NHS
Calderdale
Clinical Commissioning Group

annual report 2013/14

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

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

The Annual Report and Accounts consists of three sections:

Annual Report, which must consist of:

- Chair's Introduction
- Strategic Report
- Members' Report
- Remuneration Report

Statements by the Accountable Officer, which are:

- Statement of Accountable Officer's Responsibilities
- Governance Statement

Annual Accounts, which must consist of:

- Report by the Auditors to the Members of the Clinical Commissioning Group
- Financial Statements

The Annual Report and Accounts 2013/14 for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on the 4th June 2014 under delegated authority from the Governing Body.

Dr Matt Walsh, Accountable Officer
5th June 2014

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Chair's Introduction

Welcome to the first annual report of NHS Calderdale Clinical Commissioning Group (CCG). This has been a full and positive year for us as a CCG and as a Governing Body.

We began the year by setting out our strategic priorities in the Commissioning Prospectus. These priorities confirmed our commitment to addressing the real and significant challenges faced by our local health economy, by working with local partners across health and social care and in the third sector.

I am pleased to be able to report that we have made excellent progress this year in delivering our plans which have contributed to the achievement of the local wellbeing priority outcomes for people across Calderdale. The achievement of these objectives has in no small part been due to the commitment and hard work of our staff, governing body members and member practices.

I have been involved in different commissioning arrangements for over 20 years now, but this is the first time that it feels that clinicians have a clear voice and responsibility in terms of leadership in the commissioning process.

Many of our Governing Body members are also highly experienced and have a long track record of working in commissioning. The majority of the members have been working as a group whether as part of Practice Based Commissioning or as part of the developing Clinical Commissioning Group for a number of years.

This year, we have been able to draw on this experience in order to drive forward the CCG's strategic and business planning processes. We have exercised a much tighter grip than in previous years, on the delivery of our performance targets and our financial position. The success of this is demonstrated by the delivery of our QIPP (Quality, Innovation, Productivity and Prevention) target and financial balance at the end of the year. We have also played a clear leadership role in the work with our partners on the Strategic Review Programme - *Right Care, Right Time, Right Place* (see page 22).

Ensuring patient safety and improving quality is core to our business and is central to our planning. The lessons from the Francis and Winterbourne reviews and the Berwick report are that quality is as much about our behaviours and attitudes to patients as it is about the processes that we need to develop to ensure that services improve. The relationship between the CCG as commissioners and our providers is critical in taking forward the learning from these reviews.

As a CCG we have considered the Berwick Review of patient safety alongside our implementation of the recommendations of the Francis Review. We are working closely with partners to further enhance a strong patient safety record across Calderdale.

One of the key differences between our predecessor, the Primary Care Trust, and the CCG is that the CCG is a membership body made up of all the GP practices in Calderdale. Over the year we have developed our understanding of what this means in practice. One of the most encouraging things for me is that we now have tangible

evidence of the engagement of our practice clinical leads and their understanding and ownership of the health agenda and the challenges that lie ahead.

In March, we carried out a self-assessment of Governing Body effectiveness. What came out of this was the demonstration of a clear understanding of our responsibilities, a commitment to ensuring that patients are at the heart of everything we do and a desire to continually improve our performance. Over the next year we will continue to develop our effectiveness in a number of ways including:

- Continue to develop the way that we learn from patient and public engagement and experience.

- Continuing to embed the understanding of what it means to be a membership organisation for both the members and the Governing Body.

- Providing training and support to ensure that all Governing Body members are able to provide high quality scrutiny and challenge across the breadth of the CCG's agenda.

- Increase the focus on developing future clinical leaders and talent management.

Dr Alan Brook, Chair, NHS Calderdale CCG

5th June 2014

STRATEGIC REPORT

1. Who we are

NHS Calderdale Clinical Commissioning Group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the Clinical Commission Group being authorised to take on its full powers. We were licenced to operate from 1 April 2013 under the NHS Reforms that were brought in by the Health & Social Care Act 2012, which amended the National Health Service Act 2006. This was without conditions.

The CCG is a membership organisation consisting of the 26 GP practices in Calderdale. This means that local doctors – who have a good understanding about the needs of their patients – are in charge of commissioning the health services used by local people.

Whilst the CCG is very different from its predecessor, the Primary Care Trust, we have been able to draw on a strong history of working in Calderdale. Many of our staff and Governing Body members have been working in the area for many years, whether as part of practice based commissioning or the Primary Care Trust. This means that we have a continually developing understanding of the health and social care needs of our population and are able to draw on our experience of close partnership working across the district.

Over the past year, we have worked hard to build on these strong foundations in order to deliver our vision, values and strategic objectives.

Our vision

To achieve the best health and wellbeing for the people of Calderdale, within our available resources.

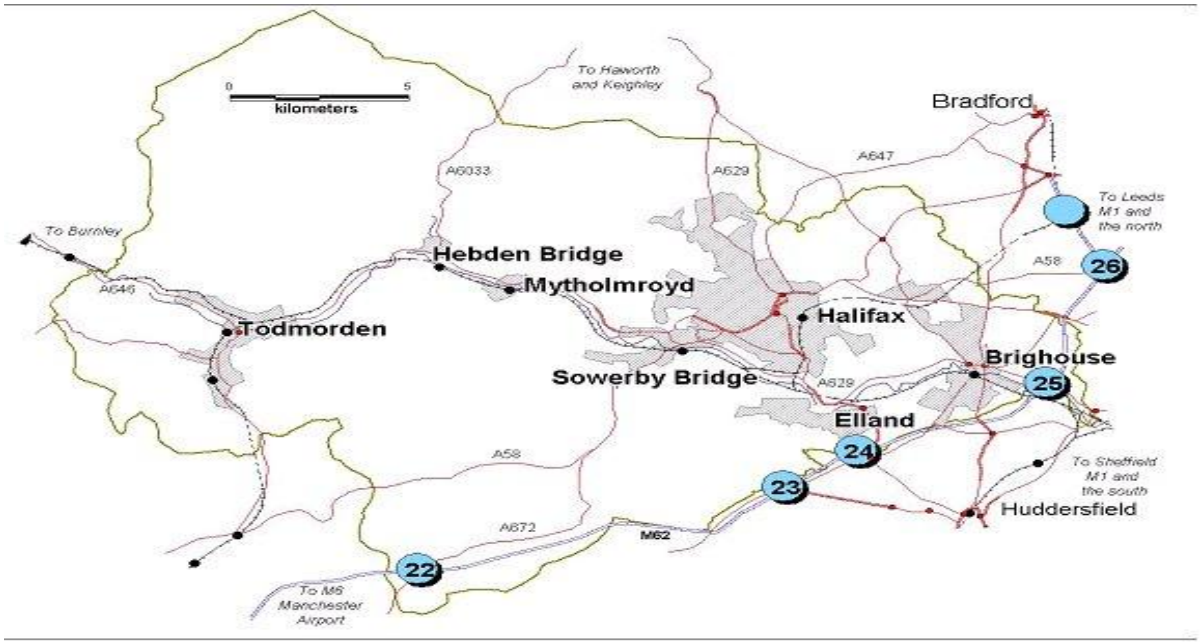
Our Aims

- Commission high quality services that are evidence based and make the most of available resources
- Seek to ensure that all Calderdale residents have access to appropriate clinical care at all times.
- Encourage and enable the development of care closer to home.
- Continue to tackle variation in the quality of services provided to ensure improved experience and outcomes.
- Improve access to and choice of services
- Enhance integration and collaboration for service delivery
- Improve infrastructure to support delivery
- Encourage the development of supportive learning environments.

Our Values

- Preserve and uphold the values set out in the NHS Constitution
- Treat each other with dignity and respect
- Encourage innovation to inspire people to do great things
- Be ambassadors for the people of Calderdale
- Work with our partners for the benefit of local people
- Value individuality and diversity and promote equity of access based on need
- Commission high quality services that are evidence based and make the most of available resources
- Encourage and enable the development of care closer to home.

2. Local Context



Calderdale is located in Pennine West Yorkshire and consists of the towns of Halifax, Elland, Brighouse, Sowerby Bridge, Hebden Bridge and Todmorden. The area borders the Manchester and Central Lancashire City Regions, being located within the M62 corridor, on the main trans-pennine rail route between two expanding and prosperous city regions, Leeds and Manchester. Calderdale's location allows quick and easy access to a population of 5.5 million providing significant economic opportunities.

There are over 200,000 residents in Calderdale, with over 8,000 businesses. The area is home to a number of major companies: HBOS/Lloyds; Nestle; Marshalls; Crosslee and Eureka! Calderdale's high value sectors are manufacturing and finance, with high growth sectors being creative and digital industries, tourism and leisure. Calderdale has a large number of employment sites; however these are often constrained making development difficult. The proportion of residents with a qualification of NVQ level 4 or above is significantly below the national average. In 2009, Calderdale's Total Gross Value Added (GVA) was £3.24 billion, this being a measure of the scale, type and efficiency of business activity as well as overall income. Despite being a metropolitan district, most of the area is classified as rural, with up to a quarter of the population living in these areas. As a consequence it faces many of the issues related to rurality and dispersed populations, with a mix of service needs and access issues which are distinctly different from a more urban area. Increasing the diversity of Calderdale's business base will contribute to a reduction in unemployment and an increase in skills.

Both nationally and in Calderdale there are a number of challenges facing the health and social care system. These include an ageing population with increasing needs, greater prevalence of long-term and lifestyle related health and social care problems.

In Calderdale there is the need to narrow the gap between those communities with the worst health outcomes and those with the best.

As a CCG we are working with partners at Calderdale Council and health providers to:

- Deliver the strategic priorities set out in the local Wellbeing Strategy
- Tackle national issues such as an ageing GP workforce, a shortage of middle grade doctors in Accident and Emergency and national recruitment issues across a range of specialties.
- Ensure that we continue to follow the national clinical standards
- Meet the needs and aspirations expressed by local communities, patients, service users and carers.
- Address the significant financial challenges that we face as a local health and social care economy

Improving outcomes: tackling loneliness in Calderdale

The CCG and Calderdale Council are jointly investing nearly £1 million to tackle the problem of loneliness in Calderdale.

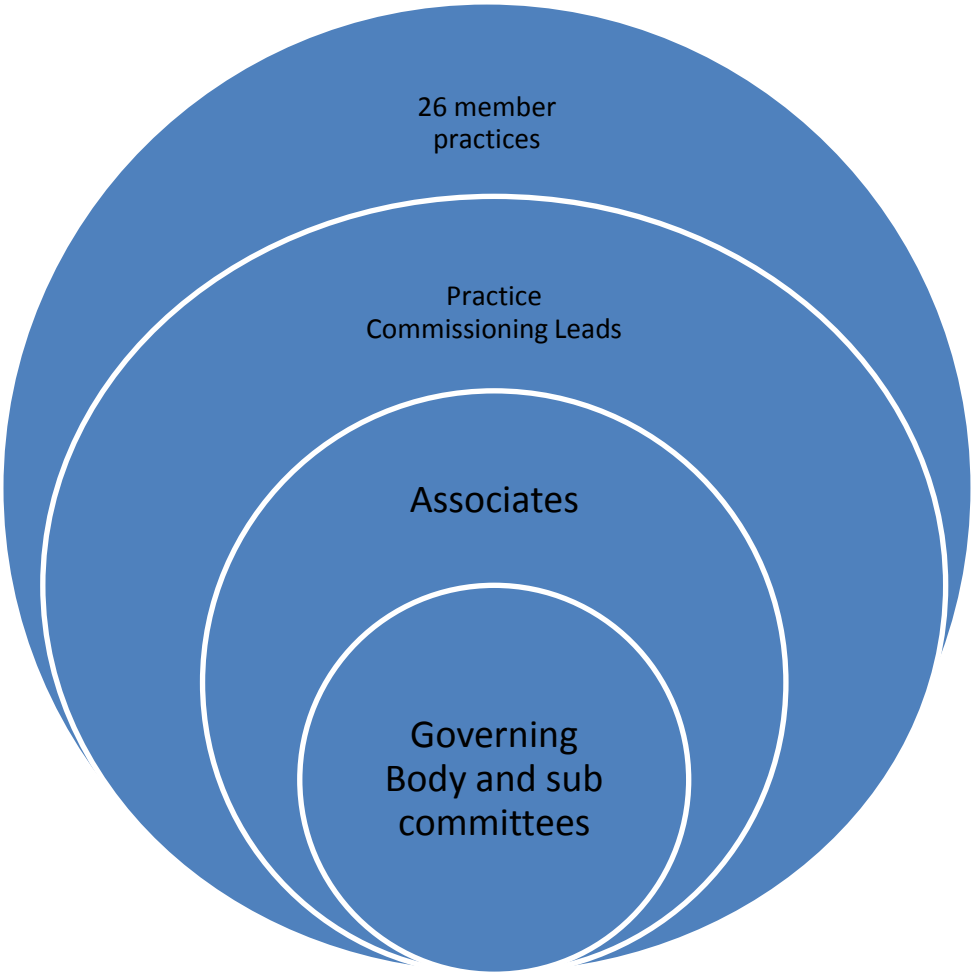
- 11,520 people aged over 65 live alone
- About 30% feel lonely
- 12% feeling trapped in their home. Particularly affects people over 75

Lonely people are more likely to:

- Have higher use of medication,
- Fall more frequently
- Become depressed
- Have a 64% increased chance of developing clinical dementia
- Visit their GP
- Become more reliant on care services.

The programme will work with established community organisations and development trusts across Calderdale to strengthen existing support across a range of schemes.

3. Structure of the CCG



The CCG consists of 26 member practices that look after the health needs of the estimated 213,000 people living and/or registered with a Calderdale GP. The practices that make up the CCG have delegated authority to the Governing Body to oversee the work of the organisation.

The Governing Body is made up of GPs elected by the members, a Chief Officer (Accountable Officer), Chief Finance Officer, a Secondary Care Specialist, a Registered Nurse and two independent lay members.

In addition, the CCG has invited four individuals to attend and advise the Governing Body. These are the Directors for Adult Health and Social Services and for Public Health (Calderdale Metropolitan Borough Council), a Lay Advisor for Finance, Performance and External Relations and the Head of Quality. More details on the Governing Body members can be found in the Members' Report, the Remuneration Report (Remuneration Committee membership) and the Governance Statement.

The Governing Body is supported in its work by four sub committees for Finance and Performance, Quality, Remuneration and Audit.

The CCG also has a number of clinical and lay associates drawn from the practices who provide additional capacity and expertise, focusing on specific priority areas for the CCG such as diabetes and patient safety.

Each practice has nominated a Practice Commissioning Lead (see pages 49-51). The role of this clinical lead is to be a two way conduit between the practices and the Governing Body. This includes sharing what is happening on the ground, representing practice views and acting on behalf of the practice in matters relating to the CCG – including priority setting and testing plans and proposals. They also disseminate information from the Governing Body on strategies and potential developments.

The CCG is based at Dean Clough Mills in Halifax and has 40.5 whole time equivalent (WTE) staff who commission services on behalf of the local population. The CCG also commissions a number of support functions from the West and South Yorkshire and Bassetlaw Commissioning Support Unit (CSU). These functions include business intelligence, service transformation and organisational development, communications, Human Resources, risk and governance support, patient and public engagement.

4. Our Commissioning Activities

The commissioning activities of the CCG over this year have focused on the delivery of our QIPP (quality, innovation, productivity and prevention) priorities and strategic review programme (Right Care, Right Time, Right Place). Other key activities have centred on the preparation for the implementation of the Better Care Fund, quality improvement and the work of the quality boards and engagement with the public and patients. The commissioning intentions designed to help us achieve our priorities were set out in our Commissioning Prospectus published in April 2013. www.calderdaleccg.nhs.uk/documents

5. Our External Environment

Our CCG is clear about both our regulatory and social responsibilities when it comes to the external environment in which we operate. We aim to utilise our spending power to good effect over and above the commissioning of high quality, safe, effective services that also deliver value for money for our population.

NHS Calderdale CCG commissions from a number of NHS and non-NHS providers of care. These types of provider can be described as the acute; community and primary care; mental health and learning disabilities; continuing health care; local authority and third sector.

The table below sets out the proportion of services that we directly commission from the different types of provider.

Type of Provider	By Value
Independent Sector – Primary Care (inc GP Practices)	1.5%
Independent Sector – Continuing Health Care/Funded Nursing Care/Mental Health/Learning Disabilities	9.0%
Independent Sector – Elective & Diagnostics	1.7%
NHS	80.1%
Local Authority	3.8%
Not for Profit	3.9%

The acute footprint is primarily shared with NHS Greater Huddersfield CCG (GHCCG) as the local provider, Calderdale and Huddersfield NHS Foundation Trust (CHFT) accounts for the largest proportion of acute spend within our CCG. Our patient flow to CHFT represents 87% of the total with other significant patient flows to Leeds Teaching Hospitals (3.7%) and Bradford Teaching Hospitals (2.6%). Our two local independent sector acute providers, BMI and Spire account for 2.6% of our activity. Non-contracted activity, which typically reflects out of area patient choice and emergency attendance at hospital accounts for 2.7% of activity.

The community and primary care footprints are co-terminus with that of Calderdale Council. The majority of community services are provided by CHFT. There are a number of primary care community services provided by Calderdale practices, dentists and optometrists as well as a range of services that have been commissioned to be delivered within a community setting.

There are currently a number of Any Qualified Provider services in place across Calderdale covering services closer to home: Adult Hearing; Non Obstetric Ultrasound; and MRI.

The mental health footprint is shared with Calderdale Council, but the provider landscape is dominated by one main provider. Across South West Yorkshire NHS Calderdale CCG, together with GHCCG, NHS North Kirklees (NKCCG) and NHS Wakefield CCG (WCCG) jointly contract core mental health services from South West Yorkshire Partnership Foundation Trust (SWYPFT). Our CCG with GHCCG and NKCCG leads a jointly commissioned contract with SWYPFT for the provision of Child and Adolescent Mental Health Services (CAMHS).

Services for people with learning disabilities

Our CCG and Calderdale Council are committed to working together to review and improve local services. Since September 2013 and building on the consultation carried out in the previous year, we have gathered the views and actively engaged with service users, families and carers as well as the statutory and 3rd sector in planning our new Calderdale model for Learning Disabilities.

A key principle is that services are in place to support individuals to remain in the community close to home and families.

We have put this into practice by:

Working closely with local providers to commission a number of new supported living services. This has enabled 10 people to move back into Calderdale so far, so that they can be closer to their families and support networks.

Other more specialist mental health and learning disabilities provision is managed directly by the CCG or jointly with Calderdale Council.

The continuing health care footprint is shared with Calderdale Council and is characterised by a broad range of providers, contracted either directly or through a framework agreement covering domiciliary care, these providers are mainly across the Calderdale district but with patient placements outside of the local area.

The footprint for the third sector (not-for-profit organisations) is also shared with Calderdale Council with a range of joint funding agreements in place with the local authority to support provision across the Calderdale area. The CCG has worked jointly on a range of procurements led by the Council. The CCG has developed a supportive approach to working with the third sector in Calderdale with the emphasis being on building future capacity and capability.

'Health Connections' is one such initiative designed to build capacity and capability in the third sector. More information on this is contained within the Sustainability Report (see page 42).

Health Connections

Health Connections

Help-Support-Advice-Guidance-Assistance

Connecting the Voluntary and Community Sector with the NHS

Voluntary Action Calderdale

NHS

6. Strategic Objectives of the CCG

Our role is to commission high quality services for the people of Calderdale. In fulfilling this role we aim to ensure that healthcare is available for anyone who needs it and to help people to maintain a healthy lifestyle.

We have identified the following strategic objectives which are in line with our aims and are set out in our Assurance Framework:

Strategic Objectives
1. Prevent People from dying prematurely
2. Enhancing the quality of life for people with a long-term condition
3. Helping people to recover and maintain their independence
4. Ensuring people have a positive experience of care
5. Ensuring a safe environment and protecting people from harm
6. Reducing inequalities in Calderdale
7. Achieving strong financial control and best value for money
8. An organisation that is fit for purpose

The strategic objectives fall into three main categories:

- Ensuring that the organisation is fit for purpose. Information on how we have implemented this can be found within the Equality and Diversity Report, Members' Report, Remuneration Report and the Governance Statement.

- Achieving strong financial control and best value for money

- Clinical commissioning priorities

Achieving strong financial control and best value for money

Clinical Commissioning Groups are required to comply with a number of financial duties under the NHS Act 2006 (as amended). The three main requirements are:

- *Expenditure not to exceed income* (This represents the underspend against revenue resource limit)

- *Revenue resource use does not exceed the amount specified in Directions*: (This represents the total expenditure against budgeted expenditure and does not exceed the revenue resource limit)

- *Revenue administration resource does not exceed the amount specified in Directions* (This represents the total administration expenditure against budgeted administration expenditure and does not exceed the administration target.

The CCG fulfilled all these financial duties in 2013/14. Further information can be found in the Accounts section of the Annual Report and specifically in note 42 on page 35 of the Accounts.

Clinical commissioning priorities

A number of our strategic objectives form the basis for our clinical commissioning priorities. Over the past 18 months we have been working with partners on the Health and Wellbeing Board to:

- Develop the Joint Wellbeing Strategy which sets out six priority outcomes. The outcomes focus on those issues that impact on health inequalities and the wellbeing of the population.

- To develop our clinical commissioning priorities which seek to achieve our strategic objectives in addressing the major health issues in Calderdale and contribute to the achievement of the priority outcomes set out in the Joint Wellbeing Strategy.

In setting our clinical commissioning priorities, we drew on information from a range of sources.

- We used indicative data to identify the most significant opportunities:

    - Yorkshire Public Health Observatory (YPHO) information pack
    - Programme budgeting information
    - Joint Strategic Needs Assessment
    - Joint Wellbeing Strategy for Calderdale

- NHS key performance indicators set out in *NHS England: Everyone Counts 2013/14,* including those that meet the duties and pledges under the NHS Constitution.

- The findings of our local public and patient engagement and patient experience activity.

We tested our early proposals with our member practices through the practice commissioning leads' meetings, with our key stakeholders including the Calderdale Forum which consists of representatives from GP Patient Reference Groups; local voluntary and community groups.

The resultant clinical commissioning priorities, which are in line with the national priorities, were set out in our commissioning prospectus in April 2013. The delivery of each of these priorities is managed through a programme of work:

NHS Calderdale CCG: Programmes

Programme	Timeline			Projects within the programme
	13/14	14/15	15/16	
Respiratory	X			▪ Smoking related deaths ▪ Chronic Obstructive Pulmonary Disease related deaths ▪ Improving the management of conditions where care can be provided outside hospital
Infant mortality	X	--	--	▪ Infant mortality rate ▪ Maternal smoking at delivery ▪ Breast feeding 6-8 weeks ▪ Low birth weight babies
Cardiovascular disease	X			▪ Smoking related deaths ▪ Management of hypertension ▪ Primary care management of Coronary Heart Disease
Endocrine	X			▪ Prevalence of diabetes ▪ Management of blood glucose ▪ Blood pressure ▪ Reducing Length of stay in hospital for patients with Diabetes
Dementia	X			▪ Improving diagnosis, care and support
Re-admission (<30 days)	X			▪ Keeping people well at home ▪ Joined up working ▪ Coordinated discharge ▪ Annual audit on readmissions ▪ Audit and learning to Urgent Care Board for development of action plan
Improving patient experience	X			▪ GP out of hours services ▪ Hospital care
Care homes	X			▪ Flag ship programme identified by the member practices as part of 13/14 prioritisation programme ▪ New service being procured – technology and Multi-disciplinary Team approach.

Improving outcomes - Intermediate Tier: Supporting Independence Team (SIT)

This service delivers an integrated approach to assessment via a single point of access (Gateway to Care) into a seamless service. The team consists of crisis response, falls prevention, community, rapid response and re-ablement.

Patients on these pathways were experiencing higher than average lengths of stay at Calderdale and Huddersfield Foundation Trust. Working with partners, our aim was to reduce the length of stay for patients waiting to receive home care and/or for access to re-ablement services which was approximately 13 weeks. The aim also was to close gaps, remove any duplication, improve quality and provide an efficient service across Calderdale.

The reinvestment of the Intermediate Care pathway and new investment of re-ablement funding has reduced emergency short stay and emergency long stay activity. It has also improved the quality of experience. These quotes were received during the evaluation of the new approach.

"As busy GPs we love single point of access services and Gateway to Care is a great example of this. There is now no duplication of services and communications and record-keeping is much more efficient. All contacts with the team are dealt with in a professional and courteous manner and I feel this is a flagship service moving forwards."

"Hi – I had to text to thank you properly for all you have done today, the relief is indescribable, my mum is very happy that she will be visited four times a day for now and our family has had a great weight taken off its mind . Thanks for everything."

6.1 Strategies for achieving the clinical commissioning Priorities

Our learning within the health and social care system is that a number of factors need to be in place if we are to achieve the degree of transformational change required to address current and future challenges. These include:

- Embedding common approaches to improvement.
- Aligning organisational culture to the large scale change required.
- Commissioner and provider partners working to shared vision and goals.
- Rigorous scrutiny and performance management.
- Commissioners and providers with the right skills and knowledge.

For the past two years we have worked with *Right Care* and the *Yorkshire Public Health Observatory (YPHO*) on our approach to planning our future business. Once the priorities have been identified we use the programme methodology (*Managing*

Successful Programmes) to take the work forward – through the work with partners across Calderdale and Huddersfield in the Strategic Review Programme, the Urgent Care Board and through schemes that form part of the QIPP (Quality, Innovation, Productive and Prevention) programme.

Delivery of the priorities is monitored using key performance indicators set out in the *NHS Commissioning Board (now NHS England): Everyone Counts 2013/14*[1]. This ensures a consistent approach which can be benchmarked locally, regionally and nationally.

Key performance indicators used by NHS Calderdale CCG.

NHS Constitution rights and pledges: outcome measures

- Referral to treatment times (admitted, non-admitted, incomplete)
- Waiting times for diagnostic tests
- Accident and Emergency waits
- Cancer waiting times (2 week waits, 62 days)
- Ambulance response time
- Incidence of Health Care Acquired Infections (HCAIs), MRSA, C.Dificile
- Cancellation of operation for non-clinical reasons
- Mental Health - Care Programme Approach (CPA)
- Mixed Sex Accommodation

(See appendix 1 (a) for the detail of the outcome measure and target/baseline)

Physician & Senior Nurse in A&E

The team is made up of a senior and experienced medical doctor and a senior nurse from the Medical Assessment Unit. They work at the front of A&E between 10am and 6pm Monday to Friday. They assess the individual patient's needs and are able to make a decision to discharge wherever appropriate. These patients might have otherwise been admitted to hospital.

The scheme has had a significant, measurable impact on the number of patients safely discharged home who would otherwise have required admission to hospital.

Quality premiums

Quality premiums are intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The four national measures are based on measures in the NHS Outcomes Framework. The three local measures are based on local priorities and were agreed by the CCG with the Health and Wellbeing Board and with the NHS area team.

[1] NHS Commissioning Board, Everyone Counts: Planning for Patients 2013/14 Technical definitions 2012

In 2013/14 we worked with partners to achieve the quality targets in the following areas:

National Target	Detail
Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing the quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care. (Using the Friends and Family Test to assess experience in maternity services, A&E and acute inpatient care)
Health Care Acquired Infections (HCAIs)	MRSA (acute only), C-Diff (acute only)
Local targets	
Indicator 1	Increase the number of smoking quitters
Indicator 2	Increase the number of referrals to Pulmonary Rehabilitation
Indicator 3	Increase the effectiveness of re-ablement services
NHS Constitution Rights and Pledges	
Referral To Treatment waiting times - Patients on incomplete non-emergency pathways	Waiting no more than 18 weeks from referral
A&E	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
Cancer waits – 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer
Category A, ambulance calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)

(See appendix 1 (b) for the detail of the national and local measure and target/baseline)

The CCG has a rigorous approach to the monitoring of performance against delivery of the programmes through its internal governance processes.

This approach has led to a very positive year for the CCG – with the local health economy achieving the required standards across a range of national priorities including urgent care (waiting times in A&E, ambulance response times), cancer waiting times, referral to treatment times, incidence of HCAI (C.Difficile) and mixed sex accommodation. Performance against the key performance indicators as at the 1st April is included in Appendix 1 to this Strategic Report.

The CCG has a rigorous approach to the monitoring of performance against delivery of the programmes through its internal governance processes. Where there is in-year variation this is reported and performance managed through the monthly Finance and Performance Committee. Issues regarding variation are escalated through the appropriate governance structures such as the Planned Care Board, the Urgent Care Board or the Partnership Steering Group.

Future targets

As with all NHS Commissioners, the CCG will continue to use the national key performance indicators as its means of measuring and monitoring performance. In terms of local outcome indicator sets, we have agreed to use the following indicator:

Indicator 1 – Preventing people from dying prematurely; Improvement area: Emergency admissions for alcohol related liver disease.

In terms of CQUINS, we will be using local indicators in the following areas for 2014/15:

- Respiratory
- Diabetes
- Medicines Management
- End of Life Care
- Hospital Food

Further information on our strategies for achieving the Objectives of "strong financial control and best value for money" and "an organisation that is fit for purpose" is contained in section 6.5 Levels of Investment and in the Governance Statement.

6.2 Significant features of the development and performance in the year

The work of the CCG has focused on a number of key areas over the year in order to achieve our objectives:

1) QIPP (Quality, Innovation, Productivity and Prevention)

The aim of QIPP is to improve quality whilst delivering efficiency savings. Sir David Nicholson had set the challenge of saving £15-20 billion through efficiency savings from 2011 to 2014. In 2013/14 we delivered our share of the above and achieved £4m of QIPP savings. This has been achieved in part through the delivery of a

range of QIPP schemes, which were identified through our prioritisation process at the beginning of the financial year. These schemes have included continuing care, early supported discharge for people following stroke care, medicines management and RAID (Rapid Assessment, Interface and Discharge) which supports people with mental health problems to receive timely and effective support. A significant scheme has been the Quest for Quality in Care Homes.

- **Quest for Quality in Care Homes**

Our work with care homes is being rolled out in three phases, the first being telecare and the second telemonitoring. In partnership with Calderdale Council, we are supplying technology to 25 nursing and residential care homes in Calderdale.
Summerfield House in Halifax was the first nursing home to have Telecare installed. The home provides residential, nursing and dementia care to 106 people. Accommodation is arranged over three floors, and each floor has a telecare system including a CareAssist pager which receives alerts from the individual sensors installed in the residents' rooms.

Telemonitoring – supporting patients with COPD

24 Tunstall Mymedic telemonitoring systems have initially been installed with the aim of:

- Improving self-management
- Enabling early intervention
- Preventing hospital admissions
- Supporting early discharge
- Improving medication compliance
- Preventing future complications for those who haven't yet started to access extensive healthcare
- Supporting the COPD specialist nurses' workload

Telemonitoring

Gerald, 71 has been using **telemonitoring** to help him manage his Chronic Obstructive Pulmonary Disease (COPD).

"With a condition like mine you do worry, and telemonitoring gives you confidence. Some mornings I wake up feeling rough and I do my readings and it tells me whether I need to contact my nurse or if I'm ok. Before I would have rung the doctors anyway, so it saves time for them and puts my mind at rest. If I am ill I don't panic now, because I know it will be nipped in the bud and it keeps me out of hospital. It's really reassuring for me and my wife, like a pair of arms around you."

The third phase involves the rolling out of telemedicine. Calderdale and Huddersfield NHS Foundation Trust (CHFT) has partnered with Airedale NHS Foundation Trust to deliver Telemedicine to residential care homes in Calderdale and Huddersfield.

2) Strategic Review (Right Care, Right Time, Right Place)

Seven partners across the two Local Authorities: Calderdale and Kirklees; Calderdale and Huddersfield Foundation Trust, South West Yorkshire Partnership Foundation Trust, Locala CIC, Greater Huddersfield and Calderdale CCGs came together in 2011 and agreed to undertake a shared strategic transformation programme to address the significant challenges across the health and social care system that we were facing. The aim is to deliver the level of service improvement required whilst achieving financial sustainability. The work of the Strategic Review is being taken forward through four working groups:

Strategic Review

To secure the Right Care, at the Right Time and in the Right Place, whilst providing the best possible outcomes through integrating the total resource for health, social care and welfare around the individual.

Right Care, Right Time, Right Place Programme Working Groups Phased Delivery (Phases 1 & 2)

Working Groups	Phase 1	Phase 2
Integration / Commissioning & Personalisation		1. Integrated Workforce 2. Pooled Budget/ money flow 3. Integrated Care Model 4. Supported Self Care 5. Workforce Development
Children's	1. Care Closer to Home 2. Single Care Plan	6. Building Resilience in the Community 7. Navigable Services 8. Transition
Capacity & Capability	3. RAID	9. Out of Hours Care 10. Frailty 11. Common Approach to Change
Digitisation (Enablers)		12. Mobile Working 13. Tele-health 14. Unified Communication 15. Shared Patient Record 16. Self-Care Hub

During the year, the three providers; CHFT, SWYPFT and Locala CIC developed a Strategic Outline Case (SOC) which contained a set of proposals in response to the work of the Strategic Review and the key considerations referred to earlier in this Strategic Report. The CCG will be leading the engagement activity and any necessary consultation in response to the proposals in 2014/15.

3) Better Care Fund Planning

The Better Care Fund is a national initiative to promote integrated out of hospital care. The CCG has worked closely with Calderdale Council, since the introduction of the guidance in August 2013, to develop local plans which would deliver both the national commitments and the transformational agenda set by the local Strategic Review Programme. These plans seek to support the shift from unplanned hospital care to planned, integrated primary and community services. (See Appendix 2 to this Strategic Report)

4) Engagement work undertaken

The CCG is committed to improving patient experience and to the use intelligence from a range of sources to drive improvement. We also work with patients and local groups to help develop our plans. The patient engagement and experience team in Calderdale have undertaken some excellent engagement activities this year which have informed our strategic planning for 2014/15 and beyond. (See Appendix 2 Strategic Report, Compliance with Statutory Duties)

- **Unscheduled Care[2] Services engagement** – we gathered information about preferences of the public about unscheduled services in community and primary care settings – obtaining over 2,500 responses.
- **Call to Action** - obtaining views from 280 people/community groups

Engagement on unscheduled care

- More than 2,500 people directly engaged
- 300 young people
- 44 people at planned care event
- 1,700 people unscheduled care survey
- 500 staff
- All national and local surveys, PALS (Patient Advice and Liaison Service), complaints, patient opinion and NHS choices information from the past 3 years collated.

People told us they wanted:

- Timely and consistent access to services
- Co-ordinated and integrated care
- Services closer to home
- Involve us in decisions about

2

5) Developing as a membership organisation

Our CCG has begun to address the issue of how to ensure a vibrant and engaged membership that is so vital to achieving our clinical commissioning responsibilities.

The notion of the CCG as a membership organisation is unusual. The CCG exists primarily for the benefit of the community and not for the members, but it is the members who will secure success or otherwise for the CCG.

In support of this, NHS Calderdale CCG has been working in partnership with NHS Greater Huddersfield CCG and was supported by Ashridge Business School to: examine the notion of membership; research good working practices within and outside of NHS to inform the actions that need to be taken to nurture a strong feeling of membership amongst prime stakeholders; and produce a model and toolkit that can be used by the CCGs as a structure for future development.

As a result of this work, we have produced a member engagement agreement that sits underneath our Constitution. We have also developed a High Performing Membership Organisation (HPMO) competency based toolkit for the CCG.

6.3 Our statutory duties

The CCG is required to comply with a number of statutory duties. Whilst we have complied with all the statutory duties, we have summarised our activities in some of the areas below and in Appendix 2 to this Strategic Report:

Ensuring the Continuous Improvement in Quality (Section.14R, The National Health Service Act 2006 (as amended)

Ensuring patient safety and improving quality is core to our business. The relationship between the CCG as commissioners and our providers is critical in taking forward the learning from these reviews.

As stated in the Chair's introduction to this Annual Report, as well as learning the lessons from the Francis and Winterbourne Reviews, we have considered the Berwick Review of patient safety. We are working closely with partners to further enhance a strong patient safety record across Calderdale. Our focus on reducing harm includes:

- Reporting system for primary care to alert on quality concerns
- Local CQUIN(Commission for Quality and Innovation) targets
- Supporting incident reporting
- Sharing lessons learned
- Members of the Local Patient Safety Improvement Collaborative
- Development and use of quality impact assessments

Promoting education and training (Section.14Z, The National Health Service Act 2006 (as amended)

The CCG has carried out a number of activities to promote education and training. Specifically a Vocational General Practice Nurse Training Scheme and a Non-Medical Clinical Workforce Mentor Development Scheme were supported through our Innovation Grants scheme.

Reducing inequalities (Section.14T The National Health Service Act 2006 (as amended)

The CCG has complied with the statutory duty relating to the reduction of inequalities by:

- Active membership of the Health and Wellbeing Board;
- Active engagement in the development of the Joint Wellbeing Strategy
- Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions;
- Testing the strategic plan and delivery plans against the JSNA and the wellbeing priority outcomes (Joint Wellbeing Strategy)

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

As set out earlier in this Strategic Report, the strategic priorities of the CCG were developed with the Health and Wellbeing Board and contribute to the delivery of a number of the priority outcomes contained in the Joint Wellbeing Strategy. They have been reviewed, together with the new programme areas identified in our Strategic Plan 2014 – 2019. The aim of the review was to identify the extent to which the CCG had contributed to the delivery of the Joint Wellbeing Strategy and the alignment of our 5 year Strategic Plan. The analysis below was shared with the Health and Wellbeing Board at its meeting on the 3rd April 2014.

Joint Wellbeing Strategy: Priority Outcomes

Calderdale is a place…

1. Where people have good health
2. With a balanced and dynamic local economy
3. Where children and young people are ready for learning and ready for life
4. Where fewer children under 5, live in and are born into poverty
5. Where older people lead fulfilling and independent lives
6. Where everyone has a sense of pride and belonging based on mutual respect.

NHS Calderdale CCG Strategic Priorities – contribution to delivery of Joint Wellbeing Priority Outcomes in 2013/14 and continuing into 2014/15		
CCG – Clinical commissioning Outcomes	**CCG –Change Programmes***	**Alignment with Joint Wellbeing Strategy Priorities**
Empowered Citizens & resilient communities	- Call to Action Initiatives - Better Care Fund Initiative 3 (resilient local communities and individuals) - PPI initiatives (Appendix B) - £2m investment in third sector capacity and capability building on 13/14 investment - **Loneliness prevention programme**	5, 6
Reduced Preventable deaths	- Respiratory Programme - Cancer Programme - CVD Programme - **Mental Health Programme** - **Alcohol programme**	1,5
Reduced health inequalities	- Respiratory Programme - Cancer Programme - CVD Programme - **Mental Health Programme** - **Alcohol programme (linked to reduction in domestic violence)**MSK programme (inc. prevention**/obesity)** - Partnership working to reduce infant mortality - Focus on childhood asthma (training delivered to all practices) -	4,5
Improved Quality of life of patients with a long-term condition or illness	- Better Care Fund – Scheme 3 (Integrated, community based health and social care teams) - New community/frailty model being commissioned (started 13/14 Strategic Review - Primary Care Strategy - CVD programme - Diabetes programme - Respiratory programme - **Mental Health programme (inc. RAID programme– started 13/14)** - MSK programme (inc. prevention**/obesity)** - **Alcohol programme (linked to reduction in domestic violence)** - Cancer programme - Local Contract procurement (started 13/14) - **Loneliness prevention programme**	1, 4,5

	- Detailed review – children & maternity (started 13/14) - New End of Life Care model (procured in 13/14) - Self-Care Hub – Strategic Review	
Improved patient experience and perception	- Primary Care Strategy – focused on access and improving out of hours services - Initiatives set out in our Patient and Public Engagement and Experience Strategy (published in 2013) Implementation of next state of Friends and Family Test	1, 4
People are helped to recover for illness and injury	- Better Care Fund – Scheme 3 (Integrated, community based health and social care teams) - **Loneliness prevention programme** - MSK programme (inc. prevention**/obesity)** - Procurement of intermediate care beds & GP support (started 13/14) - **Alcohol programme (linked to reduction in domestic violence)** - Evaluation of joint Support & Independence Team (started 13/14)	1,4,5
Ensure the services we commission are safe	- Quest for Quality in Care homes programme (procured in 12/13 - Right staff, right skills initiative – led through Clinical Quality Boards - Increasing medication incident reporting - Implement local CQINs to stretch improvements in reduction of pressure ulcers and falls causing harm.	1,4,5
Reduce reliance on unplanned hospital based care – by shifting to planned community services	- Better Care Fund – Scheme 1 (Hospital Support Services) - Better Care Fund Scheme 2 (7 day a week working) - Refreshed Urgent Care Action Plan (Urgent Care Board) 2013/14 - Unplanned Care Project - EDIT and Physician in A&E schemes piloted in 13/14 – to be funded recurrently in 14/15 - MSK programme (inc. prevention**/obesity)** - Respiratory Programme - Alcohol programme - CVD Programme - **Mental Health Programme** - Cancer Programme - **Loneliness prevention programme** - Review of thresholds to planned care interventions (started 13/14)	1,2,5

*In bold - shows potential link to emerging JWS priority area

Further information is contained in Appendix 2 of the Strategic Report on our compliance with the statutory duties as identified in the NHS England Assurance Framework.

We certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

6.4 Trends and factors likely to impact on the future

The CCG will continue to work with partners to deliver the transformational change required to meet the challenges set out earlier in this report.

The main focus for the CCG in 2014/15 and beyond will be:

- The implementation of our 5 year strategic plan which sets out our contribution to the delivery of the Strategic Review. Part of our strategic plans include the creation of an environment that enables general practice to play a much stronger role in the integrated system of out of hospital care.

- The development of integrated out of hospital care through our Better Care Fund Plans.

- Develop our capacity and capability to deliver whole system transformational change and common approaches to improvement.

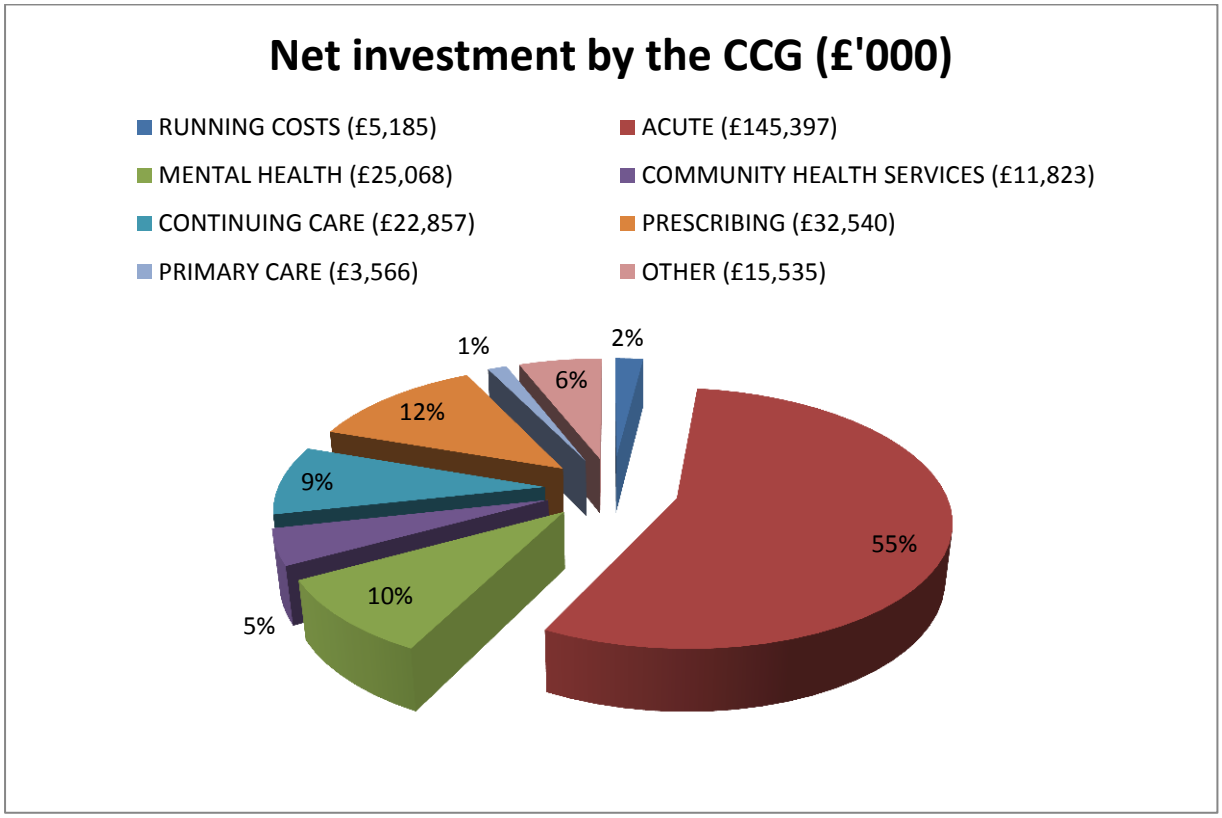
- Continued rigorous performance management of the delivery of the CCG's priorities.

During the year, the three providers; CHFT, SWYPFT and Locala CIC developed a strategic outline case (SOC) which contained a set of proposals in response to the work of the strategic review and the key considerations referred to above. The SOC, which forms an outline offer to the CCG, proposes a new model for the provision of hospital and community services across Calderdale and Greater Huddersfield.

One of our key areas of work in 2014/15 will be to lead engagement with the local population on the content of the Strategic Outline Case.

6.5 Level of Investment expenditure

During 2013/14 we invested over £260m to improve the health of local people through the commissioning of high quality services.



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

- **Quest for Quality Service** - a new service to support 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** – a new programme aimed to educating health professionals around good palliative care provision and also providing dedicated out of hours crisis intervention/community nursing service.

- **Mental Health** - a new specialist multi-disciplinary service working with acute hospitals to support people with mental health problems get timely and effective support. The service is called RAID (Rapid Assessment, Interface & Discharge Service).

- **Stroke** – a new early supported discharge service for patients leaving hospital after stroke care.

- **Respiratory** – additional pulmonary rehabilitation services to keep people with respiratory conditions well and reducing exacerbations of their condition.

- **A&E** – additional physician and nursing capacity in A&E to help patients receive timely and effective support when they are in the emergency department.

- **Third Sector** – new support for a wide range of third sector organisations in Calderdale to enable them to develop and strengthen the services they deliver.

In the last 12 months we have had some very challenging targets and I am pleased to say, that by working with our partners, we delivered these within our financial resources.

The accounts for the Clinical Commissioning Group in respect of 2013/14 have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

In order that we continue to deliver the transformational and service change set out in our strategic plan, a number of Investment Funds have been created within our financial plan for 2014/15, these include:

- Non Recurrent funding - 1.5% of total CCG budget
- Call to Action - 1.0% of total CCG budget
- Over 75s funding

Financial Risk

There are a number of risks that threaten delivery of our 14/15 financial plan, 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 and that:

Investments are only committed if there is robust assurance that they are affordable;

- Effective processes identify and realise opportunities for disinvestment and reinvestment in healthcare, 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.

6.6 Resources

The CCG draws on a range of resources putting us in a strong position to achieve our priorities. These resources can be categorised as:

a) Financial

The focus of the CCG is to ensure that we continue to achieve the most effective use of our £260m resource and deliver best value for money.

b) Members

One of the most important differences between the Primary Care Trust and the CCG is clinical leadership. Without this level of clinical knowledge and understanding of patient concerns and issues we would be unable to achieve the degree of transformational change required. Some of our most important resources for the CCG are the members of the Governing Body, the Associates, Practice Commissioning Leads and the Practice Managers as well as the member practices. Details of these roles are set out in the section on Structures.

c) Staff

The CCG has a total of 40.5 WTE staff, some of whom are in shared posts with NHS Greater Huddersfield CCG and across the three CCGs in Calderdale and Kirklees. Over the past year the CCG has benefitted from the real commitment of staff, most of whom have brought their experience and expertise across from Calderdale Primary Care Trust. This has enabled us to ensure a high degree of continuity in our work and build on existing good relationships with local stakeholders and partners.

Commissioning Support Unit

The CCG contracts with the West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU). The CSU not only brings additional capacity and subject matter expertise to the CCG, but also enables us to access intelligence across the wider footprint.

d) Working with commissioners and providers

Our significant piece of transformational work (Strategic Review - Right Care Right Time, Right Place) being taken forward is in a shared partnership with six organisations across Calderdale and Greater Huddersfield.

e) Professional, regulatory, legal advice

The CCG makes full use of the professional clinical, audit and legal advice available to it. We hold a contract with West Yorkshire Audit Consortium for the delivery of a programme of independent assessment of the internal systems of control within the CCG and counter-fraud services

We are also members of professional, financial and governance networks to ensure that we are continuously working to best practice.

Risks to the achievement of our strategic objectives in 2014/15

There are a number of risks to the delivery of our strategic objectives which we manage through our risk management processes:

Strategic
The strategic plans are not owned by key stakeholders
The strategic plans do not ensure the sustainability of the health and social care system
The need to maintain strong relationships and trust in order to deliver the strategic review programme and integrated out of hospital model
The governance processes are insufficiently robust to effectively performance manage the plans and manage risks.
Commercial
Sustainability of current providers and access to high quality new providers
Operational
There is insufficient capacity and capability at the CCG and in the system to deliver the strategic objectives
The current primary care contractual models reduce provider ability to deliver the new integrated community provision.
Financial
The financial plans do not enable us to deliver our ambitions
System financial sustainability is not deliverable
Failure to maintain strong financial control and best value for money

The CCG's system of internal control is set out in our risk management framework. The Framework consists of the Governing Body Assurance Framework containing the strategic risks for the organisation and the system of risk control and reporting.

Further detail on the CCG's system of internal controls can be found in the Governance Statement.

Relationships with key stakeholders

Critical to the success of the CCG in delivering the strategic objectives are the relationships that have developed with key stakeholders through collaborative working and other mechanisms. Our work with a number of these partners has already been referred to earlier in this report – namely through working with our member practices, the commissioning support unit, patient and the public, Calderdale Council, the Health and Wellbeing Board, partner agencies as part of the strategic review (Right Care, Right Time, Right Place); neighbouring CCGs and the CCGs across the wider West Yorkshire footprint.

The CCG takes seriously its responsibilities in terms of its impact on local communities and wider society. Some of the ways in which we address this,

including our approach to community engagement and working with partners on tackling inequalities are set out earlier in the Strategic Report. Further information on our approach is contained in the Sustainability Report.

Dr Matt Walsh, Accountable Officer

5th June 2014

Appendix 1 (a)

NHS Constitution Rights and Pledges 2013/14

Outcome/Measure		Target/ Baseline	Apr	May	Jun	Qtr 1	Jul	Aug	Sep	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	Mar	Qtr 4	YTD
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	93.4%	92.7%	91.5%	92.6%	91.3%	91.6%	92.4%	91.7%	91.5%	92.5%	92.3%	92.1%	92.5%	90.3%		91.5%	92.0%
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	98.2%	98.8%	98.5%	98.5%	98.6%	98.4%	98.5%	98.5%	98.7%	98.4%	98.7%	98.6%	98.3%	98.5%		98.4%	98.5%
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	95.0%	95.4%	94.8%	95.1%	94.4%	94.7%	94.9%	94.7%	95.4%	95.0%	94.6%	95.0%	94.5%	94.3%		94.4%	94.8%
	Patients on incomplete pathways waiting more than 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99.0%	98.8%	98.9%	98.9%	98.7%	98.5%	98.6%	98.6%	99.3%	99.5%	99.2%	99.3%	99.3%	99.7%	99.7%	99.6%	99.1%
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (Week Ending 30/03/2014)	95%	95.0%	94.7%	96.4%	95.3%	95.4%	94.5%	95.6%	95.1%	95.5%	93.9%	97.2%	95.5%	95.1%	95.2%	97.2%	95.8%	95.4%
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	2
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93.3%	97.0%	99.1%	96.4%	99.0%	99.7%	98.9%	99.2%	98.9%	99.7%	97.6%	98.7%	99.1%	99.4%	98.6%	99.0%	98.4%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	95.8%	96.2%	91.5%	94.7%	94.8%	94.7%	96.7%	95.4%	98.7%	96.8%	98.5%	97.9%	98.0%	97.1%	97.3%	97.4%	96.4%
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	98.1%	98.8%	98.5%	98.4%	100.0%	97.5%	100.0%	99.6%	99.0%	98.7%	100.0%	99.3%	100.0%	98.2%	98.6%	99.0%	99.1%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.3%	100.0%	96.4%	95.5%	90.5%	100.0%	87.5%	92.5%	96.6%
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	100.0%	96.0%	99.1%	100.0%	96.0%	100.0%	99.0%	96.8%	93.1%	100.0%	96.5%	86.7%	90.3%	95.8%	90.9%	96.6%

Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	81.4%	89.2%	91.4%	87.8%	90.5%	89.7%	93.8%	91.3%	75.0%	91.2%	81.8%	81.5%	86.7%	89.3%	80.6%	85.3%	86.4%
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	94.1%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	98.1%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	N/A	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	50.0%		85.7%	100.0%		100.0%	100.0%	94.1%
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	83.9%	84.9%	80.4%	83.0%	80.5%	86.7%	89.3%	85.5%	83.8%	79.0%	80.8%	81.3%	86.2%	80.0%	72.2%	79.9%	82.8%
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	86.1%	84.5%	83.1%	84.6%	79.9%	79.3%	79.3%	79.5%	78.3%	76.9%	76.0%	77.0%	81.1%	79.4%	78.0%	79.5%	80.2%
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	98.7%	98.2%	98.2%	98.4%	97.6%	97.1%	97.0%	97.3%	97.8%	97.5%	97.7%	97.7%	97.8%	97.4%	97.4%	97.5%	97.7%
	All handovers between ambulance and A&E must take place within 15 minutes	95%	85.0%	80.5%	82.2%	82.5%	84.8%	84.8%	82.5%	84.0%	84.5%	84.5%	84.9%	84.7%	90.8%	91.1%	92.5%	91.5%	85.8%
	All crews should be ready to accept new calls within a further 15 minutes	95%	49.3%	55.9%	52.4%	52.6%	62.0%	67.0%	66.0%	65.0%	68.6%	70.6%	72.8%	70.6%	70.2%	70.8%	79.1%	73.6%	66.0%
Mixed Sex Accommodation	Minimise breaches	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1
MRSA	Number of MRSA reported infections	0	1	0	1	2	0	0	0	0	0	2	0	2	0	0	0	0	4
C_Diff	Number of C-Diff blood stream infections	50	1	3	6	10	4	6	8	18	2	4	5	11	5	1	2	8	47

Outcome/Measure		Target/ Baseline	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD	Performance Trend
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission , for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice.	0	1	1	1		3	
	No urgent operation to be cancelled for a 2nd time	0	0	0	0	0	0	
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period.	95%	95.2%	95.1%	95.6%	97.4%	95.8%	

Appendix 1 (b)

Quality Premiums 2013/14

National Measures		Target/Baseline	2009/10	2010/11	2011/12	2012/13	2013/14	Performance Trend
Domain 1: Preventing People from dying prematurely	Potential years of life lost from causes considered amenable to health care: adults, children and young people	3.2 reduction from 12/13 outturn						

National Measures			Target/ Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Domain 2: Enhancing the quality of life for people with long term conditions and Domain 3: Helping people to recoever from edisodes of ill health or following injury	* See Note to the right, Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (All ages)			177	183	162	147	119	176	156	174	168	188	168		1,818
	* See Note to the right, Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s			12	18	16	13	6	24	24	24	15	16	13		181
	* See Note to the right, Number of emergency admissions for acute conditions that should not usually require hospital admission (All ages)			311	277	260	222	195	221	272	293	311	248	228		2,838
	* See Note to the right, Emergency admissions for children with lower respiratory tract infections (Aged 0-18)			9	11	6	1	4	10	14	50	74	30	13		222
	* See Note to the right, Total Avoidable Emergency Admissions			509	489	444	383	324	431	466	541	568	482	422		5,059
Domain 4: Ensuring that people have a positive experience of care	Friends and Family Test: **Maternity Services** - "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"	SCORE	Improve Score													
		RESPONSE RATE	15%													
	Friends and Family Test: **Acute Inpatient Care** - "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"	SCORE	Improvement in Average on Q1 13/14 to Q1 14/15 (score between - 100 & +100)	74	73	73	78	77	82	75	74	74	77	72	76	905
		RESPONSE RATE	15%	22.9%	25.4%	25.5%	25.2%	26.6%	24.1%	26.7%	31.6%	27.3%	25.5%	28.9%	33.6%	26.9%
	Friends and Family Test: **A&E Services** - "How likely are you to recommend our A&E Department to friends and family if they needed similar care or treatment?"	SCORE	Improvement in Average on Q1 13/14 to Q1 14/15 (score between - 100 & +100)	37	41	46	40	39	29	37	39	38	47	46	49	488
		RESPONE RATE	15%	23.8%	20.9%	23.9%	26.0%	24.8%	15.8%	20.9%	19.0%	18.3%	20.0%	24.4%	22.4%	21.7%
Health Care Acquired Infections (HCAIs)	MRSA (* acute cases only)		0	1	0	1	0	0	0	0	2	0	0	0	0	4
	CDIFF (* acute cases only)		4.2	1	3	6	4	6	8	2	4	5	5	1	2	47

Local Measures		Target/ Baseline	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Indicator 1: Number of smoking quitters	% Patients quit					46.4%				45.4%				46.1%					46.0%
	Number of patients quit					300				277				265					842
	Number of patients setting quit date					646				610				575					1831
Indicator :2 Pulmonary Rehabilitation	% Referrals to pulmonary rehabilitation					105.7%				85.7%				115.7%				154.3%	115.4%
	Numerator:					74				60				81				108	323
	Denominator:					70				70				70				70	280
Indicator 3: Over 65s still at home 91 days after discharge into reablement/rehabilitation services	% Actual					78.5%				84.0%				64.9%					75.4%
	Number of patients still at home after 91 days					51				79				63					193
	Total number of patients					65				94				97					256

NHS Constitution Pledges and Rights		Week Ending	Target/ Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Referral To Treatment waiting times - Patients on incomplete pathways	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral		92%	95.0%	95.4%	94.8%	94.9%	94.7%	94.8%	95.4%	95.0%	94.8%	94.5%	94.5%		94.8%
A&E Waits*	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	27/04/2014	95%	94.9%	94.8%	93.4%	95.4%	94.8%	95.8%	96.5%	93.9%	97.2%	96.1%	96.2%	97.2%	95.4%
Cancer Waits - 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer		85%	81.4%	89.2%	91.4%	90.5%	89.7%	90.3%	76.0%	91.2%	81.8%	88.7%	89.5%	80.6%	88.4%
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)		75%	83.9%	84.9%	80.4%	80.5%	86.7%	89.3%	83.8%	79.0%	80.3%	88.2%	80.0%	72.2%	82.8%

Appendix 2

NHS Calderdale CCG

Compliance with Statutory Duties in 2013/14

Duty	Reference	Compliance
Acted with a view to ensuring that health services are provided in a way that promotes the NHS Constitution and promote awareness of the NHS Constitution amongst patients, staff and members of the public.	S.14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)	▪ Commitment to deliver the required standards are included in strategic plan ▪ progress is routinely discussed with NHS England as part of CCG assurance ▪ progress routinely forms part of governing body agenda ▪ provide regular updates on performance and progress made with the standards associated with NHS Constitution at the staff workshop
Assisted and supported NHS England in discharging its duties relating to securing the continuous improvement in the quality of primary medical services	See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Actively engaged member practices in the use of the primary care quality assurance web tool. ▪ Developed and implemented the Remote Care Monitoring DES (Direct Enhanced Services) ▪ Developed and implemented the Risk Profiling DES (Direct Enhanced Services) ▪ Developed and implemented the *High Performing Membership Organisation* Toolkit which contains 7 competencies that member practices have signed up to deliver. ▪
Promote the involvement of patients, their carers and representatives in decisions about their healthcare	S.14U of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Public and Patient Engagement Experience Strategy and assurance process relating to engagement in service redesign in place; ▪ Quality Committee monitors effectiveness of engagement processes and involvement in decision making through mechanisms such as PREMS.

Enabled patients to make choices	See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Demonstrated that Calderdale patients are exercising choice through acute non-elective activity. i.e. Non contract activity -£640k NHS activity, £355k non NHS activity. Choice exercised through elective AQP: Spend in 2013/14 was £3.5m representing an estimated increase of 30% against 2012/13 position. ▪ Maintained high levels of electronic booking which benchmark favourably across West Yorkshire. ▪ Progress against NHS Constitution duties and pledges routinely part of Governing Body agenda.
Promote innovation, research, use of research, education and training	S.14Y of the 2006 Act, inserted by section 26 of the 2012 Act S.14Z of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Strategic plans reflect the CCG's approach to innovation. ▪ Promotion of research, education and training overseen by Quality Committee ▪ Working in partnership with research networks. ▪ Working in partnership with the Academic Health Science Network ▪ Working with Health Education England, Yorkshire and Humber **Good practice** ▪ Conjoined analysis seeking the views of Calderdale residents on future models of unscheduled care services in primary and community settings (81% response rate) ▪ Worked with Yorkshire Public Health Observatory who undertook deep dive analyses of respiratory and CVD pathways in Calderdale. ▪ Supported via the Innovation Grant scheme: Vocational General Practice Nurse Training Scheme and the Non-Medical Clinical Workforce Mentor Development Scheme.
Consult widely when devising commissioning plans	S. 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Public and Patient Engagement and Experience Strategy and work plan produced. ▪ Public and patient involvement and experience work is overseen by a dedicated sub group of the quality committee and ensures that the findings from PPI activity, informs commissioning plans.

		▪ Calderdale Health Forum established, made up of practice reference group representatives. **Good examples:** ▪ NHS Call to Action engagement (250 responses) ▪ Engagement on shape of unscheduled care services. ▪ Engagement with key stakeholders, voluntary and community groups on strategic priorities
Take appropriate steps to secure that it is properly prepared for dealing with relevant emergency.	S. 6 Corporate Manslaughter and Corporate Homicide Act 2007 Schedule 5, paragraph 147 of Health and Social Care Act 2012.	▪ Membership of multi-agency Gold Command group ▪ Representation on the Local Resilience Group ▪ Winter plans, surge and escalation plans and business continuity plans in place. ▪ Membership of multiagency groups preparing for the Tour de France.
Cooperated with its Health and Wellbeing Board in relation to the discharge of the Health and Wellbeing Board's functions.	Section 194 Health and Social Care Act 2012	▪ Active member of the Calderdale Health and Wellbeing Board; ▪ Contributed to the development of the Joint Strategic Needs Assessment and the development of the Health and Wellbeing Strategy ▪ Continuous engagement and consultation on CCG commissioning plans including strategic review and the joint Better Care Fund plans. ▪ CCG Strategic and delivery plans informed by the JSNA ▪ CCG Strategic and delivery contribute to the delivery of the Health and Wellbeing Strategic priorities.
Discharge of functions with regard to the need to safeguard and promote welfare of children.	S. 10 Children Act 2004, Schedule 5, paragraph 128 of Health and Social Care Act 2012. Section 13 Children Act 2004, Schedule 5, paragraph 131, Health and Social Care Act 2012.	▪ Dedicated safeguarding team for vulnerable adults and children ▪ Statutory/mandatory training for all staff and Governing Body members in safeguarding adults and children ▪ Monitor provision and uptake of safeguarding training for adults and training with all providers including care homes. ▪ Active member of the Calderdale joint safeguarding board for children. ▪ Active member of the joint Children and Young People's Board. ▪ Introduced a Policy for Safeguarding Adults and Children at Risk that sets out the systems in place to safeguard and promote the welfare of children

		and protect adults at risk of harm.
Cooperation in relation to preparation of Joint Strategic Needs Assessments (JSNA)	S.116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act	▪ Active member of the Calderdale Health and Wellbeing Board; ▪ Engaged with GP members on development of JSNA ▪ CCG Strategic and delivery plans informed by the JSNA ▪ CCG Strategic and delivery contribute to the delivery of the Health and Wellbeing Strategic priorities.
Act with a view to securing continuous improvement to the quality of services	S. 14R of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Quality Committee seeks assurance from providers, raises formal queries and refers issues to the CCG's Governing Body where there are significant concerns which may compromise quality and patient safety. ▪ Quality Committee annual work plan takes account of the commissioning priorities, the regulatory framework and any national reports on quality and which will be sufficiently flexible to respond to significant concerns should they arise; ▪ Head of Quality attends Governing Body as an advisor.
Reduce inequalities	S.14T of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Active membership of the Health and Wellbeing Board; ▪ Active engagement in the health and wellbeing strategy development; ▪ Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions; ▪ Testing the strategic plan and delivery plans against the health and wellbeing priorities and JSNA.
Promoting integration	S.14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act	▪ Working collaboratively with Calderdale MB and other commissioner or provider partners on Strategic Review Programme Board, Urgent Care Board, Better Care Fund planning Board, ▪ Taking forward the development of an integrated community services model.

SUSTAINABILITY REPORT

Background

As part of our authorisation process we made a *commitment to:* ***"achieve the best health and wellbeing for the people of Calderdale within our available resources".*** *This has now been adopted as our vision.*

We recognise that our available natural resources are limited and we must work strategically to minimise our operational impact, while at the same time establishing ways to have a positive impact on the community around us.

NHS Calderdale Clinical Commissioning Group (CCG) is based at Dean Clough Mills in Halifax – formerly occupied by NHS Calderdale. Remaining in the same building, we have been able to transfer many of our internal sustainable working practices, such as the use of 'switch off' procedures for lighting as part of the central arrangements for the building.

We have also been able to continue with our commissioning approaches including the use of the NHS Standard Contract as the mechanism for contracting NHS services.

This report provides an update of our progress in year one, 2013/14, and sets out our focus for the next financial year, 2014/15.

Success in 2013/14

In 2013/14 our focus has been two-fold:

- Internal impact reduction
- Ensuring that sustainability clauses are incorporated into our contracting and procurement arrangements.

Continuing with our internal impact reduction

- **Assessment of resource impact**

Understanding our impact has been a crucial first step for our sustainability journey at the CCG. As we understand current consumption levels, we can also understand where we can make the greatest financial and environmental savings. The regular monitoring of usage will also enable us to identify carbon 'hotspots' – areas of high use that should be targeted as a priority.

NHS Property Services, our facilities management provider have been unable this year to separate out the data that we require to identify all required areas of resource impact. Work is ongoing to ensure that we can report on this and on staff miles travelled, in 2014-2015.

Resource	Quantity	CO2 Emissions (tonnes)	Cost (££)
Gas	(kWh)	-	NHS PS
Electricity	(kWh)	-	NHS PS
Business miles travelled	(miles)	tbc	tbc
Public transport miles travelled	(miles)	-	tbc
General waste	(tonnes)	n/a	NHS PS
Recycling (including confidential waste)	(tonnes)	n/a	£1,654
Water	(m3)	-	NHS PS

- **Energy reduction through print solutions**

The CCG follows a number of processes in-house to reduce the amount of paper used across the organisation. Our 'secure print' option on printers minimises paper waste. We strive to be as paper light as possible with the use of slates or tablets at senior management team and Governing Body meetings to avoid the need to print large volumes of agenda papers.

- **Waste reduction, Re-use & Recycling**

The CCG makes use of confidential waste, paper shredding and recycling bins throughout the office. We re-use stationery where-ever possible and the buying of new stationery is strictly controlled through the Corporate Administration Team. Printer toner cartridges are recycled.

All of our IT systems are managed by The Health Informatics Service (THIS). Where-ever possible, our old IT equipment is re-used within the organisation. Where this is not possible, we seek to use pieces of old IT equipment to support our repair function. If unfit for use, we undertake a formal decommissioning process following the Waste, Electrical, Electronic Equipment (WEEE) Regulations 2013.

- **Sustainable travel**

Our Human Resources' policies, procedures and guidance incorporate our expectations in terms of sustainable travel. Specifically staff are:

- expected to share vehicles where possible and where it is practical to do so,
- reimbursed for the use of pedal cycles when making journeys in the performance of their duties,
- encouraged to make use of public transport where possible,
- encouraged to make use of teleconferencing facilities for holding meetings rather than travelling

Sustainable contracting and procurement

The NHS Standard Contract requires that providers operate in line with the NHS Carbon Reduction Strategy and demonstrate their progress on climate change adaptation, mitigation and sustainable development. A summary of this progress should be contained within provider annual reports. The process for monitoring provider compliance with the NHS standard Contract is via the CCG's contract monitoring arrangements.

The NHS is a major employer and economic force within Calderdale, West Yorkshire and the wider region. As a CCG we recognise the impact of our purchasing and procurement decisions on the regional economy and the positive contribution we can make to economic and social regeneration (*see section two: local context of our Strategic Report).*

The CCG's Procurement Policy (April 2013) sets out our commitment to the development of innovative local and regional solutions and to the delivery of a range of activities in support of this commitment. Where-ever possible and where it does not contradict or contravene the CCG's procurement principles or provisions allowable under the Public Services (Social Value) Act 2012, we will work to develop and support a sustainable health economy.

As part of this commitment, we will, as a matter of good practice, consider how a procurement proposal might improve economic, social and environmental well-being in order to maximise value for money. The considered application of the provisions of the 2012 Act enables the CCG to broaden procurement evaluation criteria to include impact on the local economy.

Community sector commitment

The CCG recognises the importance of developing capacity and capability within the local community sector to enable our community to play their full part in providing the services we commission. In 2013 we funded "*Health Connections*" to support the voluntary and community sector to become more sustainable and 'business ready' for commissioning via the Clinical Commissioning Group. *Health Connections* offers a full package of support including:

- Organisational development activities to support voluntary and community organisations to be able to deliver services on behalf of the NHS and be sustainable.

- Safeguarding support and development so that anyone who comes into contact with vulnerable groups either by volunteering or paid work is aware of their responsibilities.
- Support in building networks and groups.

Community engagement

The CCG places a high degree of importance on public and patient engagement, including community engagement as part of its commissioning functions. Our

approach to community engagement is set out in our Public and Patient Engagement and Experience Strategy (2013).

Developments in 2014/15

In 2014/15, we will build on the foundations put in place in 2013/14. By doing this we will be in a strong position to achieve our economic, environmental and social sustainability aims for our work force and local communities.

We will do this by reducing the impact of our internal and external activities, and identifying ways in which we can have a positive impact on the communities in which we operate.

Our objectives for 2014/15 are:

- To develop a Sustainable Development Management Plan and implement the required action across our organisation.
- To determine a baseline of our resource impact, backdated to 2013/14 where possible and use this information to establish appropriate stretch targets.
- To continue to develop the way that we commission services on behalf of our local communities which achieve high levels of social value and low levels of environmental impact.

We will achieve this through:

1. Strategy and planning

Sustainable Development Management Plan (SDMP)

In 2014/15 we will develop an SDMP which will align to the NHS and Public Health joint sustainability strategy and modules:

We will set out clear governance arrangements which will:

- Confirm our senior lead for sustainability and their responsibilities,
- Confirm the process for reporting through our internal governance arrangements.
- Identify a lead for sustainability at Governing Body level.
- Set out the processes for disseminating information and good practice across our workforce.

We will develop actions that include:

- Working with NHS Property Services to collect utility and resource use data over the year, covering gas, electricity, waste, water usage.
- Back dating this information to 2013/14 wherever possible.
- Establishing our environmental baselines and reduction stretch-targets.
- Broadening our procurement evaluation criteria to include impact on the local economy in line with our Procurement Policy.

- A consideration of further opportunities for incorporating our sustainability responsibilities in our strategic planning processes.

We will accelerate our progress by working with and learning from others by:

- Working with our CCG neighbours and with West and South Yorkshire and Bassetlaw Commissioning Support Unit.
- Sharing the learning from our sustainability programmes and establishing best practice.
- Learning from development at a national level through the Sustainable Development Unit and other NHS organisations.

We will improve annually through measurement and reporting of our performance by:

- Utilising the Good Corporate Citizen Tool assess how our organisation is performing in social, environmental, and financial terms.
- Reporting our targets and benchmarking ourselves against our peers.

2. Internal impact reduction

We are aware that a large element of our impact will be within our commissioning and procurement activities; however we also recognize the importance of reducing our own internal carbon footprint. Based on our learning from the work of other CCGs and other NHS organisations, we believe our programme of work is likely to concentrate on the following:

- **Energy reduction**

  Continue to work with our Landlord and NHS property services to identify opportunities for energy reduction throughout our own organisation and with other tenants in the building.

- **Sustainable travel**

  Continue to provide staff with clear guidance and opportunities for a reduction in business travel. These opportunities include an increase in the use of electronic media, reduce staff travel through more flexible working, and promote greener healthier methods of transport across the organisation.

- **Waste Reduction, Re-Use and Recycling Measures**

  Encourage the reduction, re-use and then recycle, before disposal, identify means of re-using items such as office furniture, encourage recycling, and review our internal procurement activity for office supplies to ensure we buy items that are not only fit for purpose, but that also contain recycled content and/or are easy to recycle.

3. External impact reduction

Working with our supply chain to measure, analyse and reduce the environmental impact, within our commissioning and procurement activities. We will:

- Identify ways to begin to measure our impact through our core activities
- Follow the NHS Sustainable Development Unit “Procuring 4 Carbon Reduction framework.
- Implement a rolling programme of review of contracts to ensure they encourage sustainable working practices.
- Consider possible pilot projects to trial ways of building sustainable elements into commissioning practices. This may include the carrying out of an initial social value impact assessment or the establishment of new social value baselines through our own organisation and supply chains.

4. Communications and Engagement

Ensure that we are communicating our sustainable agenda to our workforce, our stakeholders and our peers to help us to achieve a fully engaged and embedded programme of work.

EQUALITY AND DIVERSITY REPORT

NHS Calderdale CCG is pleased to be able to present its Equality and Diversity Report for 2013/14.

The CCG has worked hard this year to ensure that it meets with best practice in its approach to equality and complies with its duties under the Equality Act 2010.

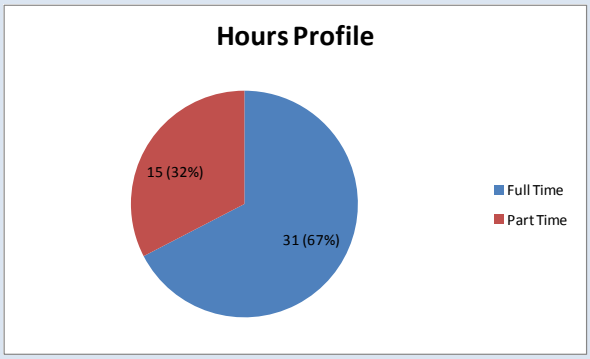
The CCG's workforce profile is shown below. All the data below is for staff employed on 28 February 2014. Some data is not shared to avoid identification of individuals.

Staff in post

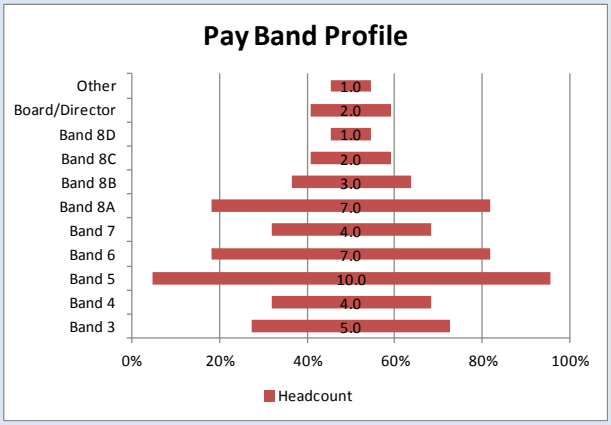
Headcount	46
FTE	40.5

Hours

Full Time	31
Part Time	15



Pay Band	Headcount
3	5
4	4
5	10
6	7
7	4
8A	7
8B	3
8C	2
8D	1
Governing Body / VSM/ Senior Manager	2
Other	1



Gender (Governing Body) (excl. Accountable Officer and Chief Finance Officer)

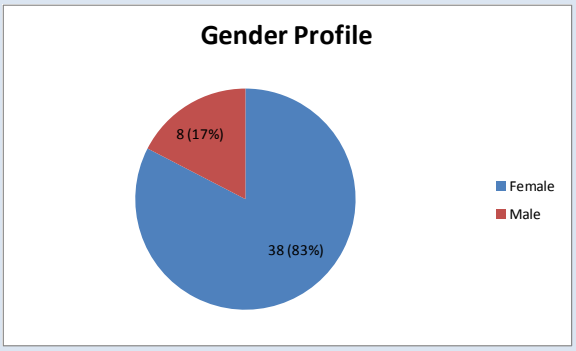
Gender	Headcount
Female	3
Male	8

Gender (Very Senior Managers VSMs)

Gender	Headcount
Female	1
Male	1

Gender (staff excl. Gov. Body and VSMs)

Gender	Headcount
Female	37
Male	7

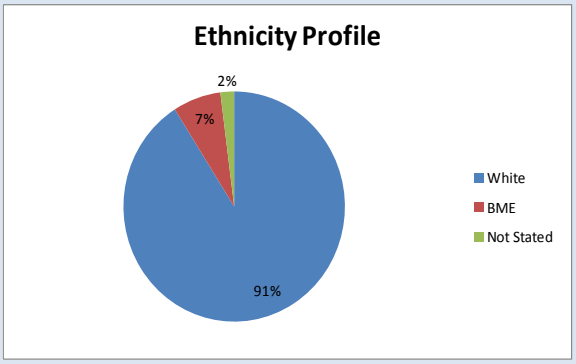


Age (staff excl. Gov. Body)

Age Band	Headcount
21 - 30	<5
31 - 40	8
41 - 50	15
51 - 60	17
Over 60	<5

Ethnicity (staff excl. Gov. Body)

Ethnic Origin	Total
A White - British	40
B White - Irish	<5
D Mixed - White & Black Caribbean	<5
J Asian or Asian British - Pakistani	<5
SC Filipino	<5
Z Not Stated	<5



Disabled employees

The CCG's commitment to disabled people is covered in a number of policies and procedures.

Requirement	Policy or procedure
Applications for employment made by disabled people	▪ Diversity and Equal Opportunities in Employment Procedure. ▪ Pre-employment Checks Procedure and Guidance ▪ Occupational Testing and Use of Psychometric Tools Procedures and Guidance ▪ Recruitment and Selection Policy
Continuing the employment of and for arranging appropriate training for employees who have become disabled during the period.	▪ Diversity and Equal Opportunities in Employment Procedure. ▪ Policy on dealing with ill health
Training, Career development and promotion of disabled people.	▪ Diversity and Equal Opportunities in Employment Procedure ▪ Employing People with Disabilities Procedure ▪ Personal Development Review and the Knowledge and Skills Framework Procedure and Guidance

Achieving the 'two ticks' award – Positive about disabled people

The CCG invested a significant amount of time into securing the "Two Ticks" award - positive about disabled people.
This was awarded to the CCG by Job Centre Plus.

The award allows us to use the logo which shows disabled people that we have made the following commitments regarding recruitment, training, retention, consultation and disability awareness:

- ✓ To interview all disabled applicants who meet the minimum criteria for a job and to consider them on their abilities.
- ✓ To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.
- ✓ To make every effort when employed become disabled to make sure that they stay in employment.
- ✓ To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.
- ✓ To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and job centre plus know about progress and future plans.

MEMBERS' REPORT

NHS Calderdale CCG is made up of 26 member practices who have delegated authority to the Governing Body to make decisions on their behalf as set out in the scheme of delegation incorporated in the CCG's Constitution.

NHS CALDERDALE CCG LIST OF MEMBER PRACTICES

Practice Name	Address	Practice Commissioning 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 D Eso
Burley Street Surgery	Burley Street, Elland,	Dr F Naz
Brig Royd Surgery	Hirstwood, Ripponden,	Dr C Littlewood
Caritas Group Practice	Woodside Surgery, Boothtown Medical Centre, Boothtown, Mixenden Stones Surgery, Mixenden Shelf Health Centre, Shelf Moor Road, Shelf	Wendy Iles
Care UK, Clinical Services Ltd	Calder Community Practice, Todmorden Health Centre, Todmorden Park Community Practice, Horne Street Health Centre, Hanson Lane, Halifax	Dr Mohammed
Church Lane Surgery	24 Church Lane, Brighouse	Dr S Chambers
Hebden Bridge Group Practice	Valley Medical Centre, Valley Road, Hebden Bridge, Grange Dene Medical Centre, Burnley Road, Mytholmroyd Mini-Clinic, Kershaw Drive, Luddenden Foot	Dr K Moore
Horne Street Surgery	Horne Street Health Centre, Hanson Lane, Halifax	Dr M Niazi

Keighley Road Surgery	Keighley Road, Illingworth	Dr K Simpson
King Cross Practice	199 King Cross Road, King Cross	Dr H Bolland
Longroyde Surgery	38 Castle Avenue, Rastrick	Dr J Grant
Lister Lane Surgery	Unit one, Victoria Lodge,30 Lister Lane, Halifax Boothtown Medical Centre, Woodside Road, Boothtown Nursery Lane, Ovenden, Halifax	Dr S Shetty/Dr S Sukumaran
Meadow Dale Group Practice	120 Nursery Lane, Ovenden, Halifax Ground Floor, Rosemount House, Rosemount Estate, Huddersfield Road, Elland Ground Floor, Allan House, Sowerby Bridge Halifax	Dr McGechaen
Northolme Practice	Kos Clinic, Roydlands Street, Hipperholme Northowram Surgery, Northowram	Dr D Chin
Plane Trees Group Practice	51 Sandbeds Road, Pellon	Dr Ormerod & Dr Ellwood
Queens Road Surgery	252 Queens Road, Halifax	Dr U Agbim
Rastrick Health Centre	Chapel Croft, Rastrick	Dr J Wilkinson
Rosegarth Practice	Rothwell Mount, Halifax 117 Oxford Lane, Siddal, Halifax	Dr M Wilshere
Rydings Hall Surgery	Church Lane, Brighouse	Dr A Wilkinson
Southowram Surgery	Law Lane, Southowram	Dr M Azeb
Spring Hall Group Practice	Spring Hall Medical Centre, Spring Hall Lane, Halifax	Dr F Price
Stainland Road Medical Centre	70 Stainland Road,	Dr K McMichael

	Greetland	
Station Road Surgery	Station Road, Sowerby Bridge	Dr S Catlow
The Todmorden Group Practice	Todmorden Health Centre, Lower George Street, Todmorden	Dr J Keighley

The Governing Body and its sub-committees

The Chair is Dr Alan Brook and the Chief Officer (Accountable Officer) is Dr Matt Walsh. They, together with the majority of the Governing Body, have been in post since the CCG was in shadow form ensuring good continuity for the CCG. Details of the Governing Body membership and attendance are set out in appendix 1 of the Governance Statement.

The Governing Body has four sub-committees: the Finance and Performance, Quality, Remuneration and Audit Committees. The details of the membership and attendance at these committees can be found in appendix 1 of the Governance Statement (Governing Body, Audit, Finance and Performance and Quality) and in the Remuneration Report (Remuneration Committee).

Register of Interests

The Register of interests of the Governing Body and its sub-committees is set out in the Remuneration Report.

Disclosure of Related Information

The CCG is able to confirm that it has nothing to report on the following:

Political or charitable donations
Important events since the end of the financial year affecting the CCG
Indication of likely future developments at the CCG
Indication of any significant activities in the field of research and development
Indication of the existence of branches outside the UK

Pension Liabilities

Detail of the appropriate pension liabilities are contained within the Remuneration Report.

Sickness absence data

A table on the sickness absence data is included in the employee benefits note to the Financial Statements.

Our CCG has a genuine interest in developing the health and wellbeing agenda to ensure a healthy working environment for all colleagues. The CCG has policies and procedures in place to support colleagues with sickness absence and is keen to develop a positive and pro-active approach to supporting colleagues through sickness absence or difficult periods in their lives. The policies covering sickness

absence management are currently being reviewed to ensure that they reflect best practice wherever possible and we are looking towards developing the Occupational Health Service to support the needs of the workforce.

In 2013/14, the CCG had no significant levels of staff sickness.

External Audit

KPMG has been appointed by the Audit Commission to be the external auditor for NHS Calderdale CCG. The cost of the work performed by the auditor in respect of the reporting period is £82,000 (excluding VAT).

Services from KPMG	£
Audit Services (statutory audit and services carried out in relation to the statutory audit, eg. reports to NHS England	72,000 (excluding VAT)
Further assurance services (ie, 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	---
Other Services (see note)	10,000
TOTAL	82,000

The additional services provided by KPMG were to review the engagement of Governing Body members, including PAYE/NIC obligations of the CCG in relation to payments and expenses reimbursed to the Members; the employment law obligations and the CCG's responsibilities with regard to the NHS Pension Scheme.

We have reviewed this and consider that this additional work has provided no potential or real conflict of interest.

Disclosure of "serious untoward incidents"

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

Cost allocation and setting of charges for information

"We certify that the Clinical Commissioning Group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information".

Principles for Remedy

The Parliamentary and Health Service Ombudsman (PHSO) has set out six principles for remedy when dealing with complaints. These are:

1. Getting it right

2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

A full explanation of the Principles can be found at: www.ombudsman.org.uk.

Good complaints handling is a high priority for our CCG. We have a robust complaints handling framework which outlines our responsibility for not just receiving and handling complaints, but also for adopting the learning to ensure that there is a continuous improvement in the way that health service delivers care. The CCG has fully adopted the principles of remedy in handling the complaints we receive. The CCG has also used the Ombudsman's six principles as a basis for its Dispute Resolution Procedure for member practices.

Employee consultation

The CCG is active in the way in which it provides information to its employees and consults staff on a range of issues including policies, proposals to improve services for the local population and CCG developments such as the website.

The CCG uses a number of mechanisms for disseminating information and consulting staff:

- The Chief Officer also holds a weekly 'blog' updating staff on business, with the opportunity to share news or useful information with colleagues.

- A local staff forum with a reporting line straight into the Senior Management Team. The local staff forum has been working in conjunction with the Senior Managers to build and develop a local staff survey. The survey has run twice over the past year and will continue to be developed as a useful tool for the organisation.

- A structured staff workshop delivered on a monthly basis. Staff receive an update on the delivery of commissioning performance targets, new policies or initiatives, briefings on areas such as counter fraud, information governance, responsibilities for patient and public involvement. The interactive session is also used to develop thinking in areas such as commissioning priorities

- Active engagement with the staff side representatives to establish a Social Partnership Forum. The forum meets on a quarterly basis and membership consists of HR professionals, Senior Managers from the CCG, branch trade union representatives and staff side colleagues. Going forward it is expected more CCG employees will become official staff side representatives to ensure a voice in the forum.

Disabled employees

The Equality and Diversity Report contained earlier in the Annual Report provides information in relation to our policies regarding disabled employees.

Emergency Preparedness, Resilience and Response

"We certify that the Clinical Commissioning Group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. As a category 2 responder we follow West Yorkshire Area Team's major incident plan. The Clinical Commissioning Group regularly reviews and makes improvements to its Business Continuity Plan and has a programme for regularly testing this plan, the results of which are reported to the Audit Committee (under delegation from the Governing Body".

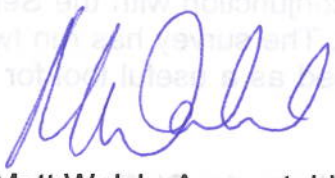
Statement of disclosure to Auditors

The Governing Body has delegated authority to the Audit Committee for the approval of the Annual Report and Accounts.

Each individual who is a member of the Audit Committee at the time the Members' Report was approved confirmed that:

- **So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group's external auditor is unaware and;**

- **That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.**



Dr Matt Walsh, Accountable Officer
5th June, 2014

Remuneration Report

This report has been produced in accordance with the Government Financial Reporting Manual.

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	4/4
Dr Alan Brook	Chair of CCG	4/4
Dr Hazel Carsley	GP Member	3/4
Dr Peter Davies	GP Member (GP substitute)	1/1
John Mallalieu	Lay Advisor to the Governing Body and member of Remuneration Committee from 16th January 2014.	0/0

John Mallalieu acted in an advisory capacity between 1st April 2013 and 15th January 2014 in order to strengthen the independent lay input.

The Remuneration Committee is supported in its determinations, by a senior HR specialist (WSYBCSU) who provides specialist advice and support to the committee. The role of specialist HR support was agreed by the committee in April 2014 and is set out in the terms of reference of the committee.

The Governance Statement contains more information about the Remuneration Committee.

For the purposes of this Remuneration Report, all members of the Governing Body are treated as senior managers.

2. Policy on Remuneration of Senior Managers

To support the principle of local determination there are no set rates of pay for the different groups of Governing Body members. 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 benchmarking and legal guidance from DAC Beachcroft LLP were used to inform the determinations of the Remuneration Committee:

Hutton review fair pay principles (2011):-

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

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

- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay is 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.

For the Lay Members, GP members and the Clinical Chair, the decisions were also informed by a range of available documentation providing guidance both in relation to contractual status and remuneration or reimbursement:

- RSM Tenon – Technical Employment Status Guidance (2012)

- RSM Tenon FAQs

- Annex 2 of the April 2012 NHS Commissioning Board (NHS CB) publication "*Clinical Commissioning Group Governing Body members: Role outlines, attributes and skills*". This provides guidance on the principles relating to reimbursement and remuneration for governing body members.

- NHS Commissioning Board (now referred to as NHS England) "*Clinical Commissioning Groups – HR Frequently Asked Questions*" (June 2012) notes the importance of considering the employment status of all CCG posts in order to determine the correct contractual status under current legislation and HM Revenue & Customs (HMRC) rules;

- The NHS Confederation briefing "Deciding how to pay: remuneration for clinical commissioners" (June 2012)

- David Nicholson letter – Gateway Reference 17993 (August 2012)

In determining the appropriate rate, the Remuneration Committee took into account:

- The key and guiding principles set out
- Comparative rates for each of the Governing Body posts
- The requirement to obtain best value for money

- The need for an affordable staffing and remuneration structure within its running cost allowance.

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

- 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.

For **GPs on the Governing Body**, including the clinical Chair, remuneration should be either:

- At a reasonable rate, in line with practice earnings;
- 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.

For the **Accountable Officer and the Chief Finance Officer**, consideration also took account of:

- Pay benchmarking information provided by the NHS Commissioning Board
- Complexity factors
- Availability of guidance on recruitment and retention premiums
- Prevailing economic climate and local market conditions
- Any joint management arrangements. This approach will be retained in respect of any new determinations for 2014/15.

3. Benchmarking rates of remuneration

The proposed remuneration for each of the categories of Governing Body member including the Chief Finance Officer and Accountable Officer took into account comparative data across CCGs, recommended rates of remuneration for Chief Finance Officer and Accountable Officer.

4. Senior Managers Performance Related Pay

The Senior Managers at the CCG are not subject to performance related pay.

5. Policy on Senior Manager Contracts

The Accountable Officer and Chief Finance Officer are classed as senior managers as defined in the Annual Reporting Guidance 2014. Both 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.

6. Senior Manager Service Contracts

The CCG currently uses the following categories of terms of engagement for Governing Body members; Secondment Agreement (Registered Nurse); Individual Agreement (Secondary Care Specialist); Contract for Service for GP members, i.e. Clinical Leads; Lay Members and the Lay Advisor. A number of factors have led to a delay in finalising the contract for service. The Remuneration Committee in the next two months will consider the further advice that has been sought from KPMG on the most appropriate remuneration, terms and conditions.

As set out in the CCG's Standing Orders, the usual term of office of GPs/Nurse Practitioners (i.e. Clinical Leads including the Clinical Chair), Lay Members, the Secondary Care Specialist and the Registered Nurse is three years. However, in the first instance the terms of office vary between one, two and three years so as to ensure that vacancies arise in rotation and there is continuity of a core of the membership.

7. Compensation for loss of office

No payment has been made in compensation for loss of office

8. Payments to Past Senior Managers

No payment has been made to past senior managers.

9. Salaries and allowances

Salaries & Allowances

Name & Title	2013/2014 Staff in post	2013-14					
		Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
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 Hazel Carsley	All Year	30 - 35	0	0	0	0	30 - 35
Dr John Taylor	All Year	30 - 35	0	0	0	0	30 - 35
Dr Peter Davies	All Year	30 - 35	0	0	0	0	30 - 35
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 Sanjay Suri, Secondary Care Clinician	All Year	15 - 20	0	0	0	0	15 - 20
Jackie Bird, Registered Nurse	All Year	10 - 15	0	0	0	0	10 - 15
John Mallalieu, Lay Member	01.04.13 to 31.10.13	0 - 5	0	0	0	0	0 - 5
Kate Smyth, Lay Member	All Year	5 - 10	0	0	0	0	5 - 10
David Longstaff, Lay Member	01.11.13 to 31.03.14	0 - 5	0	0	0	0	0 - 5
Matt Walsh, Accountable Officer	All Year	130 - 135	0	0	0	55 - 57.5	185 - 190
Julie Lawreniuk, Chief Financial Officer **(Note 1)**	All Year	50 - 55	0	0	0	135 - 137.5	185 - 190

Note 1: Julie Lawreniuk is employed by NHS Calderdale CCG. This is a shared post with NHS Greater Huddersfield CCG, for whom she is also Chief Financial Officer. Her total salary is in the banding £105k - £110k, however, only 50% has been included in the Salary & Fees column. In the All Pension 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 Pensions Related Benefits.

Note 2: GP members have been remunerated via a combination of mechanisms this year, payments to their GP practice and payments through the CCG payroll.

Note 3: The amounts included in "All Pension Related Benefits" are the annual increase in pension entitlement determined in accordance with the 'HMRC' method.

The increase = ((20 x PE) +LSE) – ((20 x PB) + LSB)
• Where:
• PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;
• PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
• LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
• LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Annex 3 to Chapter 4: Salary & Pension Disclosure Tables

Pension Benefits

Name & Title	2013-2014 Staff in Post	Real increase in pension at age 60 (bands of £2,500) £000's	Real increase in pension lump sum at aged 60 (bands of £2,500) £000's	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000's	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000's	Cash Equivalent Transfer Value at 31 March 2013 £000's	Cash Equivalent Transfer Value at 31 March 2014 £000's	Real increase in Cash Equivalent Transfer Value £000's	Employer's contribution to stakeholder pension £000's
Matt Walsh, Accountable Officer (Note 1)	All Year	0 - 2.5	5.0-7.5	20 - 25	60 - 65	302	361	52	37
Julie Lawreniuk, Chief Financial Officer (Note 2)	All Year	5.0 - 7.5	17.5 - 20.0	30 - 35	95 - 100	442	570	119	83

Note 1: Matt Walsh's figures only include the pension benefits of Officer NHS Pension Scheme membership. Any Practitioner (i.e. GP) pension benefits are excluded.

Note 2: Julie Lawreniuk is employed by NHS Calderdale CCG but is a shared post also with NHS Greater Huddersfield CCG, for whom she is also Chief Financial Officer. The above info includes the full pension information, not a proportion.

Note 3: The CCG does not make pensionable payments to the GP non-executive members of the governing body therefore their pension information does not need to be disclosed.

10. Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member of the Governing Body in Clinical Commissioning Group in the financial year 2013-14 was £150k - 155k (2012-12, N/A). This was 4.9 times (2013-14, £30,764) the median remuneration of the workforce.

In 2013-14, no employees received remuneration in excess of the highest-paid member of the Membership Body/Governing Body.

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

11. 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.

Required disclosure

Off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months are as follows:

The number that have existed:	**Number**
For less than one year at the time of reporting	20
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2014	16
	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	20
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	19
Of which, the number:	
For whom assurance has been received	19
For whom assurance has not been received	0
That have been terminated as a result of assurance not being received	0

	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.	8
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.	14

Dr Matt Walsh, Accountable Officer
5th June 2014

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

Dr Alan Brook, Chair

Longroyde Surgery, Rastrick

Alan Brook has been a GP in Brighouse since 1987. Alan 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 (LMC) and later served as its Chair.

He founded the Audit Group in 1990 and helped GP practices to compare their performance with others and find areas for improvement. He chaired the Primary Care Group, which in turn became a Primary Care Trust.

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.

Alan is also chair of the Finance and Performance Committee and a member of the Remuneration Committee.

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.

Over the years he has held various posts across West Yorkshire combining clinical practice with management. Before joining NHS Calderdale as Medical Director in 2009, Matt worked as the Clinical Governance lead for Bradford South and West Primary Care Trust and as Executive Director for Commissioning at NHS Leeds.

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.

Matt is a member of the Finance and Performance Committee.

David Longstaff,
Deputy Chair,
Audit Committee Chair

David Longstaff has spent of most of his career working for BT. He started as an apprentice and finished after 38 years as a senior executive in charge of audit and risk. In that time, he covered the Calderdale area and knows it well.

As a Lay Member and Deputy Chair of the CCG, he chairs the Audit Committee. 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. David has been a local magistrate in West Yorkshire for over 25 years, covering adult law and youth law, and also undertakes a range of roles in appeals.

Julie Lawreniuk,
Chief Finance Officer

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, sitting on the Calderdale, Kirklees and Wakefield District Cluster Board prior to the establishment of the CCG.

Julie is married with two grown up daughters and lives in Bradford.

Julie is a member of the Finance and Performance Committee

Dr Steven Cleasby,
Assistant Clinical Chair

Spring Hall Medical Centre

Steven has been a GP in Calderdale since 1999, when he started at Spring Hall Group Practice. His specialist area is diabetes and also has a keen interest in medicines management. He has held a clinical leadership role in Calderdale for the last five years when he was the prescribing lead for the Primary Care Trust.

He joined the Calderdale Clinical Commissioning Group in 2007 as part of practice based commissioning where he was Vice Chair.

As Assistant Clinical Chair at the CCG, he holds a number of lead roles, including Chair of the Quality Committee and lead for safeguarding and continuing care.

He is also a member of the Health and Wellbeing Board. Steven is keen to develop the quality agenda amongst provider organisations as well as in primary care. He lives in Calderdale with his wife and three boys.

Dr Peter Davies,
GP member

Keighley Road Surgery

Peter qualified from University of Leeds in 1989 and went into general practice in 1995. He initially worked in East Kilbride and then joined the Mixenden Stones Surgery in 2001, and subsequently to Keighley Road Surgery in 2005.

He is active in clinical practice and holds a number of lead roles for CCG including mental health and sits on the Audit Committee.

As well as his GP role, he also works with the Royal College of GPs and is provost of the Yorkshire Faculty, representing them on the College's ruling council. He was honoured with his college fellowship in 2009. Peter is the appraisal lead for NHS Calderdale CCG.

Peter is passionate about general practice and thinks and writes extensively about its development, particularly in the British Journal of General Practice.

Dr Hazel Carsley
GP Member

Boulevard Medical Practice

Hazel has been a GP in Calderdale since 1988. She trained at Leeds Medical School and underwent vocational training on the Bradford VTS scheme. Hazel is a partner at the Boulevard Medical Practice.

She has been children's and women's clinical lead for the CCG for the past year, and was previously Cancer and Palliative Care lead during Practice Based Commissioning. She finds her work through partnerships stimulating and challenging.

Hazel plays a key role in developing the CCG as a high performing membership organisation.

As a GP, her goal has always been to make sure she provides the best healthcare possible for patients, liking them to see her as part of their "extended family".

Dr Nigel Taylor,
GP Member

Valley Medical Practice

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 where he is also the clinical lead for respiratory medicine, a role he also holds on the CCG.

Nigel dedicated to effective prescribing locally and a champion for better equity of care and improving the quality of prescribing across Calderdale.

Prior to joining the CCG, Nigel was one of the Practice Based Commissioning leads. In his spare time he is very active, enjoying walking, skiing and sailing. He also enjoys wine tasting.

Originally from Yarm in North Yorkshire, Nigel has lived in Calderdale with his wife and two daughters since joining his practice.

Nigel is a member of the Quality Committee

Dr John Taylor,
GP Member

King Cross Surgery

Dr John Taylor, 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.

Dr Taylor believes that putting the patient at the centre of decision making regarding service redesign is the key to success. He is the CCG lead clinician for the redesign of the Intermediate Tier Services which involves close working with Local Authority and Secondary Care colleagues as well as patient representatives and other key stakeholders.

He is also a member of the Finance and Performance Committee.

Dr Majid Azeb,
GP Member

Southowram Surgery

Majid studied medicine at the University of Liverpool and qualified in 1999 before moving into general practice in 2005. He has been a partner at Southowram Surgery for the last seven years.

As well as his practice role, Majid holds a number of lead roles within the CCG including urgent care and non- elective care which put him at the heart of developing services in these areas. He also sits on the Audit committee.

Away from medicine, Majid has many past times including playing five-a side football and also growing his own vegetables which he has also been teaching his children about.

Majid grew up in Halifax and has strong ties to the Park Ward area of the town.

Kate Smyth,
Lay Member
(Public and Patient Involvement)

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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 provides 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 full time wheelchair user, Kate (and her trusted assistance dog Hal), has direct experience of how the delivery of health and care services impact on patients and service users. Kate 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.

Kate is a member of the Audit and Quality Committees and chairs the Remuneration Committee.

Jackie Bird,
Registered Nurse

Jackie has the statutory role of 'Registered Nurse' on the CCG's Governing Body. She is seconded to this role for the equivalent of 2.5 days per month, from her substantive position as Executive Director of Nursing & Quality at The Christie NHS Foundation Trust.

Jackie is a member of the Audit Committee at the CCG.

Prior to commencing at Christie's, Jackie was Chief of Quality and Standards and Chief Nurse at the Rotherham NHS Foundation Trust and prior to this she was the Deputy Director of Nursing and Governance at Salford Royal NHS Foundation Trust. Her 'Registered Nurse' role allows her to develop her long standing interest in patient safety, patient experience and clinical outcomes from a commissioning perspective.

Jackie was awarded a Florence Nightingale Leadership Scholarship in 2013 and has used her scholarship to investigate the development of a 'kite mark' for patient experience. Jackie is the elected Director of Nursing representative on Health Education (NW) Board. A registered nurse and a mental health trained nurse, she holds an honours degree in nursing studies and a Masters in Management and Leadership.

Sanjay Suri,
Secondary Care Specialist

Dr Sanjay Suri MBBS,MD (Paeds), MRCPI,FRCPCH, has the statutory role of 'Secondary Care Specialist' on the CCG's Governing Body. Sanjay is a Consultant Paediatrician working at The Rotherham NHS Foundation Trust since 2000. He qualified from the University of Poona in India in 1985 and completed his postgraduate degree in Paediatrics (MD) in India before travelling west to Ireland and then to the UK in 1993. He completed most of his UK training in Yorkshire.

He has a keen interest in Medical education and is the Royal College Tutor in Paediatrics, Honorary Senior Clinical lecturer, University of Sheffield and Training Programme Director, Health Education Yorkshire and Humber for ST1-3 trainees. He was Clinical Director Children's Services Rotherham from 2009-2012

He is keen on developing team working, patent safety initiatives and communication at the interface between primary and secondary care.

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

John joined the Clinical Commissioning Group having been a Non-Executive Director of Calderdale Primary Care Trust since 2009. He saw the CCG safely through authorisation as Deputy Chair and Chair of Audit before becoming the Lay Advisor from 1st November 2014.

John is currently 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 period as Business Operations Manager for Dixons Stores Group International.

John is a Lay Advisor on the Audit Committee and a member of the Finance and Performance Committee. John has acted as an advisor to the Remuneration Committee since 1st April 2013 and became a full member in January 2014.

Penny Woodhead,
Head of Quality Advisor to Governing Body

Penny has worked in the NHS for 25 years, trained as a general nurse in a London teaching hospital, specialised in oncology and palliative care and has experience clinically and managerially across tertiary, secondary, primary care and the voluntary sector.

Penny has also been involved in clinical governance since 1998 at service and organisational level.

Penny's role within the CCG is as Head of Quality and Safety and 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's hobbies are exercising at the gym, walking and spending time with her family.

Penny is a member of the Quality Committee.

NHS Calderdale Clinical Commissioning Group

Governing Body and
Audit, Finance and Performance, Quality and Remuneration Committees

REGISTER OF INTERESTS

Name	Own interests	Interests of family members and close associates
Dr. Alan Brook	GP Principal at Longroyde Surgery, Rastrick, Brighouse	Spouse is an employee of Mid Yorkshire Hospitals Trust (Dewsbury)
Dr. Majid Azeb	Director of M & N Medicals Ltd (a company not believed to have any direct dealings with the NHS) GP Principal at Southowram Surgery, Halifax A member of the LMC	Brother is an employee of Calderdale and Huddersfield NHS Foundation Trust
Jackie Bird	Executive Director of Nursing and Quality at the Christie NHS Foundation Trust Elected nurse representative for Health Education England North West Volunteer at Willow Wood Hospice, Ashton-Under-Lyne	No interest declared
Dr. Hazel Carsley	GP Principal at Boulevard Medical Practice, Halifax	Mother is resident in a Calderdale Nursing Home Spouse is an employee of Calderdale Metropolitan Borough Council
Dr. Steven Cleasby	Director of Ryecroft Medicines Management Solutions GP Principal at Spring Hall Group Practice, Halifax	Spouse is an employee of Parents & Carers - Calderdale
Dr. N. Peter G. Davies	GP Principal at Keighley Road Surgery, Halifax Provost of Yorkshire Faculty of Royal College of General Practitioners Member of Royal College of General Practitioners' Council Trustee of Royal College of General Practitioners, London	No interests declared

Julie Lawreniuk	Employed jointly as Chief Finance Officer of both NHS Calderdale Clinical Commissioning Group and NHS Greater Huddersfield Clinical Commissioning Group	No interests declared
David Longstaff	Magistrate, West Yorkshire Chairing of Mental Health Tribunals in West Yorkshire Chairing of School Appeals	Spouse is a Kirklees Council Manager, Gateway to Care
John Mallalieu	Director of Social Enterprise – Turning Point (a provider of Health and Social Care services across England and Wales but not presently providing services to NHS Calderdale) Independent Steering Group Member of Orangebox Young People's Centre, Halifax	No interests declared
Dr Sanjay Suri	Consultant Paediatrician at Rotherham District Hospital	No interests declared
Kate Smyth	Secretary of Disability Partnership Calderdale (a user-led organisation of people with physical and/or sensory impairment) Member of Calderdale and Huddersfield Foundation Trust (member only in the capacity of a Calderdale resident and not serving on the Membership Council) Volunteer at Calderdale Royal Hospital and Huddersfield Royal Infirmary Independent Board Member of Kirklees Neighbourhood Housing	Spouse is a consultant at DLA Piper Solicitors (although the organisation deals with NHS related matters, the spouse does not practice in the NHS field) Sister in law is an employee of Pennine Acute Hospitals NHS Trust
Dr. John Taylor	GP Principal at King Cross Practice, Halifax Provider of primary care to 15 intermediate care beds at Brackenbed View, Fernside and Bankfield Care Homes Occupational health Physician to Aquaspersions Limited (the company does not have any NHS contracts)	Spouse is an employee of King Cross Practice, Halifax Sister in law is an employee of Northolme Practice, Halifax Stepson is an employee of Hear Care, Specsavers, Barnsley
Dr. Nigel Taylor	GP Principal at Hebden Bridge Group Practice	Spouse is an employee of Bradford Teaching Hospital NHS Foundation Trust
Dr. Matt Walsh	Ownership of a $^{2}/_{9}$ share of premises at Thornton Medical Centre, Bradford (a GMS practice with a Bradford contract)	Spouse is an employee of Calderdale and Huddersfield NHS Foundation Trust

PART TWO

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 the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including 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) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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 *Manual for Accounts* 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 *Manual for Accounts* 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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Dr Matt Walsh
Accountable Officer, 5 June 2014

GOVERNANCE STATEMENT

NHS Calderdale Clinical Commissioning Group

Governance Statement

By Dr Matt Walsh as Accountable Officer

Introduction and context

The Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

The Clinical Commissioning Group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2013, the Clinical Commissioning Group was licensed without conditions.
Since the 1st April, the CCG has been able to build on the strong foundations put in place over the previous 18 months due to:

- Transition from a single Primary Care Trust
- High degree of continuity in terms of Clinical Commissioning Executive Members and staff
- Shared geography with Calderdale MBC
- Good partnership working with our main providers and the Calderdale MBC
- Good partnership working with the independent and third sector.

Over the past year, the CCG has further developed close partnership working with the Local Authority and main providers through the Strategic Review delivering Right Care at the Right Time and in the Right Place. This is a joint transformational programme across seven key organisations in Calderdale and Greater Huddersfield.

The CCG also shares a number of its management team with Greater Huddersfield CCG bringing greater efficiencies. It is these relationships that put us in a strong position to deliver the level of transformational change that will be required to meet the needs of our local populations and financial challenges over the next few years.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.
I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the Clinical Commissioning Group's compliance with the principles set out in Code. For the financial year ended 31 March 2014, and up to the date of signing this statement, we have complied with the principles set out in the Code in the main. However we have only partially complied with some of the principles and have identified a number of actions which will be taken forward by the CCG in 2014-15 in order to ensure full compliance.

These actions include:

- Ensuring arrangements in place to ensure that Governing Body members, on resignation, provide a written statement to the chairman, for circulation to the board, if they have any ongoing concerns about the Governing Body. (A4.3).

- Keep under review the balance of independent lay members and other governing body members (B1.2).

- Review our governance arrangements for the process of election/appointment to the Governing Body and for evaluating the balance of skills, experience, independence and knowledge of Governing Body and sub-committee members (B.2).

- Review the need for an externally facilitated evaluation of our Governing Body every 3 years.

- Review the requirement for a two yearly review of the continued effectiveness of internal audit.

We will be including these actions into our Governance work plan for 2014/15.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it 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.

Key Features of the CCG Constitution in relation to Governance

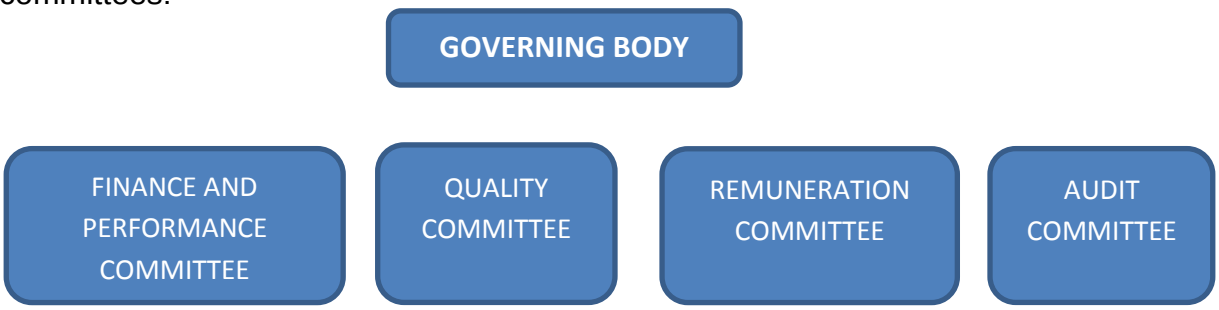
The Governance Framework for NHS Calderdale CCG is clearly set out in our Constitution. It contains the principles of good governance and internal control by which we operate, these principles include:

- Operating to the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- Compliance with the Good Governance Standard for Public Services;
- Compliance with the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles;
- Compliance with the seven key principles of the NHS Constitution and with the Equality Act 2010

The key elements of the CCG's Constitution relating to the organisation's governance and internal control are:

- Decision making: The Governance Structure
- Roles and responsibilities
- Standards of Business Conduct and managing conflicts of interest
- Transparency, ways of working and standing orders
- Scheme of reservation and delegation

The governance structure for the CCG comprises the Governing Body and four sub-committees:



The membership of the Governing Body and its sub-committees, together with the attendance record is set out Appendix 1 at the end of this Governance Statement. Details of the membership and attendance of the Remuneration Committee is set out in the Remuneration Report. Attendance at the Governing Body and sub-committees throughout the year has been strong and all meetings have been quorate, except for the Finance and Performance Committee which was not quorate on one occasion.

Work of the Governing Body and Sub-Committees

The main function of the Governing Body as set out in the Health and Social Care Act 2012 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 as outlined above.

The membership currently comprises the Chair; seven GPs (including the chair) as elected by the 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); one registered nurse; one secondary care specialist; the Accountable Officer and the Chief Finance Officer.

The Executive Director of Public Health and the Director of Adult Health and Social Care Services, Calderdale Council also attend the Governing Body as advisors. The role of these individuals is to support the CCG in taking forward key elements of the health and wellbeing agenda, ensure good communications, strong relationships and an integrated approach to commissioning.

In November, following the approval of a variation to the CCG Constitution by NHS England, the CCG formalised the attendance of the Head of Quality as an advisor and added the role of lay advisor (finance, performance and external relations) to the Governing Body. These appointments confirm the importance placed by the CCG on

quality, safety and patient engagement as well as strengthening the degree of lay scrutiny on the Governing Body; improving its overall effectiveness.

Coverage of Work by the Governing Body

In 2013/14, the Governing Body met in public on nine occasions.

The CCG held its establishment meeting on the 11 April 2013 where it received a range of reports covering authorisation and establishment of the governance arrangements of the CCG; Corporate and Quality Legacy and transfer documentation; Planning documents including the Assurance Framework and policies; commissioning plans 2013/14, financial plans and budgets for 2013/14.

During the year, the Governing Body has considered a suite of performance reports at each planned meeting. These include finance, QIPP (Quality Innovation, Prevention and Productivity) and contracting, quality and safety and performance. These reports are submitted to the Governing Body following a detailed review in the Finance and Performance or Quality Committees. This enables the Governing Body and the CCG to maintain a high degree of rigour in its management of quality, safety, finance and performance – including performance against contract for clinical and non-clinical services.

Other areas of work covered by the Governing Body include:

Governance

- Assurance Framework, High Level Risk Log and Report
- Committee Terms of Reference and Policies
- Variation to the CCG Constitution
- Minutes from sub-committees other groups reporting into the CCG

Work with the CCG membership

Quality and safety

- Safeguarding and Francis Inquiry reports
- Public and patient experience and engagement reports
- Equality Objectives

Strategic and financial planning

- Business planning and investment of resources
- Strategic Review Programme updates
- Unplanned care review
- Procurements
- Financial plans and budgets

Governing Body Performance

At the time of writing, the CCG is on track to deliver against its key NHS Constitution duties and its key statutory financial duties. There has been an unremitting focus upon the delivery of key performance targets and key financial and contractual requirements through the year. The CCG is in a strong financial position moving into 2014-15.

Governing Body and Sub-Committee Effectiveness

Ensuring that the Governing Body and its sub-committee are working effectively is key to our ability to achieving our statutory duties, strategic priorities and strong financial position. Throughout the year we have held Governing Body development sessions as well as monthly meetings of the commissioning development forum.

The aim of these sessions is two-fold:

- To provide members with sufficient knowledge to understand the key financial, strategic and performance issues facing us,
- To continue to develop the skills needed, ensuring the right degree of scrutiny and challenge on critical and sensitive matters.

Towards the end of the year we carried out our annual self-assessment of committee performance and for the first time conducted a self-assessment on Governing Body effectiveness. The Governing Body self-assessment was based on national guidance on effective governing bodies and healthy Boards.

Some of the key strengths that have been identified through the Governing Body and committee self-assessments are:

- A clear understanding of our roles and responsibilities
- A strong culture of openness and transparency in our decision making.
- A high level of scrutiny and rigour across our work.
- A strong focus on patient safety and high quality services
- We have seen real value in the way that we bring together discussions about performance and contracting with the insights that clinicians bring on pathways and patient experience.
- A robust risk management system
- A real commitment to continually improve our effectiveness and performance

We have also identified a number of areas for development as we move forward:

- Providing training and support to ensure that all Governing Body and committee members are able to provide high quality scrutiny and challenge across the breadth of the CCG's agenda.

- Strengthening the skills and knowledge of our Governing Body and committee members as well as staff,

- Continuing to embed the understanding of what it means to be a membership organisation for both the members and the Governing Body.

- Increase the focus on developing future clinical leaders and talent management.

- Continue to develop the way that we learn from public and patient engagement and experience.

- Implement the recommendations made by the internal auditors about the ways in which we can develop the Assurance Framework as part of the development of our systems of internal control.

We will continue our focus on developing these areas next year.

Developing as a Membership Organisation

During the year NHS Calderdale CCG joined forces with NHS Greater Huddersfield CCG and invited Ashridge Business School to help us develop an understanding of what it means to be a membership organisation. This work included the development of a membership agreement and a competency based toolkit for developing a High Performing Membership Organisation. All the practices have signed up to the Agreement and the Toolkit which will help shape the culture, behaviours and relationships across the CCG. It will also enable us to further develop structures and systems to safeguard transparency, accountability, value for money and good governance.

We will be building on this work with the Governing Body, its committee and with the wider membership in 2014/15. All this work, together with the development of our staff, will be brought together in a single organisational development plan over the next few months.

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 duties and responsibilities of the committee are set out in their terms of reference.

The membership of the committee is set out in appendix 1. In addition, 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 but one occasion.

A Lay Advisor role was established in November, following a review of the terms of reference. The Lay Advisor has a specific focus upon the finance and performance agenda.

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 completed in full. Each month, the Committee receives and scrutinises reports on finance, contracting, QIPP (Quality, Innovation, Productivity and Prevention) and performance. It also reviews the finance, performance and corporate risks every second month.

The Committee's terms of reference were reviewed in September 2013. The review found that changes were necessary in order to clarify the quoracy arrangements and rationalise membership. This has enabled the committee to deliver its business more effectively.

Finance and Performance Committee Highlights

Unremitting focus upon the delivery of key performance targets

Improved effectiveness by amendment of terms of reference and addition of lay advisor on finance and performance

Strong financial position moving into 14/15 and 15/16 due to financial grip by the committee and CCG

Commissioner approach to delivery of QIPP sharpened achieving £4m target.

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 responsibilities are set out in the terms of reference.

The members of the committee are set out in appendix 1 attached to this report. They are supported by the attendance of the Head of Primary Care Quality and Improvement, Head of Service Improvement, a Clinical Associate for Patient Safety and a public health representative from Calderdale MBC. 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 the annual work plan and has been completed in full.

The types of activities undertaken by the Committee include monitoring, reviewing, receiving and providing assurance, and supporting improvement in the areas of patient safety, clinical effectiveness, patient experience, governance and scrutiny of quality data.

Quality Committee Highlights

Robust contribution to governance arrangements across all aspects of quality.

Overseeing the patient and public engagement work on 'call to action' obtaining 280 contributions and on unplanned care obtaining 2,500 views

Provision of leadership and direction on the quality work of the organisation

Overseen the CCG's contribution to the joint safeguarding work for adults and children

Remuneration Committee

The Remuneration Committee has two key functions:

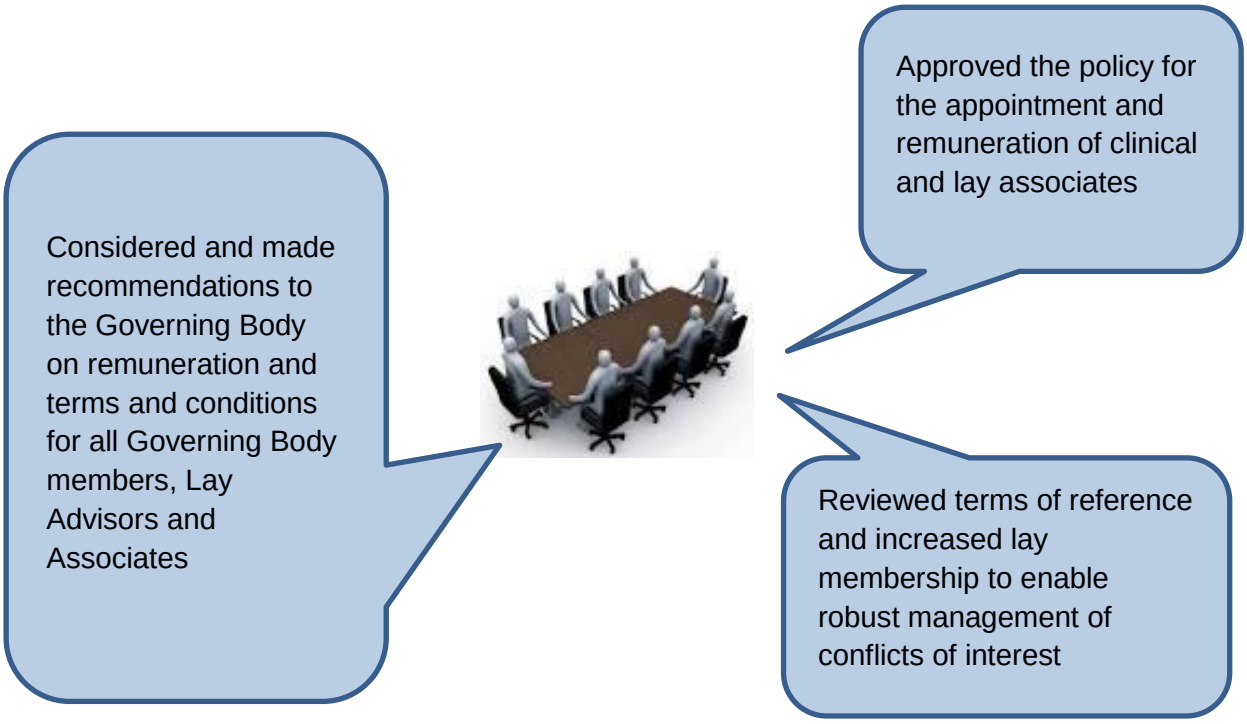
- It advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; provisions for other benefits and allowances under any pension scheme. It also includes any arrangements for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

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

Four meetings were held in 2013/14 all of which were quorate.

The Remuneration Committee reviewed their terms of reference in November. The amendments, which were approved by the Governing Body in January 2014, improved the effectiveness of the committee by inviting the Lay Advisor (Finance, Performance and External Relations) to become a member. The members of the committee are set out in the Remuneration Report. The Committee is supported by the attendance of the Chief Finance Officer, the human resources specialist from the Commissioning Support Unit, The Chair of the Audit Committee in an advisory capacity only between 1 April 2013 and 31 October 2013. The committee is also supported by either the Corporate and Governance Manager or the Governance Lead.

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 audit, risk management, information governance and business continuity.

The committee meets every second month with additional meetings being held as business requires. The members of the committee are included at appendix 1 to this Governance Statement. The committee is supported by the attendance of the Chief Finance Officer, the Corporate and Governance Manager and Governance Lead and the external and internal auditors. The committee has been quorate on all occasions.

The terms of reference were reviewed in November and as a result the committee was strengthened by the attendance of the Lay Advisor (Finance, Performance and External Relations). This position was confirmed as a non-voting member of the committee following approval of the amended terms of reference at the Governing Body in January 2014. The addition of the Lay Advisor ensures a majority of independent lay members on the Audit Committee.

Audit Committee Highlights

The Committee has worked well in providing assurance and keeping the organisation safe.

Head of Internal Audit Opinion provided significant assurance 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 Committee oversaw the variation to the CCG's constitution

The Audit Committee in shadow form reviewed the end of year accounts for 2012/13 to gain learning for 2013/14.

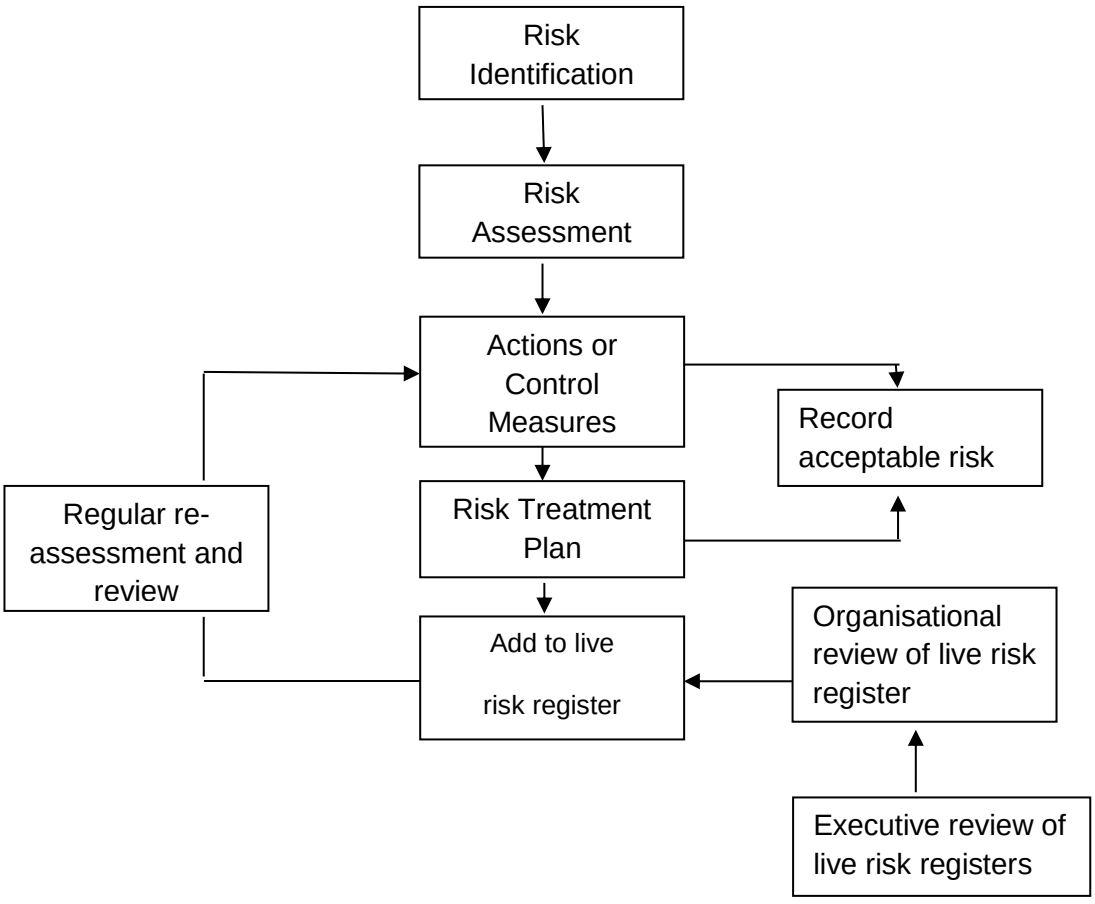
The Committee has overseen the achievement of Level 2 compliance with the Information Governance Toolkit.

The Clinical Commissioning Group Risk Management Framework

The CCG Governing Body established its governance structures and systems of internal control in April 2013. This system includes a Governing Body Assurance Framework and a comprehensive and Integrated Risk Management Framework (IRMF). Detail of the Assurance Framework is contained in the section on the Internal Control Framework later in this Governance Statement. I have set out a description of the CCG's risk management framework and risk control system below.

The IRMF describes our approach to managing all risks and has five key objectives:

1. Appropriate and effective systems in place to identify, report and manage risk



Risk can only be managed if it is identified. Triangulation of soft and hard 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 and quality dashboard data

- Compliance with regulatory requirements such as Ofsted reviews, Care Quality Commission, Parliamentary Ombudsman, information governance systems.

- Routine review of serious incidents, incident reports and complaints

- Intelligence through partner networks and from stakeholders

- Early warning on serious or major adverse events.

- Risk review and discussion through operational groups and formal meetings, e.g. Senior Management Team, Governing Body and sub-committees which highlight problems and issues that should be reflected in the Risk register;

Risk Assessment is a structured process used to:

- Identify a risk;

- Understand its potential impact;

- Examine what control measures can be applied and their effectiveness;

- Decide if further actions are necessary other than control measures;

- Score Risks and categorise the potential of any outstanding risk after the above processes.

Staff record their risks on the single corporate Risk register which is a server based system that was developed by Calderdale Primary Care Trust and transferred to the Commissioning Support Unit as part of the transition arrangements. The online system allows staff to actively monitor their risks and manage actions to mitigate against the risk.

In preparation for the formal establishment of the CCG on 1 April 2013, all risks relevant to the CCG were transferred across onto the corporate risk register. In this way, the CCG remained sighted on risks across the Calderdale health economy during transition to the new commissioning arrangements.

Whilst the on-line risk register is a live system, a formal review of risks is carried out every eight weeks. The Senior Management Team reviews and oversees the management of risks as part of the risk cycle. They review the Risk register to:

- Assess the appropriateness of the risk score, controls and assurance

- Identify any new risks. Triangulation of soft and hard information from different sources is used to provide assurance that all significant risks have been captured.

Following review by the Senior Management Team; the Finance and Performance and the Quality Committees scrutinise the risks in line with their terms of reference. This ensures that the CCG benefits from a clinical, lay and managerial view of risks across the organisation and health economy.

The Audit Committee maintains an overview of the adequacy and effectiveness of the integrated risk management system. It is also responsible for reviewing risks scored as 'high' or above. The High Level Risk register and report is presented to the Governing Body at the end of each risk cycle.

In terms of risk appetite, the High Level Risk Log and Report with all risks scored as 12 or above (ie, categorised as high, serious or critical) is reviewed by the Audit Committee and any risks deemed to be serious or critical (i.e. 15 or above) are reviewed by the Governing Body.

2. Effective processes to capture and learn from mistakes to reduce future risks

An effective risk management process learns from experience so that risks do not reoccur. There are two main elements to this objective:

a) Learning from experience in the organisations

Our predecessor organisation - NHS Calderdale Primary Care Trust worked hard to embed a culture that encouraged the following principles in the reporting and management of risks:

- People to work together to recognise and effectively manage risks;
- An improvement philosophy – when things go wrong we want to learn from them;
- Honesty and openness;
- The involvement of patients, partners, stakeholders , families and staff in our learning processes;
- Appropriate response in our investigations when things go wrong.

Our CCG is committed to a continuation of these principles.

Valuable learning information can be identified through a variety of systems and activities. The CCG has robust processes in place to capture this learning:

- Reviewing the risks as they are closed to identify any learning for the future.

- Reporting and investigation of incidents, complaints and claims using root cause analysis to identify underlying issues which require improvements or interventions to reduce the chance of reoccurrence. The reporting of all incidents or near misses is encouraged across the organisation and in services that we commission. Incidents and near misses are recorded on the online system – DATIX, together with actions taken to mitigate against a re-occurrence. Reports on clinical incidents are taken into the Quality Committee and in March 2014, we started reporting the numbers of corporate incidents by category to the Audit Committee. These include breaches/near misses under the Data Protection Act. This information informs plans to prevent a re-occurrence as well as the information governance work plan for 2014/15.

- Triangulation of intelligence on complaints, incidents and claims with soft intelligence and feedback from stakeholders.

- The completion and review of 'learning logs' following the close down of major projects or programmes.

b) The collation of information sources to identify and implement best practice where applicable. Examples of data sources are listed below:

- National Patient Safety Agency (NPSA) guidance and learning from accidents will be implemented into organisational systems and procedures.

- Feedback from external reviews of organisational systems e.g. internal audit, external audit, independent audit of our support services, Care Quality Commission reviews, Ofsted, Health and Parliamentary Ombudsman.

- Using local or national professional networks to identify best practice and benefit from the experience of others.

- Research and guidance published by professional bodies.

- Recommendations from external investigations and formal enquiries.

Using these principles and processes to capture and learn from risks ensures that risk management is firmly embedded within everything that the CCG is involved in.

3. An effective accountability framework for the management and reporting of risk in place

The accountability arrangements in place consist of two elements:

a) Effective internal governance arrangements for risk management and reporting through the sub committees and into the Governing Body as described above.
b) Accountability to the NHS England for the operational management of risk.

4. To provide sufficient evidence and assurance to ensure compliance with relevant external assessment and best practice

The Risk Management Framework is designed to support the collection of evidence to comply with external assessments and best practice by, for example:

- Scheduling programmes of work for baseline self-assessment for key areas of compliance e.g. Care Quality Commission standards

- Scrutiny of the effectiveness of the Governance arrangements by the Audit Committee.

5. Risk management arrangements in place for key partnerships and major projects

The key partners for the CCG include a number of NHS providers, Calderdale MBC, independent contractors including Locala Community Interest Company and the voluntary sector.

In addition to having robust internal scrutiny arrangements; the organisations are required to contribute to joint "Risk registers" and frameworks with partner organisations. This recognises the need to manage risk across organisations and partnerships to deliver whole system change and improvement.

In addition, major programmes such as the Strategic Review, the Urgent Care Board and the Better Care Fund have their own programme management and governance arrangements which include a risk register and reporting systems. These risk registers contain risks for all the stakeholders associated with the programme.

There is a clear link between the risks captured on the programme risk registers and those that may have an impact on the CCG's ability to deliver its objectives. These risks are also captured on the CCG corporate risk register.

The CCG's key control mechanism of the risk register is complemented by a range of other control mechanisms designed to deliver assurance on the prevention of risk and management of current risks. These include:

- The CCG has approved an Anti-Fraud, Bribery and Corruption Policy, which has been reinforced by mandatory training for both employees and Governing Body Members. There is a clear link on our intranet for all staff to be able to confidentially report suspected fraud.

- The CCG has a Business Continuity Plan in place, which sets out the CCG's contingency plans to maintain an effective service in the event of a critical incident.

- The CCG undertakes regular health and safety, fire and premises risk assessments to help prevent risk.

- The CCG commissions the CSU to provide equality and diversity expertise, guidance and support to ensure that we are compliant with the Equality Act 2010 Public Sector Equality Duty.

  All CCG staff participate in equality & diversity training, with staff directly involved in commissioning work attending a two hour session which describes the implications of the Public Sector Equality Duty for people commissioning health services and other staff completing an e-learning course. This means that staff can identify CCG policies, Governing Body papers and improvement programmes that will need a detailed equality impact assessment (EIA) to identify and mitigate any potential adverse impact on any group of local people with an Equality Act protected characteristic – age, disability, gender reassignment, marriage or civil partnership, pregnancy & maternity, race, religion or belief, sex and sexual orientation.

  In addition, the equality and diversity manager has provided a bespoke session for the Governing Body members focusing on their role in relation to the Equality Act, ensuring that they are able to provide the level of scrutiny and challenge required.

The Clinical Commissioning Group Internal Control Framework

The system of internal control is the set of processes and procedures in place that ensures that the CCG delivers its statutory functions, policies, aims and strategic objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The Assurance Framework, which was approved by the Governing Body in April, is the key source of evidence that links strategic objectives to risks and provides the CCG with a simple but comprehensive method for the management of the principal risks and assurances associated with the strategic objectives.

Unlike the Risk Management Framework - which records all risks that materialise, is highly dynamic and requires regular reporting - the Assurance Framework contains a relatively small number of strategic objectives which are largely derived from the business plan and therefore are unlikely to change over time. As a consequence the principal risks in the Assurance Framework need to be sufficiently significant to prevent the objective being achieved and will rarely change.

An audit was undertaken by West Yorkshire Audit Consortium which concluded that NHS Calderdale CCG has developed and improved its Assurance Framework over the last few months. This means that the Governing Body is in a better position to see clearly its key strategic risks, controls, gaps and assurances. It is reviewed bi-annually by the Audit Committee to ensure that it is regularly updated and has been received and reviewed by the Governing Body in April 2013 and January 2014.

There were two issues identified during the review, both of which have now been addressed:

- assurances were noted as not being very specific; and
- lack of evidence of action plans being in place to address the identified gaps in assurances.

Information Governance

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

The CCG is taking appropriate steps to ensure compliance with information governance standards in relation to the management of information in line with the requirements of the Information Governance (IG) Toolkit (version 11). The CCG has attained a level 2 or above in all the requirements against the IG Toolkit with an overall grade of satisfactory.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The roles of Senior Information Risk Owner, Caldicott Guardian and Information Governance lead have been assigned. The CCG is supported by the West and South Yorkshire and Bassetlaw Commissioning Support Unit Information

Governance Team, which is an experienced team of experts and offers advice and assistance on all areas of information governance. Information governance assurance is provided through quarterly reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving data security) and any actions to mitigate.

Information Governance compliance is managed and controlled through the implementation of the organisation's Information Governance Framework and annual Information Governance Improvement Plan which includes a programme of work around Information Asset Risk Management.

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

There is an effective system in place to for incident capture, reporting and investigation of serious incidents including those relating to Information Governance security incidents and near misses. There have been no serious untoward Information Governance security incidents.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity & Human Rights Obligations

Control measures are in place to ensure that the Clinical Commissioning Group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable Development Obligations

The Clinical Commissioning Group is required to report its progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.
We will ensure the Clinical Commissioning Group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

Risk Assessment in Relation to Governance, Risk Management & Internal Control

Risks 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 annual review of the CCG constitution, new national guidance or regulations, external inquiries such as the Francis review or the Winterbourne Review.

- Through the identification of targeted work by the **West Yorkshire Audit Consortium** as part of the annual work plan, which focus on areas within the organisation that require strong governance and risk management arrangements in place.

- Through **external audit** throughout the year by KPMG which includes attendance at the Audit Committee, meeting with Audit Committee members twice a year to discuss any concerns without the executive being present and focused pieces of external audit work as set out in the auditors annual work plan, culminating in the risk review undertaken prior to annual reporting and accounts.

The outputs and recommendations from each of these reviews are presented to the Audit Committee. In year, these reviews have made recommendations which have led to a number of improvements, for example; the Assurance Framework; a variation to the CCG Constitution – strengthening the independent lay scrutiny at the Governing Body and in the sub-committees; the amendment of committee terms of reference to improve the effectiveness of working and quoracy arrangements; an improvement in the governance arrangements on PENPALS.

We will continue to implement the recommendations in order to develop our systems and processes in 2014/15.

Major Risks to Governance, Risk Management and Internal Control

The major risks to governance, risk management and internal control identified in-year are summarised as:

Risks classed as 'serious' on our risk register, i.e. with a score of 15-16 or above

Risk	Action to manage	Assessment of outcome
There are a number of risks associated with the WYSBCSU associated with the introduction of the new arrangements, leading to an inability of the CSU to deliver the service required by the CCG.	Continue to build relationships between the Senior Management Team and the CSU; performance manage the contract; Lay Advisor to provide for scrutiny at contract meetings.	Monthly heat map reporting responsiveness, delivery and value for money. Closed February 14 as risk moved from transition into maintenance with a lower risk score.
Capacity and capability of the different Governing Body members to provide the necessary level of scrutiny.	Continue to develop skills and experience through a variety of mechanisms including training, shared development sessions and personal development. Additional capacity and capability brought by new Lay Advisor. Increase capacity and talent management through member practices.	Committee and Governing Body self-assessments reporting greater understanding of business of CCG, roles and responsibilities and confidence ability to deliver.
The clarity of where the responsibility lies for different statutory functions under the NHS reforms.	Clarity achieved through national guidance. Close partnership working across the new organisations to ensure seamless service.	**Closed -** Clarity achieved. Good multi-agency working leading to effective delivery of services.
13/14 Financial Plan includes a number of pressures/risks which may impact in failure to deliver control total.	Plans approved by the Governing Body and performance managed through Finance and Performance Committee and the Governing Body. Contingency budget in place.	Control total delivered. Risk updated for 2014/15 and risk score reduced from 'serious' to 'high'
CCG may not have the appropriate systems and processes in place to ensure the system model is affordable going forward. This may result in the non-achievement of control total and/or failure to achieve QIPP targets.	Performance management through the Finance and Performance Committee. Medium Term Financial Planning in place. Clinical and provider engagement.	Robust performance monitoring and management. Achievement of control total and QIPP targets.
Avoidable Health Care Acquired Infections (HCAIs) are not prevented, and	Performance managed through Quality Board and Contract Board.	Evidence that lessons learned are implemented leading to the prevention of

lessons learned are not implemented, 13/14 objective is zero tolerance for all avoidable case	Performance reports to Quality Committee and Governing Body.	avoidable HCAIs
New provisions regarding the use of patient identifiable data for secondary purposes leading to delays in invoice validation and obstacles to service improvement work such as risk stratification.	Use of CSU with ASH accreditation allowing the required pseudonymisation of data flows.	Compliant with regulations and delays in invoice validation and service improvement removed.
Failure to deliver the performance metrics affecting the ability of the CCG to draw down national funding, reducing the range of services commissioned under the Better Care Fund.	Ensure robust governance and reporting arrangements in place. Performance reporting into the Finance and Performance Committee with assurance reporting to the Audit Committee.	Good project management and reporting ensuring robust performance management leading to delivery of performance metrics.

No major risks have been identified since 31 March 2014.

The CCG's Governing Body Assurance Framework describes the CCG's principal risks to its licence and being able to fulfil its strategic objectives.

	Principal Risk: failure to
1.1/ 1.2	Work sufficiently closely with partners and the HWB to develop strategies for preventing people from dying prematurely.
1.3	Communicate our strategic objectives for reducing mortality, affecting provider ability to respond effectively
2.0	Have strategies in place with partners that are fit for purpose to help people with long terms conditions
3.0	Have strategies in place with partners that are fit for purpose to help people recover and maintain independence
4.1	Measure patient experience at the right level
4.2	Use public and patient engagement and patient experience information in developing commissioning plans or service specifications
5.0	To ensure a safe environment and protect people from harm
6.1	Develop robust commissioning plans
7.0	Achieve strong financial control and best value for money
8.1	Understand all our statutory and other duties leaving the CCG open to challenge, waste of valuable resources and potential reputational damage.

Effectiveness of the Governance Structures

The CCG keeps under review the principal risks as set out in the Assurance Framework and in compliance with our licence. The Assurance Framework is kept under review by the Senior Management Team as part of the risk cycle. New risks

identified on the risk register are assessed to identify any impact of achieving our strategic priorities set out in the Assurance Framework.

An audit was undertaken by West Yorkshire Audit Consortium regarding integrated governance. The general objective was to provide assurance regarding the consistency of terms of reference for the various sub-committees and scheme of delegation with the approved constitution. No significant issues were identified however a recommendation was made for duties and functions stated within the CCG's Constitution to be adequately reflected in the terms of reference of the Governing Body and its sub-committees.

We will be implementing the recommendations made during the year by the internal auditors as part of our development of the Assurance Framework and risk management systems over the next year.

KPMG our external auditors conducted a review of our risk control system as part of the preparation for the review of final accounts. They reported no significant concerns as a result of this work.

The Responsibilities of the Senior Management Team and Committees

The CCG's principle risks to achieving our strategic objectives are set out in the Governing Body's Assurance Framework. Each of the principle risks has an identified senior manager, Governing Body clinical lead and named committee with responsibility.

Each senior manager lead together with the Governing Body Clinical Lead is responsible for regularly reviewing the risk, assessing the key controls for mitigating the risk and sources of assurance, identifying positive assurance and any gaps in control or assurance are identified as well as taking forward specific actions within the timescales outlined.

The roles and responsibilities of staff as risk owners, senior management team as reviewers are clearly set out in the Risk Management Framework. This ensures that there is clarity about the levels of accountability for the management and monitoring of risks. The senior management team is expected to ensure that there are robust control measures in place and that the appropriate assurances are generated.

Reporting lines and accountabilities between the Governing Body, its sub-committees and the Senior Management Team

The reporting lines and accountabilities are set out in the Integrated Risk Management Framework and reflected in committee terms of reference. As stated earlier in this report, the Senior Management Team undertakes the first formal review of all risks at the beginning of each reporting cycle and identifies any new risks or changes to risk score as they arise.

Following review by the Senior Management Team, the risk register is submitted to the appropriate committee for review. 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 Audit Committee requires assurance of the effectiveness of the risk management system and reviews the high level risk log and report, before recommending it as an accurate position statement to the Governing Body. These reports are received at each meeting.

Submission of timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's licence

The assessment of risks is a continuous process as set out earlier in this Governance Statement.

The degree and rigour of oversight the Governing Body has over the Clinical Commissioning Group's performance.

At each of its meetings, 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 (Quality, Innovation, Productivity and Prevention) and contracting report
- Quality and safety report and dashboard
- Performance Report
- High level Risk Log and report.

This level of grip, which has been supported by the detailed work of the sub-committees, has placed the CCG in a strong position to deliver its performance and financial targets this year.

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, financial and contractual matters as set out above. These, taken together with the opinions available from the work of the internal and external auditors to the Clinical Commissioning Group and the assurances from the Audit Committee, the Governing Body is able to make a determination on the economic, efficient and effective use of resources by the Clinical Commissioning Group.

Review of the Effectiveness of Governance, Risk Management & Internal

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

Capacity to Handle Risk

The CCG takes the identification and management of risks extremely seriously. As Chief Officer I am supported by the senior management team in ensuring that we have a positive and open approach to the identification of risk. Throughout the year we have reviewed the way that we record risks, carried out a separate review of risks that had been on the Risk register for over 12 months and risks where the score had not changed for a period of time.

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.

We are supported in the management of risks by the Commissioning Support Unit (CSU). The CSU provides expert advice on the use of the risk management system, identifies good practice from elsewhere and provides guidance to staff on the identification of risks and associated controls and assurances.

Over the next year we will be rolling out further training sessions on the management of risks as part of our learning and development programme.

Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit, Finance and Performance, Quality Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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 is involves the following:

- Governing Body keeps under review the systems of internal control through reports on risk management and the assurance framework as well as the performance, contracting, finance and quality reports.

- At a committee level the **Finance and Performance and Quality Committees** take responsibility for keeping under review the governance arrangements relating to finance, contracting, performance and clinical governance.

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

- **Auditors** External and internal auditors provide further assurance through the delivery of their annual work plan and providing assurance as well as recommendations on different aspects within the system of internal control.

- **Self-assessment** of the risk management system and committee governance arrangements undertaken on an annual basis.

- **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 the NHS Shared Business Services and West and South Yorkshire and Bassetlaw Commissioning Support Unit. Whilst some minor issues were raised in these reports, action plans are in place to address these and there is no significant risk to our internal control environment.

During the year no significant internal control issues were raised.

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of Internal Audit concluded that (the Head of Internal Audit Opinion in full is included at Appendix 2):

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

During the year the Internal Audit issued the following audit reports with a conclusion of 'limited assurance':

C03/2014 - PENPALS.

The CCG's Head of Primary Care Quality and Improvement requested a review to be undertaken on the PENPALS scheme. The audit was assigned a limited assurance opinion. The main reason for this was the lack of central monitoring of practice based training. An action plan was agreed with management. A follow up was undertaken on the revised process put in place in January 2014 which addressed the weaknesses highlighted in the original report. The opinion was therefore revised to significant assurance.

During the year, no audit reports were issued by the Internal Auditors with a conclusion of 'no assurance'.

Data Quality

The quality of data being presented to the Committees and the Governing Body has developed well over 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 patient experience. Themed reports enable the Governing Body and Committees to understand at a much more detailed level some of the issues operating around areas such as 111, Ambulance Service contract performance and the relationship between our performance on 18 weeks Referral to Treatment Time (RTT) and the management of acute service contracts. In a similar vein, the performance report has been extremely helpful in drawing the focus of the CCG towards key areas which require challenge. Recent discussions and agreements at the committee about performance on 62 day cancer waiting times have demonstrated the value of bringing together discussions about performance and contracting with the insights that the clinicians bring about pathways and the experience of patients. Those discussions have helped us to clarify the linked responsibilities of the Finance and Performance and the Quality Committees.

We are continuing to work with practices to develop the quality of data packs circulated for analysis within the five commissioning groups. The data packs contain benchmarked utilisation of secondary care services and prescribing information. The practices use this information to compare their activity within the commissioning group and across the groups to identify areas of good practice.

Over the next year we will continue to develop and refine this information to support practices in improving their care for patients.

Business Critical Models

In the Macpherson report 'Review of Quality Assurance of Government Analytical Models', published March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance framework is in place and is used for all business critical models. Business critical models were deemed to be analytical models that informed government policy. The

CCG can confirm that it has not developed any analytical models which have informed government policy.

Data Security

As outlined above, I am pleased to be able to report that we have submitted a satisfactory level of compliance with the information governance toolkit assessment. Detail of our information governance processes for the capture, reporting and management of incidents/near misses; including those relating to data security is set out in section "information governance" above.

We have no Serious Untoward Incidents relating to data security breaches.

Discharge of Statutory Functions

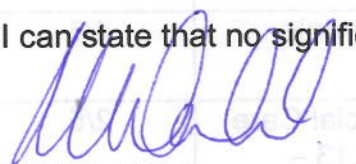
During establishment, the arrangements put in place by the Clinical Commissioning Group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to the appropriate member of the senior management team. The Heads of Service have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Conclusion

I can state that no significant internal control issues have been identified.



Dr Matt Walsh

Accountable Officer, 5 June 2014

Appendix 1

Governing Body and Sub-Committees

Membership and Attendance (1 April 2013 – 4 June 2014)

Governing Body		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair and GP member [3]	9/9
Dr Matt Walsh	Chief Officer (Accountable Officer)	7/9
Julie Lawreniuk	Chief Finance Officer	9/9
John Mallalieu	Lay Member and Deputy Chair (1.4.13 – 31.10.13)	4/5
David Longstaff	Lay Member and Deputy Chair (1.11.13 – present)	4/4
Kate Smyth	Lay Member (patient and public involvement)	9/9
Dr Steven Cleasby	Assistant Clinical Chair and GP member	7/9
Dr Majid Azeb	GP Member	8/9
Dr Hazel Carsley	GP Member	8/9
Dr Peter Davies	GP Member	9/9
Dr John Taylor	GP Member	6/9
Dr Nigel Taylor	GP Member	7/9
Jackie Bird	Registered Nurse	6/9
Dr Sanjay Suri	Secondary Care Specialist	7/9
Paul Butcher (non-voting member)[4]	Director of Public Health (Calderdale MBC) 1.4.13 – 18.9.13	4/5
Bev Maybury (non-voting member)	Director of Adult Health and Social Care Services (Calderdale MBC) 1.4.13 – 18.9.13	2/5

[3] All the GP members on the Governing Body also have the statutory title of 'Clinical Leader'.
[4] Paul Butcher and Bev Maybury were non-voting members of the Governing Body until a variation of the CCG's Constitution on the 19th September 2013, when they became advisors to the Governing Body.

Advisors to the Governing Body		
Paul Butcher	Director of Public Health (Calderdale MBC) 19.9.13 – present	3/4
Bev Maybury	Director of Adult Health and Social Care Services (Calderdale MBC) 19.9.13 - present	3/4
John Mallalieu	Lay Advisor (finance, performance and external relations) (1.11.13 – present)	4/4
Penny Woodhead	Head of Quality (19.9.13 – present)	4/4
Finance and Performance Committee		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair (and Chair of CCG)	12/14
Dr Matt Walsh	Chief Officer	14/14
Julie Lawreniuk	Chief Finance Officer	9/14
Dr John Taylor	GP Member	13/14
John Mallalieu	Lay Advisor (finance, performance and external relations)	13/14
Quality Committee		
Member	**Role**	**Attendance**
Dr Steven Cleasby	Chair and Assistant Clinical Chair	10/14
Dr Nigel Taylor	Governing Body member	12/14
Kate Smyth	Lay member	14/14
Penny Woodhead	Head of Quality	14/14
Audit Committee		
Member	**Role**	**Attendance**
John Mallalieu	Lay member and Chair of the Audit Committee (1.4.13 – 31.10.13) Lay advisor (1.11.13 – present)	8/8
David Longstaff	Lay member and Chair (1.11.13 - present)	4/5
Kate Smyth	Lay member	9/9
Dr Hazel Carsley	GP member (1.4.13 – 30.6.13)	1/1

Dr Peter Davies	GP member	8/9
Dr Majid Azeb	GP member	7/9
Jackie Bird	Registered Nurse	4/9

Appendix 2

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS CALDERDALE CCG FOR THE YEAR ENDED 31 MARCH 2014

Roles and responsibilities

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

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of 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 AGS requirements.

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

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My overall opinion is that;

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

The basis for forming my opinion is as follows:

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

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

<u>The design and operation of the Assurance Framework and associated processes.</u>

Throughout the year Internal Audit has liaised closely with the CCG with regard to its Assurance Framework and associated processes. The CCG has identified its objectives, risks, controls, sources of assurance and gaps in control/assurance and created an assurance framework. The assurance and risk management process have been reviewed during the year. Consequently I can conclude that the methodology surrounding the design and operation of the framework has been sound.

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

Internal Audit work is planned using a Risk Based Approach. The Audit Committee approved the annual plan at the start of 2013/14. This plan took into consideration the changing risk profile of the CCG in the period following its authorisation. Further the plan is derived from a combination of the risks highlighted in the Assurance Framework and from a separate Internal Audit and management assessment. This ensures that an audit plan is developed that is targeted towards the areas of greatest risk and allows Internal Audit to discharge its duties effectively.

In summary the Internal Audit reports issued in the year have generated the "significant assurance" opinion highlighted on the previous page. Whilst a significant overall opinion has been provided, attention is drawn to the fact that there has been one report issued in 2013/14 with a "limited assurance" opinion.

- C03/2014 - PENPALS. Management requested a review to be undertaken on the PENPALS scheme. The audit was assigned a limited assurance opinion. The main reason for this was the lack of central monitoring of practice based training. An action plan was agreed with management. A follow up was undertaken on the revised process put in place in January 2014 which addressed the weaknesses highlighted in the original report. The opinion was therefore revised to significant assurance.

Whilst the matters raised in this report are important they do not have a bearing on my overall significant opinion.

The Audit Plan has been delivered in full. Wherever variances from the plan have occurred these have been undertaken with the approval of the Chief Finance Officer and the Audit Committee. No departures from the plan that are material for the purposes of this opinion have occurred.

NIGEL BELL
HEAD OF AUDIT
May 2014

PART THREE

Annual Accounts

Annual Accounts

Independent Auditor's Report to the members of NHS Calderdale Clinical Commissioning Group

NHS
Calderdale
Clinical Commissioning Group

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2013-2014

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2014 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 2013-14

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	2,696
Other costs	5	262,807
Other operating revenue	2	(3,542)
Net operating costs before interest		261,961
Other operating revenue	8	0
Other (gains)/losses	9	0
Finance costs	10	0
Net operating costs for the financial year		261,961
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		261,961
Of which:		
Administration Costs		
Gross employee benefits	4	2,101
Other costs	5	3,661
Other operating revenue	2	(588)
Net administration costs before interest		5,174
Programme Expenditure		
Gross employee benefits	4	595
Other costs	5	259,146
Other operating revenue	2	(2,954)
Net programme expenditure before interest		256,787

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	0
Net gain/(loss) on revaluation of property, plant & equipment	0
Net gain/(loss) on revaluation of intangibles	0
Net gain/(loss) on revaluation of financial assets	0
Movements in other reserves	0
Net gain/(loss) on available for sale financial assets	0
Net gain/(loss) on assets held for sale	0
Net actuarial gain/(loss) on pension schemes	0
Share of (profit)/loss of associates and joint ventures	0
Reclassification Adjustments	
On disposal of available for sale financial assets	0
Total comprehensive net expenditure for the year	261,961

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	13	631
Intangible assets	14	0
Investment property	15	0
Trade and other receivables	17	0
Other financial assets	18	0
Total non-current assets		631
Current assets:		
Inventories	16	0
Trade and other receivables	17	444
Other financial assets	18	0
Other current assets	19	0
Cash and cash equivalents	20	11
Total current assets		455
Non-current assets held for sale	21	0
Total current assets		455
Total assets		1,086
Current liabilities		
Trade and other payables	23	15,871
Other financial liabilities	24	0
Other liabilities	25	0
Borrowings	26	0
Provisions	30	0
Total current liabilities		15,871
Total Assets less Current Liabilities		(14,785)
Non-current liabilities		
Trade and other payables	23	0
Other financial liabilities	24	0
Other liabilities	25	0
Borrowings	26	0
Provisions	30	0
Total non-current liabilities		0
Total Assets Employed		(14,785)
Financed by Taxpayers' Equity		
General fund		(14,785)
Revaluation reserve		0
Other reserves		0
Charitable Reserves		0
Total taxpayers' equity:		(14,785)

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

The financial statements on pages 1 to 4 were approved by the Audit Committee on 4th June 2014, under delegated authority from the Governing Body and signed on its behalf by:

Accountable Officer
Dr. Matt Walsh

Chief Finance Officer
Julie Lawreniuk

6/6/14

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	13	631
Intangible assets	14	0
Investment property	15	0
Trade and other receivables	17	0
Other financial assets	18	0
Total non-current assets		631
Current assets:		
Inventories	16	0
Trade and other receivables	17	444
Other financial assets	18	0
Other current assets	19	0
Cash and cash equivalents	20	11
Total current assets		455
Non-current assets held for sale	21	0
Total current assets		455
Total assets		1,086
Current liabilities		
Trade and other payables	23	15,871
Other financial liabilities	24	0
Other liabilities	25	0
Borrowings	26	0
Provisions	30	0
Total current liabilities		15,871
Total Assets less Current Liabilities		(14,785)
Non-current liabilities		
Trade and other payables	23	0
Other financial liabilities	24	0
Other liabilities	25	0
Borrowings	26	0
Provisions	30	0
Total non-current liabilities		0
Total Assets Employed		(14,785)
Financed by Taxpayers' Equity		
General fund		(14,785)
Revaluation reserve		0
Other reserves		0
Charitable Reserves		0
Total taxpayers' equity:		(14,785)

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

The financial statements on pages 1 to 4 were approved by the Audit Committee on 4th June 2014, under delegated authority from the Governing Body and signed on its behalf by:

Accountable Officer
Dr. Matt Walsh

Chief Finance Officer
Julie Lawreniuk

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	715	0	0	715
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted CCG balance at 1 April 2013	**715**	**0**	**0**	**715**
Changes in CCG taxpayers' equity for 2013-14				
Net operating costs for the financial year	(261,961)	0	0	**(261,961)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	**0**
Net gain (loss) on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	0	0	**0**
Net actuarial gain (loss) on pensions	0	0	0	**0**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	0	0	0	**0**
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial	0	0	0	**0**
Transfers by absorption to (from) other bodies	0	0	0	**0**
Transfer between reserves in respect of assets transferred under absorption	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	**0**
Net Recognised CCG Expenditure for the Financial Year	(261,246)	0	0	**(261,246)**
Net funding	246,461	0	0	**246,461**
Balance at 31 March 2014	**(14,785)**	**0**	**0**	**(14,785)**

Statement of Cash Flows for the year ended 31 March 2014

	2013-14 £000
Cash Flows from Operating Activities	
Net operating costs for the financial year	**(261,961)**
Depreciation and amortisation	**84**
Impairments and reversals	**0**
Other gains (losses) on foreign exchange	**0**
Donated assets received credited to revenue but non-cash	**0**
Government granted assets received credited to revenue but non-cash	**0**
Interest paid	**0**
Release of PFI deferred credit	**0**
(Increase)/decrease in inventories	**0**
(Increase)/decrease in trade & other receivables	**(444)**
(Increase)/decrease in other current assets	**0**
Increase/(decrease) in trade & other payables	**15,871**
Increase/(decrease) in other current liabilities	**0**
Provisions utilised	**0**
Increase/(decrease) in provisions	**0**
Net Cash Inflow (Outflow) from Operating Activities	**(246,450)**
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for property, plant and equipment	**0**
(Payments) for intangible assets	**0**
(Payments) for investments with the Department of Health	**0**
(Payments) for other financial assets	**0**
(Payments) for financial assets (LIFT)	**0**
Proceeds from disposal of assets held for sale: property, plant and equipment	**0**
Proceeds from disposal of assets held for sale: intangible assets	**0**
Proceeds from disposal of investments with the Department of Health	**0**
Proceeds from disposal of other financial assets	**0**
Proceeds from disposal of financial assets (LIFT)	**0**
Loans made in respect of LIFT	**0**
Loans repaid in respect of LIFT	**0**
Rental revenue	**0**
Net Cash Inflow (Outflow) from Investing Activities	**0**
Net Cash Inflow (Outflow) before Financing	**(246,450)**
Cash Flows from Financing Activities	
Net funding received	**246,461**
Other loans received	**0**
Other loans repaid	**0**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	**0**
Capital grants and other capital receipts	**0**
Capital receipts surrendered	**0**
Net Cash Inflow (Outflow) from Financing Activities	**246,461**
Net Increase (Decrease) in Cash & Cash Equivalents	**11**
Cash & Cash Equivalents at the Beginning of the Financial Year	**0**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	**0**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**11**

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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2013-14 issued by the Department of Health. The accounting policies contained in the Manual for Accounts 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 Manual for Accounts 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.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

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

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.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies’ own returns is removed. 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.

Notes to the financial statements

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.

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 has made no key estimations during the period.

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.

Notes to the financial statements

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.

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 fair value.

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.

Notes to the financial statements

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.

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.

Notes to the financial statements

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.

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'.

Notes to the financial statements

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.

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

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

1.18.6 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 using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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.

Notes to the financial statements

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 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements.

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 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.

1.25 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.

Notes to the financial statements

1.26 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.

1.26.1 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.

1.26.2 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.

1.26.3 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.

1.26.4 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

1.27 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.

1.27.1 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.

1.27.2 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.

1.27.3 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.

1.28 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.

1.29 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.

1.30 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.

1.31 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).

1.32 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

1.33 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'.

1.34 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'.

1.35 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.

1.36 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.

1.37 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 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2 Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	**218**	217	1
Patient transport services	**0**	0	0
Prescription fees and charges	**0**	0	0
Dental fees and charges	**0**	0	0
Education, training and research	**0**	0	0
Charitable and other contributions to revenue expenditure: NHS	**0**	0	0
Charitable and other contributions to revenue expenditure: non-NHS	**0**	0	0
Receipt of donations for capital acquisitions: NHS Charity	**0**	0	0
Receipt of Government grants for capital acquisitions	**0**	0	0
Non-patient care services to other bodies	**3,133**	352	2,781
Income generation	**0**	0	0
Rental revenue from finance leases	**0**	0	0
Rental revenue from operating leases	**0**	0	0
Other revenue	**191**	19	172
Total other operating revenue	**3,542**	**588**	**2,954**

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 down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	**3,542**	**588**	**2,954**
From sale of goods	**0**	**0**	**0**
Total	**3,542**	**588**	**2,954**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**2,361**	1,593	768	**1,828**	1,289	539	**533**	304	229
Social security costs	**137**	137	0	**114**	114	0	**23**	23	0
Employer Contributions to NHS Pension scheme	**198**	198	0	**159**	159	0	**39**	39	0
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	**2,696**	**1,928**	**768**	**2,101**	**1,562**	**539**	**595**	**366**	**229**
Less recoveries in respect of employee benefits (note 4.1.2)	**(218)**	(218)	0	**(217)**	**(217)**	**0**	**(1)**	**(1)**	**0**
Total - Net admin employee benefits including capitalised costs	**2,478**	**1,710**	**768**	**1,884**	**1,345**	**539**	**594**	**365**	**229**
Less: Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Net employee benefits excluding capitalised costs	**2,478**	**1,710**	**768**	**1,884**	**1,345**	**539**	**594**	**365**	**229**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	(183)	(183)	0
Social security costs	(15)	(15)	0
Employer contributions to the NHS Pension Scheme	(20)	(20)	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total recoveries in respect of employee benefits	**(218)**	**(218)**	**0**

4.2 Average number of people employed

	2013-14 Total	Permanently employed	Other
	Number	Number	Number
Total	**51**	37	14
Of the above:			
Number of whole time equivalent people engaged on capital projects	**0**	0	0

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	80
Total Staff Years	40
Average working Days Lost	2

	2013-14 Number
Number of persons retired early on ill health grounds	**0**
Total additional Pensions liabilities accrued in the year	**0**

Ill health retirement costs are met by the NHS Pension Scheme

The staff sickness absence statistics relate to the calendar year. As the CCG came into existence on 1st April 2013, the statistics are for the nine month period ending 31st December 2013.

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

4.4 Exit packages agreed in the financial year

There were no exit packages agreed by Calderdale CCG.

4.6 Severance Payments agreed in the financial year

There were no severance payments agreed by Calderdale CCG.

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 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.

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 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding executive governing body members	2,399	1,804	595
Executive governing body members	297	297	0
Total gross employee benefits	**2,696**	**2,101**	**595**
Other costs			
Services from other CCGs and NHS England	**3,838**	1,973	1,865
Services from foundation trusts	**161,200**	210	160,990
Services from other NHS trusts	**16,708**	0	16,708
Services from other NHS bodies	**0**	0	0
Purchase of healthcare from non-NHS bodies	**43,307**	57	43,250
Chair and lay membership body and governing body members	**335**	335	0
Supplies and services – clinical	**0**	0	0
Supplies and services – general	**11**	11	0
Consultancy services	**109**	109	0
Establishment	**162**	119	43
Transport	**0**	0	0
Premises	**1,460**	222	1,238
Impairments and reversals of receivables	**0**	0	0
Inventories written down	**0**	0	0
Depreciation	**84**	84	0
Amortisation	**0**	0	0
Impairments and reversals of property, plant and equipment	**0**	0	0
Impairments and reversals of intangible assets	**0**	0	0
Impairments and reversals of financial assets	**0**	0	0
· Assets carried at amortised cost	**0**	0	0
· Assets carried at cost	**0**	0	0
· Available for sale financial assets	**0**	0	0
Impairments and reversals of non-current assets held for sale	**0**	0	0
Impairments and reversals of investment properties	**0**	0	0
Audit fees	**86**	86	0
Other auditor's remuneration			
· Internal audit services	**43**	43	0
· Other services	**10**	10	0
General dental services and personal dental services	**0**	0	0
Prescribing costs	**34,015**	0	34,015
Pharmaceutical services	**0**	0	0
General opthalmic services	**105**	0	105
GPMS/APMS and PCTMS	**1,239**	307	932
Other professional fees excl. audit	**36**	36	0
Grants to other public bodies	**0**	0	0
Clinical negligence	**0**	0	0
Research and development (excluding staff costs)	**0**	0	0
Education and training	**59**	59	0
Change in discount rate	**0**	0	0
Other expenditure	**0**	0	0
Total other costs	**262,807**	3,661	259,146
Total operating expenses	**265,503**	**5,762**	**259,741**

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

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	8,088	40,623
Total Non-NHS Trade Invoices paid within target	8,038	39,001
Percentage of Non-NHS Trade invoices paid within target	99.38%	96.01%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,854	181,000
Total NHS Trade Invoices Paid within target	1,700	176,871
Percentage of NHS Trade Invoices paid within target	91.69%	97.72%

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, whichever is later.

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

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	**0**
Compensation paid to cover debt recovery costs under this legislation	**0**
Total	**0**

7 Income Generation Activites

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

8. Investment revenue

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

9. Other gains and losses

The Clinical Commissioning Group has no other gains or losses during the period.inverstment revenue 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

	Land	Buildings	Other	2013-14 Total
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	**0**	**1,131**	**0**	**1,131**
Contingent rents	**0**	**0**	**0**	**0**
Sub-lease payments	**0**	**0**	**0**	**0**
Total	**0**	**1,131**	**0**	**1,131**

The lease payments above include £602K for NHS Property Services.

12.1.2 Future minimum lease payments

	Land	Buildings	Other	2013-14 Total
	£000	£000	£000	£000
Payable:				
No later than one year	**0**	**704**	**0**	**704**
Between one and five years	**0**	**2,814**	**0**	**2,814**
After five years	**0**	**7,506**	**0**	**7,506**
Total	**0**	**11,024**	**0**	**11,024**

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

While our arrangements with NHS property Services Ltd fall within the defintion 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

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	0	0	0	0	0	0	0	0	0
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**	**0**	**0**	**64**	**651**	**715**
Adjusted Cost or valuation at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**64**	**651**	**715**
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	**0**
Additions purchased	0	0	0	0	0	0	0	0	**0**
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**
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**64**	**651**	**715**
Depreciation 1 April 2013	0	0	0	0	0	0	0	0	**0**
Adjusted depreciation 1 April 2013	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**
Charged during the year	0	0	0	0	0	0	28	56	**84**
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**
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**56**	**84**
Net Book Value at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**
Purchased	0	0	0	0	0	0	36	595	**631**
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 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**
Asset financing:									
Owned	0	0	0	0	0	0	36	595	**631**
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 PFI & LIFT assets	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2013	0	0	0	0	0	0	0	0	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0	0	0	0	0	**0**
Adjusted balance at 1 April 2013	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**
At 31 March 2014	0	0	0	0	0	0	0	0	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group do not have 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 Commissioning Group

13.6 Write downs to recoverable amount

Not applicable to Calderdale Commissioning Group

13.7 Temporarily idle assets

Not applicable to Calderdale 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:

	2013-14 £000
Information technology	7
Total	7

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 Donated Assets.

14.2 Government granted assets

The Clinical Commissioning Group do not have Government granted assets.

14.3 Revaluation

The Clinical Commissioning Group did not conduct a revaluation.

14.4 Compensation from third parties

Not applicable to Calderdale Commissioning Group

14.5 Write downs to recoverable amount

Not applicable to Calderdale Commissioning Group

14.6 Non-capitalised assets

Not applicable to Calderdale Commissioning Group

14.7 Temporarily idle assets

Not applicable to Calderdale Commissioning Group

14.8 Cost or valuation of fully amortised assets

Not applicable to Calderdale Commissioning Group

14.9 Economic lives

Not applicable to Calderdale Commissioning Group

15 Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2014

16 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2014

17 Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	186	0
NHS receivables: Capital	0	0
NHS prepayments and accrued income	0	0
Non-NHS receivables: Revenue	24	0
Non-NHS receivables: Capital	0	0
Non-NHS prepayments and accrued income	208	0
Provision for the impairment of receivables	0	0
VAT	26	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0
Interest receivables	0	0
Finance lease receivables	0	0
Operating lease receivables	0	0
Other receivables	0	0
Total	444	0
Total current and non current	444	
Included above:		
Prepaid pensions contributions	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

	2013-14 £000
By up to three months	33
By three to six months	6
By more than six months	0
Total	39

£4K 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 2014.

17.2 Provision for impairment of receivables

	2013-14 £000
Balance at 1 April 2013	0
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0
Adjusted balance at 1 April 2013	0
Amounts written off during the year	0
Amounts recovered during the year	0
(Increase) decrease in receivables impaired	0
Transfer (to) from other public sector body	0
Balance at 31 March 2014	0

18 Other financial assets

18.1 Current

The Clinical Commissioning Group have no other current assets as at 31 March 2014.

18.2 Non-current

The Clinical Commissioning Group have no non current assets as at 31 March 2014.

18.3 Non-current: capital analysis

The Clinical Commissioning Group have no non-current capital analysis as at 31 March 2014.

19 Other current assets

The Clinical Commissioning Group have no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**0**
Net change in year	**11**
Balance at 31 March 2014	**11**
Made up of:	
Cash with the Government Banking Service	**11**
Cash with Commercial banks	**0**
Cash in hand	**0**
Current investments	**0**
Cash and cash equivalents as in statement of financial position	**11**
Bank overdraft: Government Banking Service	**0**
Bank overdraft: Commercial banks	**0**
Total bank overdrafts	**0**
Balance at 31 March 2014	**11**

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 2013-14 £000	Non-current 2013-14 £000
Interest payable	**0**	**0**
NHS payables: revenue	**3,117**	**0**
NHS payables: capital	**0**	**0**
NHS accruals and deferred income	**2,368**	**0**
Non-NHS payables: revenue	**733**	**0**
Non-NHS payables: capital	**0**	**0**
Non-NHS accruals and deferred income	**9,503**	**0**
Social security costs	**0**	**0**
VAT	**0**	**0**
Tax	**0**	**0**
Payments received on account	**0**	**0**
Other payables	**150**	**0**
Total	**15,871**	**0**
Total payables (current and non-current)	**15,871**	

The CCG has no liabilities for early retirement.

Other payables include no outstanding pension contributions at 31 March 2014

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31 March 2014.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31 March 2014.

26 Borrowings

The Clinical Commissioning Group has no borrowings as at 31 March 2014.

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 31 March 2014.

28 Finance lease obligations

The Clinical Commissioning Group has no finance lease obligations as at 31 March 2014.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31 March 2014.

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0
Pensions relating to other staff	0	0
Restructuring	0	0
Redundancy	0	0
Agenda for change	0	0
Equal pay	0	0
Legal claims	0	0
Continuing care	0	0
Other	0	0
Total	0	0
Total current and non-current		

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £2,480,000.

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

The Clinical Commissioning Group do not have any Contingencies.

	2013-14 £000
Contingent liabilities	
Equal Pay	0
Amounts recoverable against contingent liabilities	0
Net value of contingent liabilities	0
Contingent assets	
Amounts recoverable against contingent assets	0
Net value of contingent assets	0

32 Commitments

32.1 Capital commitments

	2013-14 £000
Property, plant and equipment	0
Intangible assets	0
Total	0

32.2 Other financial commitments

The clinical commissioning group and consolidated group have not entered into any non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2013-14 £000
In not more than one year	0
In more than one year but not more than five years	0
In more than five years	0
Total	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 the 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 clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

The 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 clinical commissioning group has no overseas operations. The clinical commissioning group 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 clinical commissioning group's revenue comes parliamentary funding, the 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

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The 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'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:	0	0	0	0
· NHS	0	186	0	186
· Non-NHS	0	24	0	24
Cash at bank and in hand	0	11	0	11
Other financial assets	0	0	0	0
Total at 31 March 2014	0	221	0	221

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	0	0	0
Payables:	0	0	0
· NHS	0	5,485	5,485
· Non-NHS	0	10,236	10,236
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 2014	0	15,721	15,721

33.4 Maturity of financial liabilities

	Payable to DH 2013-14 £000	Payables to Other Bodies 2013-14 £000	Total 2013-14 £000
In one year or less	0	15,721	15,721
In more than one year but not more than two years	0	0	0
In more than two years but not more than five years	0	0	0
In more than five years	0	0	0
Total CCG at 31 March 2014	0	15,721	15,721

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 and consolidated group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2013-14 £'000
Total net expenditure reported for operating segments	261,961
Reconciling items:	
Total net expenditure per the Statement of Comprehensive Net Expenditure	261,961

34.2 Reconciliation between Operating Assets and SoFP

	2013-14 £'000
Total assets reported for operating segments	1,086
Reconciling items:	
Total assets per the Statement of Financial Position	1,086

34.3 Reconciliation between Operating Liabilities and SoFP

	2013-14 £'000
Total liabilities reported for operating segments	(15,871)
Reconciling items:	
Total liabilities per Statement of Financial Position	(15,871)

35 Pooled budgets

The Clinical Commissioning Group and consolidated group were not party to any pooled budget arrangements during 2013-14.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Intra-government and other balances

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	157	0	50	0
· Local Authorities	15	0	1,048	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	40	0
· NHS Trusts and Foundation Trusts	14	0	4,347	0
Total of balances with NHS bodies:	186	0	5,485	0
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	258	0	10,386	0
Total balances at 31 March 2014	444	0	15,871	0

38 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. The amounts cover enhanced services and personal remuneration to GP's who are Governing Body members.

Details of related party transactions with organisations in which individuals have a relationship are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Longroyde Surgery (Dr Alan Brook)	87	0	12	0
Spring Hall Group Practice (Dr Steven Cleasby)	134	0	33	0
The Boulevard Medical Practice (Dr Hazel Carsley)	110	0	31	0
King Cross Practice (Dr John Taylor)	110	0	31	0
Keighley Road Surgery (Dr Peter Davies)	93	0	35	0
Southowram Surgery (Dr Majid Azeb)	53	0	9	0
Hebden Bridge Group Practice (Dr Nigel Taylor)	188	0	69	0

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

CCG Chief Finance Officer, is a shared post with Greater Huddersfield CCG. There are no material transactions to declare.

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

In addition the executive Governing Body members have relatives with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Parents & Carers Calderdale,
Pennine Acute NHST.
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:

	2013/14 £000
Calderdale and Huddersfield NHSFT	137,684
South West Yorkshire Partnership NHSFT	18,475
Yorkshire Ambulance NHS Trust	9,340
Leeds Teachings Hospitals NHST	4,726
Bradford Teachings Hospitals NHSFT	3,874
CSU	2,038
NHS Greater Huddersfield CCG	1,783
East Lancashire Hospital NHS Trust	633
Mid Yorkshire Hospitals NHS Trust	586
Pennine Acute NHST.	630
Parents & Carers Calderdale,	90

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.

	2013/14 £000
Calderdale MBC	9,849

39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group or consolidated group.

40 Losses and special payments

The clinical commissioning group has no losses or special payments.

41 Third party assets

The Clinical Commissioning Group held no cash and cash equivalents on behalf of other parties.

42 Financial performance duties

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).
The clinical commissioning group's performance against those duties was as follows:

NHS Act Section	Duty	2013-14 Maximum	2013-14 Performance	Duty Achieved
		£'000	£'000	
223H (1)	Expenditure not to exceed income	270,473	265,503	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	N/A	N/A	
223I (3)	Revenue resource use does not exceed the amount specified in Directions	266,931	261,961	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A	N/A	
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	N/A	N/A	
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	5,190	5,174	Yes

43 Impact of IFRS

Not applicable to Calderdale Commissioning Group

44 Analysis of charitable reserves

Not applicable to Calderdale Commissioning Group

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS CALDERDALE CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group (CCG) for the year ended 31 March 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of NHS Calderdale CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members 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 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. 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.

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 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.

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 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 2014 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of or at the end of the audit.

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and
- locally determined risk-based work as appropriate.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of NHS Calderdale CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Timothy Cutler
For and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

Date: 5 June 2014

NHS Calderdale Clinical Commissioning Group
5th floor
F Mill
Dean Clough
Halifax
HX3 5AX

Tel: **01422 281300**
Email: ***CCG.FEEDBACK@calderdale.nhs.uk***