head of Quality is also an Advisor to the Governing Body as set out in the CCG's Constitution, and as such is classed as a senior manager[8]. This post is shared with Greater

[8] DH Group Manual for Accounts 2016-17

Huddersfield CCG and on an interim basis with North Kirklees CCG, 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.

5. Senior manager remuneration (including salary and pension entitlements

9. Salaries and allowances

Name & Title	2016/17 Staff in Post	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	All Year	60-65	0	0	0	0	60-65
Dr.Steven Cleasby, Assistant Chair	All Year	60-65	0	0	0	0	60-65
Dr Lubna Saghir	1/8/16-31/3/17	20-25	0	0	0	0	20-25
Dr.John Taylor	Left 31/01/17	25-30	0	0	0	0	25-30
Dr.Majid Azeb	All Year	30-35	0	0	0	0	30-35
Dr.Nigel Taylor	All Year	30-35	0	0	0	0	30-35
Dr.Caroline Taylor	All Year	30-35	0	0	0	0	30-35
Dr Rajesh Phatak, Secondary Care Clinican	Left 28/2/17	10-15	0	0	0	0	10-15
Jackie Bird, Registered Nurse	All Year	15-20	0	0	0	0	15-20
Kate Smyth, Lay Member	All Year	5-10	0	0	0	0	5-10
John Mallalieu, Lay Advisor	All Year	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	All Year	5-10	0	0	0	0	5-10
Matt Walsh - Accountable Officer	All Year	130-135	0	0	0	37.5 - 40.0	170-175
Julie Lawreniuk - Chief Finance Officer	Left 30/4/16	0-5	0	0	0	2.5 - 5.0	5-10
Lesley Stokey - Interim Chief Finance Officer	1/5/16 - 31/8/16	15-20	0	0	0	35.0 - 37.5	55-60
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	From 1/9/16 -	60-65	0	0	0	40.0 - 42.5	100-105

NOTE 1: Julie Lawreniuk was employed by NHS Calderdale CCG until 30 April 2016. Lesley Stokey acted as CFO from 1 May 2016 to 31 August 2016. These were shared posts with NHS Greater Huddersfield for whom they were also Chief Finance Officer. As these were shared roles only 50% of the salary has been included in the salary and fees column. In the All Pensions Related benefits column, we have included 100% of the increase in pension entitlement, as the overall increase cannot be accurately apportioned between Calderdale & Greater Huddersfield CCGs in relation to Pension Related Benefits. Neil Smurthwaite was appointed Chief Finance Officer & Deputy Chief Executive officer on the 1 September 2016. The position is solely for NHS Calderdale CCG.

NOTE 2: The following Governing Body Members received payments for associate work in addition to their roles as Governing Body members: Dr M Azeb(£ 4,837), Dr N Taylor(£1,449), Dr J

Salary and pension Disclosure tables

Annex 3 to Chapter 4 : Salary & Pension Disclosure tables

Name & Title	2016/17 Staff in Post	Real increase in pension at pension age. (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 31/03/17. (Bands of £5,000) £000's	Lump sum at age 60 related to accrued pension as at 31/03/17. (Bands	CETV at 1 April 2016 £000's	CETV at 31 March 2017 £000's	Real Increase in CETV £000's	Employer's Contribution to stakeholders pension £000's
Matt Walsh - Accountable Officer	All Year	0 - 2.5	5.0 - 7.5	25 - 30	75 - 80	444	502	58	29
Julie Lawreniuk - Chief Finance Officer	All Year	0 - 2.5	0 - 2.5	35 - 40	105 - 110	654	698	44	2
Lesley Stokey - Interim Chief Finance Officer	1/5/16 - 31/8/16	0 - 2.5	0 - 2.5	15 - 20	35 - 40	167	204	37	6
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	From 1/9/16 -	0 - 2.5	12.5 - 15	10 - 15	115 - 120	106	130	24	7

NOTE 1: The figures for the Accountable Officer only include the pension benefits of Officer NHS Pension Scheme membership. Any practitioner(i.e. GP) pension benefits are excluded.

NOTE 2: Julie Lawreniuk & Lesley Stokey were employed by NHS Calderdale but were shared posts with NHS Greater Huddersfield CCG, for whom they were also Chief Finance Officers. The above information includes

NOTE 3: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore notincluded in this table.

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 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 effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

6. Compensation for Early Retirement or Loss of Office

No payment has been made in compensation for loss of office or early retirement during 2016-17.

7. Payments to Past Senior Managers

No payment has been made to past senior managers.

8. Pay Multiples

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 steps that the CCG has taken to satisfy itself that the remuneration of Governing Body members including the Clinical Chair are set out in section 2, pages 87-89 and the CCG is satisfied that the resulting remuneration is reasonable.

The banded remuneration of the highest paid director/member in Calderdale CCG in the financial year 2016-17 was £150-155k (2015-16, £150-155k). This was 4.33 times (2015-16, 4.6) the median remuneration of the workforce, which was £35,225 (2015-16, £33,227).
In 2016-17, 0 (2015-16, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £13k to £154k (2015-16, £13k-£152k).

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

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 31 March 2017. Information relating to Governing Body members is reported separately.

1. Staff numbers and costs

The staff costs and employee benefits as at 31st March 2017 are set out as in the table below:

2016 -2017 Staff Costs and Employee Benefits	2016-17	Total		Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	3,912	3,052	860	2,363	1,881	482	1,548	1,171	378
Social security costs	354	321	34	227	200	28	127	121	6
Employer Contributions to NHS Pension scheme	430	390	40	274	242	32	156	148	8
Other pension costs	0	0	0	0	0	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	**4,696**	**3,763**	**934**	**2,865**	**2,323**	**542**	**1,831**	**1,439**	**392**
Less recoveries in respect of employee benefits	(611)	(611)	0	(288)	(288)	0	(323)	(323)	0
Total - Net admin employee benefits including capitalised costs	**4,085**	**3,151**	**934**	**2,577**	**2,035**	**542**	**1,508**	**1,116**	**392**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,085**	**3,151**	**934**	**2,577**	**2,035**	**542**	**1,508**	**1,116**	**392**

2015 -2016 Staff Costs and Employee Benefits	2015-16	Total		Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	2,739	2,033	706	1,676	1,266	410	1,063	767	296
Social security costs	212	182	30	147	124	23	65	58	7
Employer Contributions to NHS Pension scheme	317	278	39	206	178	28	111	100	11
Other pension costs	0	0	0	0	0	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	**3,268**	**2,493**	**775**	**2,029**	**1,568**	**461**	**1,239**	**925**	**315**
Less recoveries in respect of employee benefits	(212)	(212)	0	(135)	(135)	0	(77)	(77)	0
Total - Net admin employee benefits including capitalised costs	**3,056**	**2,281**	**775**	**1,894**	**1,433**	**461**	**1,162**	**848**	**315**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,056**	**2,281**	**775**	**1,894**	**1,433**	**461**	**1,162**	**848**	**315**

Note: **Admin** – Staff employed in completing CCG corporate/admin work, **Programme** – Staff employed working on delivery of patient services.

2. Staff Composition

As at 31st March 2017, the CCG employed 86 staff. This equates to 80.39 Whole Time Equivalents. The following table sets out the gender profile of the organisation.

Table 1: Gender profile of the organisation as at 31st March 2017

Gender profile	Headcount		Total
	Male	Female	
Members of the Governing Body including lay members and lay advisor (excl. VSMs)	7	4	11
All other senior managers, including all managers at grade VSM not included above	3	5	8
All other employees not included in either of the previous two categories	14	64	78

3. Sickness absence

In 2016-17, the CCG has seen fluctuating sickness absence levels. The individual cases are managed closely and from a supportive perspective by the SMT with the support of the HR staff and Occupational Health.

The yearly average sickness figures for Calderdale CCG between 1st January 2016 and 31st December 2016 are:

Total Days lost:	678
Total Staff Years	81
Average Working Days Lost:	8.37

The CCG has policies and procedures in place to support sickness absence management and continues to develop a positive and pro-active approach to supporting staff through sickness or difficult periods in their lives.

The CCG offered workplace vaccinations to all its employees, in order to support the resilience of the workforce and our community. The winter flu campaign raised awareness of the benefits of the flu vaccination. The final uptake was 48%. We also commission a comprehensive Occupational Health service, providing expert advice on the management of health conditions at work and continue to promote the Employee Assistance Programme, which offers 24 hour advice and support to staff and their dependents on a range of work and home-related issues. It also includes access to face-to-face counselling sessions.

Our CCG is committed to the health and wellbeing of our staff and works hard to promote a healthy working environment. Our Staff Forum has been proactive throughout the year in carrying out a number of initiatives which are included in the sustainable development report (see Performance Report).

Staff Survey

The CCG participated in the national staff survey, with a response rate of 78%. Overall, the CCG's results were positive, and demonstrated that our staff are highly engaged, with an overall staff engagement score of 4.09, out of a possible score of 5. This compares favourably with the CCG sector average score of 3.91. Additionally, 81% of CCG staff said that they would recommend the CCG as a place to work, which is significantly higher than the CCG sector average of 69%. 99% of staff believe that the organisation takes positive action on health and wellbeing. Our main area of focus for improvement is to develop an understanding of how workloads can be more manageable. The SMT is working closely with the Staff Forum to develop a plan using our strengths to address areas for development and to enable the CCG to contribute positively to the changing health and social care landscape.

Supporting Staff through Organisational Change

The CCG saw significant change in its staffing at the end of 2015 and into 2016. This was due to the closure of Yorkshire and Humber Commissioning Support Unit and a number of employees transferring to the CCG or working for the CCG in a range of shared staffing models.

The focus for the organisation throughout 2016-17 has been to ensure that those staff that transferred or joined the CCG during the financial year felt welcomed and part of the organisation as much as the existing staff. To this end, we held a development day for all staff and Governing Body members in June 2016. The focus on the day was on shaping the organisation's identity and values and confirming what really mattered to us as we moved forward as a CCG.

4. Staff Policies

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 which are available to all staff through the intranet and on the CCG's website. 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.	▪ Diversity and Equal Opportunities in Employment 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.	▪ Diversity and Equal Opportunities in Employment Policy; ▪ Sickness Absence Policy; ▪ Flexible Working Policy.
Training, career development and promotion of disabled people employed by the company.	▪ Diversity and Equal Opportunities in Employment Policy; ▪ Appraisal procedure; ▪ Recruitment and Selection Policy; ▪ Pay Progression Policy

The CCG has a rolling programme of policy review and awareness raising; which includes a review of our Flexible Working and Recruitment and Selection Policies as well as our appraisal procedure to further improve the focus on the quality of conversation taking place.

Disability Confident Employer

In 2016 the government made a commitment to halve the employment gap for disabled people and to achieve this introduced a new Disability Confident scheme. As a Disability Symbol 'two ticks' employer, Calderdale CCG automatically received the Level 2 - Disability Confident Employer badge for 12 months from September 2016. This award allows us to use the logo, which lets people know that we have made the commitments regarding recruitment, training, and retention of people with disabilities and disability awareness across the organisation.

As a Disability Confident Employer, the CCG will self-assess the business going forward against a set of statements under 2 themes:

1. Getting the right people for the business
2. Keeping and developing people

5. Expenditure on Consultancy 2016-17

Description	2016-17 Costs(£)
Consultancy for integrated work with Calderdale Council on the Better Care Fund and Children's Services	£10,292
Right care, Right Time, Right Place (RCRTRP) Consultation and Communications Support (*)	£62,613
Communications support for RCRTRP(*)	£1,800
Consultancy Fee – Advice and Guidance on Compliance Assessment (*)	£8,034
RCRTRP Children and Young People Consultation Engagement (*)	£1,496
TOTAL	£84,235

(*) These consultancy costs were incurred as part of the Right Care, Right Time, Right Place consultancy. NHS Calderdale CCG acted as the host partner for the consultation so that the costs represent the full cost before recharges to other partner organisations.

External Audit

KPMG has been appointed by the Public Sector Audit Appointments Limited to be the external auditor for the CCG. The cost of the work performed by the auditor in respect of the reporting period is £48,750 (excluding VAT):

Services from KPMG	£
Audit Services Statutory audit and services carried out in relation to the statutory audit, eg. reports to the Secretary of State	48,750
Further assurance services (i.e. any services unrelated to the statutory audit where the CCG has discretion whether or not to appoint an auditor e.g. review of achievement of performance indicators)	0
Other Services	0
TOTAL	48,750

Before agreeing to carry out any non-audit work, KPMG's risk and quality policies require all independence issues to be considered and cleared by senior partners, confirming that the non-audit work will not breach the requirements of their Manual and the Ethical Standards.

6. Off-payroll Engagements

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

The CCG engages with a limited number of Associates and Subject Specialists in line with the CCG's constitution, to provide additional clinical or lay input into specified priority areas.

Off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months are as follows:

Table 1: Off-payroll engagements longer than 6 months

Off payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2017	6
Of which the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	3
For between three and four years at the time of reporting	2
For four or more years at the time of reporting	0

NOTE: The CCG confirms that all existing off-payroll engagements have at some point 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.

Table 2: New Off-payroll engagements

New off-payroll engagments between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	1
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.	1
Number for whom assurance has been requested	1
Of which:	
For whom assurance has been received	1
For whom assurance has not been received	0
That have been terminated as a result of assurance not being received	0

Table 3: Off-payroll board member/senior official engagements

Off payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

	Number
Number of off-payroll engagements of membership Body and/or Governing Body members, and/or senior officials with significant financial responsibility, during the financial year.	2
Number of individuals that have been deemed "Membership Body and/or Governing Body members" and/or senior officials with significant financial responsibility, during the financial year (this figure includes both off-payroll and on-payroll engagements.	11

Note: During 2016/2017 the CCG had 2 members of its governing body who were paid through off payroll engagements. Both individuals were on secondment from other NHS organisations and acted in the roles of Registered Nurse (from 2013/14 until present) and Secondary Care Specialist (from 2014/15 until 28th February 2017). As the individuals were substantively employed by other NHS organisations, the CCG considers a secondment arrangement a reasonable form of engagement into the posts of Registered Nurse and Secondary Care Specialist.

7. Exit Packages, including Special (Non-Contractual) Payments

There have been no exit packages, including special (non-contractual) payments during 2016-17.

Dr Matt Walsh, Accountable Officer, 24 May 2017

Parliamentary Accountability and Audit Report

Calderdale CCG is not required to product a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities (see Financial Statements note 31), 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 145.

Governing Body Profiles (including non-Governing Body members of committees)

Dr Alan Brook
Chair of CCG

Alan Brook has been a GP in Brighouse since 1987 and was one of two national GP trainee representatives on the Royal College of General Practitioners. On arrival in Calderdale he joined the Local Medical Committee and later served as its Chair. In 1990 Alan founded the Audit Group, which helped local GP practices to compare their performance with others and identify areas for improvement. He then chaired the Primary Care Group, which in turn became a Primary Care Trust.

Alan is currently a member of the CCG's Remuneration Committee, the Commissioning Primary Medical Services Committee and is Clinical Lead for Information Management and Technology. He strives for excellence in his practice and encourages others to do the same.

Alan lives in Calderdale and is married with three grown-up children. His interests include gardening, beekeeping, woodturning, cooking, skiing and walking. He and his wife are season ticket holders at Huddersfield Town Football Club.

Mr David Longstaff, Lay Member
Chair of the Audit Committee

David Longstaff has spent of most of his career working for British Telecom. He started as an apprentice and finished after 38 years as a senior executive in charge of audit and risk.

As a Lay Member and Deputy Chair of the CCG, he chairs the Audit Committee and is the CCG's Freedom to Speak Up and Conflicts of Interest Guardian. He's passionate about the CCG being open and transparent and getting the best outcomes for local people.

He has lived in West Yorkshire all his life. Most of his family lives in the Brighouse area and all use the local NHS. David is married, has one child and three grandchildren. He is a big Rugby League fan.

Dr Matt Walsh
Chief Officer

Matt graduated from the University of Leeds Medical School in 1987. After various hospital and GP training posts in Bradford, he became a GP partner in 1991 and was appointed as a GP trainer two years later.

Matt spent six years in senior management as Medical Director for Bradford South and West Primary Care Trust and was responsible for bringing the four Bradford and Airedale PCTs together to create a single Bradford and Airedale PCT. He then moved to a role in NHS Leeds PCT as Medical Director and Executive Director for Commissioning, where he spent four years before joining NHS Calderdale as Medical Director in 2009. Matt is a member of the Finance and Performance Committee and the Commissioning Primary Medical Services Committee.

Matt lives in Calderdale and is married with two children. He is passionate about helping to make health and social care services in Calderdale the best they can be.

Julie Lawreniuk,
Chief Finance Officer until 30th April 2016

Julie is a qualified accountant and has worked in the NHS since 1991. During this time she has worked in a number of roles across the Calderdale and Kirklees patch including Executive Director of Finance and Efficiency for Calderdale Primary Care Trust (2010-2011) and Associate Director of Finance for the two former Huddersfield PCTs (2005-2007). She was also the Chief Operating Officer for NHS Calderdale PCT, sitting on the Calderdale, Kirklees and Wakefield District Cluster Board prior to the establishment of the CCG.

Julie was a member of the Commissioning Primary Medical Services Committee and the Finance and Performance Committee and advised both the Audit and Remuneration Committees. Julie Lawreniuk left the CCG in April 2016 to take up the Chief Finance Officer/Deputy Chief Officer role at Bradford Districts CCG.

Neil Smurthwaite,
Chief Finance Officer and Deputy Chief Officer

Neil Smurthwaite joined Calderdale CCG in September 2016 having previously been Chief Finance Officer with Airedale, Wharfedale and Craven CCG.

He is a fellow of the Association of Chartered Certified Accountants and has worked in finance for more than 20 years, joining the NHS seven years ago. Previously, he was a Director of Finance in social housing and worked for over eight years as a senior client manager in a top 10 accountancy firm in Leeds which specialised in public sector audit and consultancy.

Neil has lived in Calderdale for over 10 years and considers it his adopted home after moving from the south coast many years ago. He is married with three children and two dogs. After many years of being a slave to rugby, Neil has now turned his hand to running and gardening, in between being his kids' taxi driver!

Dr Steven Cleasby,
Assistant Clinical Chair

Steven has been a GP in Calderdale since 1999, when he started at Spring Hall Group Practice. His specialist area is Diabetes and he also has a keen interest in medicines management. He has held a clinical leadership role in Calderdale since 2002 as the prescribing lead for the Primary Care Trust and joined the Calderdale CCG in 2007 as part of practice based commissioning where he was Chair.

As Assistant Clinical Chair at the CCG, Steven holds a number of lead roles, including being a member of the Audit Committee and more recently a member of the Finance and Performance Committee and the Commissioning Primary Medical Services Committee; he is also the Governing Body lead for Safeguarding and for Cardiovascular Disease.

Steven is Vice Chair of Calderdale's Health and Wellbeing Board and is keen to develop the prevention agenda alongside Public Health, as well as see innovation in primary care. He lives in Calderdale with his wife and three boys.

Dr Majid Azeb,
GP Member of the Governing Body

Majid studied medicine at the University of Liverpool, qualifying in 1999 before moving into general practice in 2005. He has been a partner at Southowram Surgery for the last seven years. Majid holds a number of lead roles within the CCG. He is Chair of the Quality Committee and clinical lead for urgent care and non-elective care, which puts him at the heart of developing services in these areas.

Majid has many pastimes away from medicine, including playing five-a side football and growing his own vegetables. Majid grew up in Halifax and has strong ties to the Park Ward area of the town.

Jackie Bird,
Registered Nurse

Jackie holds the statutory role of Registered Nurse on Calderdale CCG's Governing Body. She is seconded to this role from her substantive position as Executive Director of Nursing & Quality at The Christie NHS Foundation Trust.

Jackie was awarded a Florence Nightingale Leadership Scholarship in 2013 and has applied it to the investigation into the development of a 'kite mark' for patient experience.

Jackie is the elected Director of Nursing representative on the board of Health Education (North West). A registered nurse and a mental health trained nurse, she holds an honours degree in nursing studies and a Masters in Management and Leadership.

As the CCG's Registered Nurse, Jackie is able to develop her long-standing interest in patient safety, patient experience and clinical outcomes from a commissioning perspective. Jackie is a member of the CCG's Audit, Remuneration and Commissioning Primary Medical Services Committees.

Dr Helen Davies
GP Member of the Governing Body (joined on the 1st April 2017)

Helen has worked as a GP, based in Hebden Bridge for 25 years, during which time she has developed a deep understanding of the needs of patients. Serving on the CCG's Governing Body will enable Helen to use this experience to help improve care systems in place across Calderdale.

Helen has a great deal of experience in both training and appraising GPs and a comprehensive knowledge of the challenges general practitioners face across Calderdale, but also the opportunities available to them to improve patients' lives.

Helen has a particular interest in developing patient self-care; improving people's knowledge facilitate healthy lifestyles, empower patients in the personal management of their illness and educate residents on how to best use their local care services to help improve the health of our population and the efficiency of our care services.

Dr Farrukh Javid
GP Member of the Governing Body (joined on the 1st April 2017)

Farrukh completed his GP training in Calderdale and Huddersfield before working in various practices across the region as a sessional GP, which gave him an understanding of local services and demographics, before taking up a partnership role at Rastrick Health Centre. Before qualifying as a GP, Farrukh was involved in the development of a psychiatric liaison service in conjunction with South West Yorkshire Partnership Foundation Trust, Calderdale and Huddersfield Foundation Trust and the CCG and also helped to develop the "Ignaz" smartphone app, which allows doctors to easily access local clinical guidelines and information.

Farrukh has recently completed an MSc in Healthcare Leadership with the NHS Leadership Academy, and in his spare time likes to stay active and enjoys playing football, badminton and running.

John Mallalieu, Lay Advisor
(Finance, Performance & External Relations)

John joined the CCG having been a Non-Executive Director of Calderdale Primary Care Trust from 2009, and is a Lay Advisor to the Governing Body.

Throughout 2016-17 John was the Managing Director of Turning Point, one of the Country's leading social enterprises, with extensive experience in public, private and social enterprise organisations. John has held senior roles in both NHS Professionals and NHS Direct and moved to healthcare following a successful periods in Senior Management Roles with Dixons Stores Group International and in Retail Financial Services. John also holds Trustee roles for a national conservation charity and a North-West Housing Association.

John has held the position of Lay Advisor to the Governing Body and is an advisor to the Audit Committee and the Remuneration Committee. He is Chair of the Commissioning

Primary Medical Services Committee and a member of the Finance and Performance Committee.

He will take on the position of the third lay member on the Governing Body from 1st June 2017.

Dr Rajesh Phatak
Secondary Care Specialist until 28th February 2017

Rajesh graduated from Mumbai University in 1997 and moved to the UK in December 2002 after completing his initial Paediatric Training. After further training posts in London, Leeds, Hull, Bradford (Anaesthesia) and Southampton (PICU), he was appointed as a Consultant Paediatric Intensivist in July 2011. He is part of the North West and North Wales Transport Service, which delivers paediatric intensive care advice and retrieval services to North West England and North Wales. He has been recently appointed as Lead Clinician for the North West Paediatric Critical Care network and is an advisor on the National Confidential Enquiry into Patient Outcome and Death Neuro-Disability Study.

Rajesh was a member of the CCG's Commissioning Primary Medical Services and Remuneration Committees.

Kate Smyth, Lay Member
(Public and Patient Involvement) & Hal

Kate has lived in Todmorden for over 30 years and has a special interest in how health and care services are delivered. Her appointment to the Governing Body provided a perfect opportunity to be a champion for commissioning the best health services for the people of Calderdale and she believes passionately that the patient and public voice should be heard. As a wheelchair user Kate (along with her trusted assistance dog Hal) has direct experience of how the delivery of health and care services impacts on patients and service users.

Kate is a member of the Audit, Quality and Commissioning Primary Medical Services Committees and chairs the Remuneration Committee. She holds a variety of non-executive posts in the voluntary sector in the local area and has a good understanding of the needs of vulnerable people. Kate has a degree in town planning and finds time to keep chickens and geese in her garden as well as being a self-appointed head gardener.

Dr Caroline Taylor
GP Member of the Governing Body

Caroline graduated from Leeds Medical School in 1992, underwent GP training in York and Otley, and has held a variety of hospital and GP jobs, including working at Overgate Hospice for two years. Caroline has been a GP in Calderdale since 1999 when she started working at Beechwood Medical Centre. She has always had a keen interest in mental health.

Caroline is the CCG's clinical lead for mental health as well as being a member of the Finance and Performance and Commissioning Primary Medical Services Committees during the year. Caroline has now joined the Audit Committee and become Vice Chair of the Quality Committee.

Caroline lives in Calderdale with her GP husband and teenage son and daughter, and is a big believer in the importance of a healthy lifestyle in maintaining both physical and mental health. Her favourite way to unwind is running and cycling in our beautiful Calderdale countryside.

Dr John Taylor
GP Member of the Governing Body until the 31st January 2017

John, originally from Sheffield, qualified from Nottingham University Medical School in 1984. After completing house officer jobs in North Yorkshire he moved to Calderdale in 1985 to join the GP Training Scheme. He has been a full time GP Partner at King Cross Surgery, Halifax since August 1988. He has always had an interest in improving healthcare delivery and was first involved in commissioning as a GP Fundholding Practice in the 1990s. John believes that putting the patient at the centre of decision making regarding service redesign is the key to success. He was the Vice Chair of the CCG Quality Committee and was one of the CCG Clinical Leads for Care Closer to Home and Frailty.

Dr Nigel Taylor
GP Governing Body Member

Nigel qualified in medicine at Kings College, London, in 1991 and completed his general practice training in Calderdale in 1995. He joined Hebden Bridge Group Practice as a GP shortly after. Prior to joining the CCG, Nigel was one of the Practice Based Commissioning leads.

Nigel chairs the CCG's Finance & Performance Committee and is the clinical lead for Planned Care, Respiratory Medicine and Medicines Management. As such, he is dedicated to effective prescribing and is a champion for better equity of care and improving the quality of prescribing across Calderdale.

Originally from Yarm in North Yorkshire, Nigel has lived in Calderdale with his wife and two daughters since joining his practice. In his spare time he is very active, enjoying walking, skiing and sailing. He also enjoys wine tasting.

Dr Lubna Saghir
GP Governing Body Member (1st August 2016 – 31st March 2017)

Lubna was born in Calderdale and qualified as a general practitioner in 2013. While working as a locum for two years she worked in a number of practices around Calderdale, gaining a first-hand insight into the different health needs across the region.

A partner at Station Road Surgery in Sowerby Bridge, Lubna's areas of interest include Diabetes and Dermatology, in which she is currently undertaking a diploma.

Penny Woodhead, Head of Quality
Advisor to Governing Body

Penny has worked in the NHS for 28 years, trained as a general nurse in a London teaching hospital specialising in oncology and palliative care, and has clinical and management experience across tertiary, secondary, primary care and the voluntary sector.

Penny has been involved in clinical governance since 1998 at service and organisational level, and she holds the role of Head of Quality and Safety for Calderdale and Greater Huddersfield CCGs as well as the interim Head of Quality and Safety for North Kirklees CCG. Penny is responsible for making sure that the services that are commissioned are of a high standard. This includes safety, safeguarding, effectiveness and patient experience.

Penny is also the organisational lead for Patient and Public Engagement, and is a member of the Quality Committee.

NHS
Calderdale
Clinical Commissioning Group

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2016-2017

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2017 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.

Calderdale Clinical Commissioning Group - Annual Accounts 2016-17

CONTENTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(3,591)	(4,041)
Other operating income	2	(1,001)	(498)
Total operating income		**(4,592)**	**(4,539)**
Staff costs	4	4,696	3,268
Purchase of goods and services	5	311,468	308,247
Depreciation and impairment charges	5	72	80
Provision expense	5	0	0
Other Operating Expenditure	5	377	383
Total operating expenditure		**316,613**	**311,978**
Net Operating Expenditure		**312,021**	**307,439**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**312,021**	**307,439**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**312,021**	**307,439**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**312,021**	**307,439**

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	13	506	547
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		506	547
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	2,074	1,037
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	45	30
Total current assets		**2,119**	1,067
Non-current assets held for sale	21	0	0
Total current assets		**2,119**	1,067
Total assets		**2,625**	1,614
Current liabilities			
Trade and other payables	23	(20,099)	(22,078)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(20,099)**	(22,078)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(17,475)**	(20,464)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(17,475)**	(20,464)
Financed by Taxpayers' Equity			
General fund		(17,475)	(20,464)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(17,475)**	(20,464)

The notes on pages 5 to 34 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit Committee on 18th May 2017 under delegated authority from the Governing Body and signed on its behalf by

Chief Accountable Officer
Dr.Matt Walsh

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(20,464)	0	0	**(20,464)**
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 2017	**(20,464)**	**0**	**0**	**(20,464)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(312,021)			(312,021)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		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 Yea	**(312,021)**	**0**	**0**	**(312,021)**
Net funding	315,010	0	0	315,010
Balance at 31 March 2017	**(17,475)**	**0**	**0**	**(17,475)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(13,783)**	**0**	**0**	**(13,783)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2016	**(13,783)**	**0**	**0**	**(13,783)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(307,439)			(307,439)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		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 Yea	**(307,439)**	**0**	**0**	**(307,439)**
Net funding	300,758	0	0	300,758
Balance at 31 March 2016	**(20,464)**	**0**	**0**	**(20,464)**

The notes on pages 5 to 34 form part of this statement

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(312,021)	(307,439)
Depreciation and amortisation	5	72	80
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(1,036)	(211)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(1,979)	7,161
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		**(314,964)**	(300,409)
Cash Flows from Investing Activities			
Interest received		0	1
(Payments) for property, plant and equipment		(32)	(29)
(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
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		**(32)**	(28)
Net Cash Inflow (Outflow) before Financing		**(314,996)**	(300,437)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		315,010	300,758
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
Net Cash Inflow (Outflow) from Financing Activities		**315,010**	300,758
Net Increase (Decrease) in Cash & Cash Equivalents	20	**14**	321
Cash & Cash Equivalents at the Beginning of the Financial Year		**30**	(291)
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		**45**	30

The notes on pages 5 to 34 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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. 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 the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
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.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector.
Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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 Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ accounts.

1.6 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.

Notes to the financial statements

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

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

1.7.1 ***Critical Judgements in Applying Accounting Policies***

The CCG has made no Critical Judgement's during the period.

1.7.2 **Key Sources of Estimation Uncertainty**

The CCG makes an estimation in relation to prescribing expenditure based on latest spend and historical trends.

1.8 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the 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.

Some employees are members of the Local Government Superannuation Scheme, 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 expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 **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.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **Property, Plant & Equipment**

1.11.1 **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.

Notes to the financial statements

1.11.2 **Valuation**

All property, plant and equipment are 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. All assets are measured subsequently at fair value.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

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. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

Fixtures and equipment are carried at depreciated historic cost 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.

1.11.3 **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.

1.12 **Intangible Assets**

1.12.1 **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.

Intangible assets acquired separately are initially recognised at fair value. 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.

Notes to the financial statements

1.12.2 **Measurement**

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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 **Depreciation, Amortisation & Impairments**

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

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

1.14 **Donated Assets**

Donated non-current assets are capitalised at their 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 as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 **Government Grants**

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 **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.

1.17 **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.

Notes to the financial statements

1.17.1 **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.

1.17.2 **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.

1.18 **Private Finance Initiative Transactions**

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses. 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;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 **Services Received**

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

1.18.2 **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 fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **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.

1.18.4 **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 their fair value.

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.

Notes to the financial statements

Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the
1.18.5 **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.

1.18.6 **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.

1.19 **Inventories**

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

1.20 **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.

1.21 **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:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

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.

1.22 **Clinical Negligence Costs**

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.23 **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 Litigation Authority 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.

1.24 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims.

1.25 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

Notes to the financial statements

1.26 **Contingencies**

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, contingencies 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 fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 **Financial Assets 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 assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.27.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the financial statements

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. Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

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, 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.

1.3 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is sterling. 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 **Subsidiaries**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

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

Notes to the financial statements

1.34 **Associates**
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **Joint Ventures**
Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 **Joint Operations**
Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 **Research & Development**
Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	611	288	323	212
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	100	0	100	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies ***1**	3,591	251	3,340	4,041
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	290	18	272	286
Total other operating revenue	**4,592**	**556**	**4,036**	**4,539**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services. Revenue in this note does not include cash received from NHS England, which is drawn directly into the bank account of the CCG and credited to the General Fund.

***1** Non-patient care services to other bodies includes £0.3K revenue received from Greater Huddersfield Clinical Commissioning Group for 2016/17 (£1.181K 2015/16)

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	4,592	555	4,037	4,539
From sale of goods	0	0	0	0
Total	**4,592**	**555**	**4,037**	**4,539**

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2016-17 Total	Total Permanent Employees	Total Other
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	3,912	3,052	860
Social security costs	354	320	34
Employer Contributions to NHS Pension scheme	430	390	40
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**4,696**	**3,762**	**934**
Less recoveries in respect of employee benefits (note 4.1.2)	(611)	(611)	0
Total - Net admin employee benefits including capitalised costs	**4,085**	**3,151**	**934**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,085**	**3,151**	**934**

4.1.1 Employee benefits	2015-16 Total	Total Permanent Employees	Total Other
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	2,739	2,033	706
Social security costs	212	182	30
Employer Contributions to NHS Pension scheme	317	278	39
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,268**	**2,493**	**775**
Less recoveries in respect of employee benefits (note 4.1.2)	(212)	(212)	0
Total - Net admin employee benefits including capitalised costs	**3,056**	**2,281**	**775**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,056**	**2,281**	**775**

4.1.2 Recoveries in respect of employee benefits	2016-17 Total	Permanent Employees	Other	2015-16 Total
	Total £'000	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits - Revenue				
Salaries and wages	(496)	(496)	0	(171)
Social security costs	(53)	(53)	0	(17)
Employer contributions to the NHS Pension Scheme	(62)	(62)	0	(24)
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(611)**	**(611)**	**0**	**(212)**

4.2 Average number of people employed

	Total Number	2016-17 Permanently employed Number	Other Number	2015-16 Total Number
Total	**79**	**65**	**14**	**64**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	678	195
Total Staff Years	81	54
Average working Days Lost	8	4

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0
	£'000	**£'000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

The staff sickness absence statistics relate to the calendar year (January to December 2016).

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

There were no exit packages or severance payments agreed by Calderdale CCG in 2016/17 & 2015/16

4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers' contributions of £430k were payable to the NHS Pensions Scheme (2015-16: £317k) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,347	2,516	1,831	2,915
Executive governing body members	349	349	0	354
Total gross employee benefits	**4,696**	**2,865**	**1,831**	**3,269**
Other costs				
Services from other CCGs and NHS England	294	97	196	2,891
Services from foundation trusts	169,420	40	169,380	162,628
Services from other NHS trusts	19,841	0	19,841	18,786
Services from other WGA bodies	19	0	19	8
Purchase of healthcare from non-NHS bodies	51,497	0	51,497	56,510
Chair and Non Executive Members	377	377	0	383
Supplies and services – clinical	3	0	3	0
Supplies and services – general	435	356	79	126
Consultancy services	84	9	76	129
Establishment	1,245	467	778	381
Transport	2	2	0	3
Premises	1,701	400	1,302	1,707
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	72	72	0	80
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees ***3**	55	55	0	58
Other non statutory audit expenditure				
· Internal audit services ***1**	0	0	0	0
· Other services	0	0	0	18
General dental services and personal dental services	0	0	0	0
Prescribing costs	37,626	0	37,626	35,968
Pharmaceutical services	0	0	0	0
General ophthalmic services	127	0	127	90
GPMS/APMS and PCTMS ***2**	28,696	0	28,696	28,399
Other professional fees excl. audit	191	72	119	42
Grants to Other bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	50	45	5	47
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies		0	0	0
CHC Risk Pool contributions	182	0	182	455
Other expenditure	0	0	0	0
Total other costs	**311,917**	**1,992**	**309,925**	**308,709**
Total operating expenses	**316,613**	**4,857**	**311,756**	**311,978**

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 £40K are included in Services from Foundation Trusts for 2016/17.
***2** GPMS/APMS and PCTMS included £27.174M for delegated responsibility for commissioning Primary Medical Services for 2016/17.
***3** Includes a rebate of £5,800.00

6.1 Better Payment Practice Code

Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,554	86,505	10,094	57,254
Total Non-NHS Trade Invoices paid within target	10,508	86,238	10,056	57,071
Percentage of Non-NHS Trade invoices paid within target	**99.56%**	**99.69%**	**99.62%**	**99.68%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,603	191,359	2,527	184,936
Total NHS Trade Invoices Paid within target	2,489	190,847	2,443	184,439
Percentage of NHS Trade Invoices paid within target	**95.62%**	**99.73%**	**96.68%**	**99.73%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice with supporting evidence, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £'000	2015-16 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities

8. Investment revenue

The Clinical Commissioning Group does not undertake any income generation activities

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

12.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	1,194	(4)	**1,190**	0	1,157	4	**1,161**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**1,194**	**(4)**	**1,190**	**0**	**1,157**	**4**	**1,161**

The lease payments above include £217K for NHS Property Services, in 20015/16 the equivalent amount was £346k.

12.1.2 Future minimum lease payments

	2016-17				2015-16			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	845	0	**845**	0	1,051	-	**1,051**
Between one and five years	0	2,947	0	**2,947**	0	3,104	-	**3,104**
After five years	0	5,652	0	**5,652**	0	6,388	-	**6,388**
Total	**0**	**9,444**	**0**	**9,444**	**0**	**10,543**	**0**	**10,543**

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

2016-17	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 2016	0	0	0	0	0	0	107	700	807
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	31	0	31
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**138**	**700**	**838**
Depreciation 01 April 2016	0	0	0	0	0	0	70	190	260
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	14	57	72
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**85**	**247**	**332**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**53**	**452**	**506**
Purchased	0	0	0	0	0	0	54	452	506
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**452**	**506**
Asset financing:									
Owned	0	0	0	0	0	0	54	452	506
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**452**	**506**

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 2016	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

2015-16	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-2016	0	0	0	0	0	0	78	700	778
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	29	0	29
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**107**	**700**	**807**
Depreciation 01-April-2016	0	0	0	0	0	0	48	132	180
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	22	58	80
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**70**	**190**	**260**
Net Book Value at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**510**	**547**
Purchased	0	0	0	0	0	0	37	510	547
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**510**	**547**
Asset financing:									
Owned	0	0	0	0	0	0	37	510	547
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**510**	**547**

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:

	2016-17 £'000	2015-16 £'000
Information technology	52	52
Furniture & fittings	0	0
Total	**52**	**52**

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 2017.

16 Inventories

The Clinical Commissioning Group has no inventories at 31st March 2017.

17 Trade and other receivables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	189	0	266	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	0	0	0	0
NHS accrued income	755	0	378	0
Non-NHS and Other WGA receivables: Revenue	943	0	58	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	170	0	244	0
Non-NHS and Other WGA accrued income	0	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	17	0	91	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	(0)	0
Total Trade & other receivables	**2,074**	**0**	**1,037**	**0**
Total current and non current	**2,074**		**1,037**	
Included above:				
Prepaid pensions contributions	0		0	

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.

17.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	984	189
By three to six months	15	9
By more than six months	0	0
Total	**999**	**198**

£966K of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2017.

17.2 Provision for impairment of receivables	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**0**	**0**

18 Other financial assets

18.1 Current

The Clinical Commissioning Group has no current assets as at 31st March 2017.

18.2 Non-current

The Clinical Commissioning Group has no non-current assets as at 31st March 2017.

18.3 Non-current: capital analysis

The Clinical Commissioning Group has no non-current capital as at 31st March 2017.

19 Other Current assets

The Clinical Commissioning Group have no other current assets as at 31st March 2017.

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	30	(291)
Net change in year	14	321
Balance at 31 March 2017	**45**	**30**
Made up of:		
Cash with the Government Banking Service	44	30
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**45**	**30**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**45**	**30**

The Clinical Commissioning Group have no bank overdraft as at 31 March 2017.

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

The Clinical Commissioning Group has had no impairments or reversal of impairments during the period.

23 Trade and other payables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,530	0	1,450	0
NHS payables: capital	0	0	0	0
NHS accruals	1,589	0	3,767	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	7,629	0	10,398	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	7,967	0	5,737	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	51	0	40	0
VAT	0	0	0	0
Tax	42	0	40	0
Payments received on account	0	0	0	0
Other payables and accruals	291	0	646	0
Total Trade & Other Payables	**20,099**	**0**	**22,078**	**0**
Total current and non-current	**20,099**		**22,078**	

The CCG has no liabilities for early retirement.

Other payables include £57K outstanding pension contributions at 31 March 2017.

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31st March 2017.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31st March 2017.

26 Borrowings

The Clinical Commissioning Group has no borrowings as at 31st March 2017.

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 2017.

28 Finance lease obligations

The Clinical Commissioning Group has no financial lease obligations as at 31st March 2017.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31st March 2017.

30 Provisions

	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	0	0	0	0
Other	0	0	0	0
Total	**0**	**0**	**0**	**0**
Total current and non-current	**0**		**0**	

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 2017 is £234,000. (2015/16 £1,102,000).

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 Contingencies

Contingent liabilities	**2016-17 £'000**	2015-16 £'000
Equal Pay		
NHS Litigation Authority Legal Claims		
Employment Tribunal	0	0
NHSLA employee liability claim	0	0
Redundancy	0	0
Continuing Healthcare	0	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	0	0
	0	0
Contingent assets	**0**	**0**
Amounts payable against contingent assets		
Net value of contingent assets		
	0	0
	0	**0**

32 Commitments

32.1 Capital commitments

	2016-17 £'000	2015-16 £'000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

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:

	2016-17 £'000	2015-16 £'000
In not more than one year	0	0
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**0**	**0**

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.

33.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	944	0	944
· Non-NHS	0	943	0	943
Cash at bank and in hand	0	45	0	45
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**1,932**	**0**	**1,932**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	645	0	645
· Non-NHS	0	58	0	58
Cash at bank and in hand	0	30	0	30
Other financial assets	0	(0)	0	(0)
Total at 31 March 2017	**0**	**733**	**0**	**733**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,119	4,119
· Non-NHS	0	15,887	15,887
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**20,007**	**20,007**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	5,217	5,217
· Non-NHS	0	16,781	16,781
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**21,998**	**21,998**

33.4 Maturity of financial liabilities

	Payable to DH 2016-17 £000	Payables to Other Bodies 2016-17 £000	Total 2016-17 £000	Payable to DH 2015-16 £000	Payables to Other Bodies 2015-16 £000	Total 2015-16 £000
In one year or less	0	20,007	20,007	0	21,998	21,998
In more than one year but not more than two years	0	0	0	0	0	0
In more than two years but not more than five years	0	0	0	0	0	0
In more than five years	0	0	0	0	0	0
Total CCG at 31 March 2015	0	20,007	20,007	0	21,998	21,998

33.5 CCG's exposure to risk

The CCG is not exposed to any type of risk as defined by IFRS 7.

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

	2016-17 £'000	2015-16 £'000
Total net expenditure reported for operating segments	312,021	307,439
Reconciling items:		
Total net expenditure per the Statement of Comprehensive Net Expenditure	312,021	307,439

34.2 Reconciliation between Operating Assets and SoFP

	2016-17 £'000	2015-16 £'000
Total assets reported for operating segments	2,625	1,614
Reconciling items:		
Total assets per the Statement of Financial Position	2,625	1,614

34.3 Reconciliation between Operating Liabilities and SoFP

	2016-17 £'000	2015-16 £'000
Total liabilities reported for operating segments	(20,099)	(22,078)
Reconciling items:		
Total liabilities per Statement of Financial Position	(20,099)	(22,078)

35 Pooled budgets

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Metropolitan Borough Council in relation to the Better Care Fund. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006.

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2016-17 £000	2015-16 £000
Income		
Calderdale Clinical Commissioning Group	13,728	13,846
Calderdale Metropolitan Borough Council	2,063	1,603
Total Income	**15,791**	**15,449**
Expenditure		
Calderdale Clinical Commissioning Group	13,725	11,392
Calderdale Metropolitan Borough Council	2,063	4,051
Total Expenditure	**15,788**	**15,443**

The NHS Clinical Commissioning Group has £1,524k of payables and £842k receivables relating to the Better Care Fund as at 31st March 2017.

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 disclosed below. In 2016/17 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 :

	2016-17				2015-16			
	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
GOVERNING BODY MEMBERS :								
Longroyde Surgery (Dr Alan Brook)	409	0	2	0	419	0	17	0
Spring Hall Group Practice (Dr Steven Cleasby)	1,370	0	11	0	1407	0	0	3
King Cross Practice (Dr John Taylor)	1,103	0	0	0	1125	0	52	0
Southowram Surgery (Dr Majid Azeb)	375	0	5	0	394	0	17	0
Hebden Bridge Group Practice (Dr Nigel Taylor)	2,462	0	0	0	2666	0	83	0
Beechwood Medical Centre (Dr Caroline Taylor)	1,105	0	0	0	1173	0	0	27
Station Road Surgery (Dr L Saghir)	1,064	0	0	0	0	0	0	0

CCG Chief Officer, spouse is an Employee of Calderdale and Huddersfield NHSFT and material transactions are detailed below.

CCG Chair, spouse is a Employee of Mid Yorkshire NHS Trust and material transactions are detailed below.

Julie Lawreniuk (1 April - 30 April) and Lesley Stokey (1 May to 30 September) acted in the role of Chief Finance Officer for both Calderdale CCG & Greater Huddersfield CCG, but had no material transactions with either organisation.

David Longstaff is the audit lay member for both Calderdale CCG

In addition the executive Governing Body members have relatives with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Pennine Acute NHST.
Leeds Teaching Hospitals NHS Trust

Two executive Governing Body members also have material transactions with:
Central Manchester University NHS FT
The Christie NHS FT

And material transactions are detailed below :

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:

	2016/17 £000	2015/16 £000
Calderdale and Huddersfield NHSFT	143,067	136,730
South West Yorkshire Partnership NHSFT	19,868	19,460
Yorkshire Ambulance NHS Trust	11,462	11,160
Leeds Teachings Hospitals NHST	5,911	5,425
Bradford Teachings Hospitals NHSFT	4,143	4,001
CSU	2	2,567
Pennine Acute NHST	583	588
East Lancashire Hospital NHS Trust	723	597
Mid Yorkshire Hospitals NHS Trust	819	474
Central Manchester University NHS FT	450	320
The Christie NHS FT	16	18
NHS Greater Huddersfield CCG	648	508

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Calderdale MBC.

	2016/17 £000	2015/16 £000
Calderdale MBC	16,971	18,252

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

The Clinical Commissioning Group has no losses or special payments

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:

	2016-17	**2016-17**	**2016-17**	2015-16	2015-16	2015-16
	Target £000	**Performance £000**	**Duty Achieved**	Target £000	Performance £000	Duty Achieved
Expenditure not to exceed income	322,476	316,645	Yes	319,446	312,007	Yes
Capital resource use does not exceed the amount specified in Directions	80	32	Yes	35	29	Yes
Revenue resource use does not exceed the amount specified in Directions	317,804	312,021	Yes	314,872	307,439	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	80	32	Yes	35	29	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,670	4,301	Yes	4,974	4,680	Yes

The CCG received revenue resource allocation totalling £317,804K and had net expenditure of £312,021K delivering an agreed surplus of £5,783K.

42 Impact of IFRS

Not applicable to Calderdale Clinical Commissioning Group.

43 Analysis of charitable reserves

Not applicable to Calderdale Clinical Commissioning Group.

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS CALDERDALE CCG

We have audited the financial statements of NHS Calderdale CCG for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. These financial statements comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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 of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that 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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- 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; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS Calderdale CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

25 May 2017