NHS
Calderdale
Clinical Commissioning Group

Annual Report 2018-19

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

The Annual Report and Accounts (2018-19) for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on 16 May 2019 under delegated authority from the Governing Body.

Cover image

The fourth and final stage of the Tour de Yorkshire 2018 starts at the Piece Hall in Halifax.

Image courtesy of SWpix.com

Highlights of 2018-19

The Autism Experience at the Piece Hall, Halifax

Doing good ...

and building community resilience through volunteering

Calderdale's Health Forum

What better reason to eat cake?

Rolling out Red Bags to care homes across Calderdale

At the ICC Awards

Proud winners at the Health Business Awards

Calderdale's Action on Autism Summit - January 2019

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Introduction to the Annual Report

I'm writing this introduction whilst sitting in my office in Dean Clough, looking out upon the glorious woodland scene which unfolds behind the glass of the 5th floor office. It is remarkable that within a few yards of the windows we have been able to see foxes, deer, owls and many small woodland birds over the past few weeks. This juxtaposition of nature and industry is one of the things which best defines Calderdale. The wild is close to home and easy to get to. It does the heart good – literally, to connect with nature and the outdoors.

In my introduction to last year's annual report I talked with pride about the change which I felt to be happening in Calderdale. I used the Piece Hall transformation as a metaphor for the transformation in relationship that I was sensing around us. In thinking about this year's annual report, and my pride in our ability to report on another successful year for the organisation and the local system it has become clear to me that the transformation that we were sensing last year has gathered in momentum and meaning.

This has been a difficult year in many ways. My Chief Officer reports to the Governing Body over the past 12 months have told stories of winter pressures, political and at times existential turmoil, with the NHS along with all other sectors being drawn into a challenging planning process in order to attempt to mitigate unknown risks in relation to EU Exit. Whilst there is no doubt that pressure has been exerted upon us as an organisation, we have responded well. Levels of performance against the key NHS constitutional standards is as good as the best nationally and the fantastic progress that we made last year on issues like Delayed Transfers of Care and the better management of length of stay in our hospitals – that is keeping people in hospital for the minimum time necessary in order to properly manage their acute care needs and then getting people home again with the right support in place, has been further strengthened.

My reports to the Governing Body have told that story too. Despite all of the challenges that we are facing in the local health and care system, we are making a real difference. That is something to be proud of. At the AGM last year, I introduced my visual representation of a version of leadership…

All we have are:

- the words we use and the words we choose to hear;
- our relationships and our ability to create and maintain them;
- the choices that we make, and the learning we take from them;
- our courage – the courage to be our best selves;

- Our willingness to support and develop others.

My sense is that over the past year, the partnership of organisations across Calderdale is spending more time in this space. The leaders of those organisations are spending more time together, talking about the challenges that we face, but more importantly than that we are talking together about the way in which we want to be in facing those challenges. We have gathered around 5 words which represent something important about Calderdale as a place and how we feel about it – those words are;

- Kindness
- Talented
- Distinctive
- Resilient
- Enterprising

We have made choices this year, as an organisation and as a partnership. One of those choices has been to invest time in improving relationships. This is beginning to bear fruit. Part of the reason that our levels of performance on Delayed Transfers of Care is so strong compared to others, and has improved so dramatically in such a short period of time, is that relationships are working better, at all levels across the system. There is still much more to be done, and we have some ideas about how we might do it, but investing in, and commissioning for, great relationships, great team-working, the right values is the future.

I made some commitments at last year's AGM.

- That we would continue to work to secure the future of our hospitals.
- That we would progress the work we need to do to deliver integrated community services.
- That we would work with partners to address the emotional wellbeing of children and young people, focussing upon ASD as our first challenge.

Nothing is ever 'finished' – it is my view that we need to accept change and the need for change as a constant in health and care. Having said that, the fact that, working with our hospitals and our regulators, we have secured access to significant capital to deliver sustainable hospital services has been a real and significant achievement this year. There is still much work to do, but we have reached a watershed moment.

Similarly, the work that we have done with partners in support of Calderdale Cares and the CCG response to it – Care Closer to Home, has been significant. We have established processes through which we can work with partners to integrate services at locality level across Calderdale.

In terms of Autism Spectrum Disorder (ASD), the CCG convened and hosted a really successful workshop in January. The participants in that process included NHS, Local Authority, Education, Voluntary Sector and most importantly, the voice of parents and young people. We agreed the following actions;

- To continue the focus on ASD, particularly as a whole system approach to ASD;
- Work with partners to develop and agree a new ASD pathway building on the pathway produced as a consequence of our recent independent review;
- To implement the new agreed pathway for ASD diagnosis;
- To adopt and embed an approach to supporting those children and families prior to diagnosis.

Subsequently we have;

- Convened a Children and Young People's Health Leaders Group;
- Working with affected families we have co-produced a detailed information pack which has been distributed to all parents whose children are on the waiting list for assessment. Over 500 packs have been distributed and the information is also available on the local offer website;
- With partners, we supported the recent Ofsted/Care Quality Commission Inspection for Children and Young People with Special Educational Needs and Disability including a focus on ASD;
- Appointed to our vacant Children's Lead Nurse and Designated Clinical Officer post and we welcome Helen Shepherd into that role;
- Established a planning group which will convene a stakeholder event later in the year, at which we will discuss and agree further improvements - building on the outputs from the January summit meeting;
- Established a task and finish group to develop the new ASD pathway for implementation once the waiting list has reduced sufficiently;
- Worked with partners to establish the Open Minds Partnership and have agreed a contract for 2019/20.

We have invested an additional £250k non-recurrently in-year in order to support the reduction in waiting times in children's ASD services. More significantly, we have also invested from April 2019, £250k additional resources recurrently to manage the demand and capacity of the THRIVE model in Calderdale (which will include working to ensure that the model is sustainable and resilient.) There is still much work to do, but this represents real progress and I will maintain my own personal commitment to this agenda over the coming months. It is our intention to move to no longer than 12 months wait for an assessment by March 2020, and to deliver further improvements thereafter to get down to a maximum of 18 weeks.

The commitments I will make at the AGM for the forthcoming year will be in the following areas;

- The implementation of the new GP contract and the relationship with Calderdale Cares,
- The relationship between mental and physical health, and the investments we are making into mental health services,
- Our continued focus upon the emotional health and wellbeing of children and young people.

The NHS in particular has been fortunate to benefit from continued growth at a time when funding to other public sector services has been decimated. I understand clearly the responsibility the local NHS has to work with partners in order to ensure that the challenges they are experiencing are mitigated as far as possible by better use of NHS resources. As a CCG, we need to think clearly and critically at the work that we do and the way that we do it, and we need to do that in partnership with other organisations and with the public.

There are three transformations that I believe are necessary in order for health and care services to survive and prosper in this time of inexorable growth in demand and expectation. They are;

1) A transformation in the way in which people relate to their own health and wellbeing, and the way in which they relate to the services which are there to support them when they need help. Active Calderdale is a prime example of how we are working together to support this transformation.
2) A transformation in the way in which the people who work in health and care relate to each other, and the way in which they relate to their work. Calderdale Cares is a prime example of how we are working together to create the conditions in which this transformation is possible.
3) The digital and technological innovations which we can deploy in support of the first two transformations. The fantastic work that has been done in our hospitals over the past two years, which has delivered an internationally recognised transformation in the way in which clinical care is delivered with the support of better and more accessible information.

Our challenge over the next two years will be to describe with clarity how we will accelerate our work in each of these spaces through partnership, capacity and resources. The relationship that we have established as a partnership in Calderdale with the West Yorkshire and Harrogate Health and Care partnership, and the ability that will give us to draw in transformation resource will be vitally important through that period.

Dr Matt Walsh
Accountable Officer

The Performance Report

Dr Matt Walsh
Accountable Officer

22 May 2019

The Performance Report - Overview

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

Purpose of the CCG

NHS Calderdale CCG is a membership organisation consisting of 25 general practices. Our purpose is to improve the health and lives of the estimated 221,678[1] people living in Calderdale and/ or registered with a Calderdale GP practice.

This is achieved by working collaboratively with our partners and stakeholders in Calderdale and as part of the West Yorkshire and Harrogate Health and Care Partnership to:

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

Our overall budget allocation was £321.6m in 2018-19 which we have used to commission health and care services in a range of areas including mental health, learning disabilities, continuing health care, emergency and urgent care, hospital and community services, primary care and services for children and young people. The performance analysis section of this report contains further detail of our financial position and plan for 2019-20.

Chief Officer's view of the Performance of the CCG in 2018-19

Throughout 2018-19, we have continued to work with our partners on the transformation agenda across Calderdale as a Place and across Calderdale and Greater Huddersfield on the hospital change programme (Right Care, Right Time and Right Place – RCRTRP) which resulted in December, with the allocation of £196.5m capital funding from the Department of Health and Social Care, to support implementation of the RCRTRP enhanced proposal.

[1] NHS Digital – registered GP population

We have worked hard with partners to improve access to general practice services, sustain performance in A&E services as well as in a range of other areas including Improving Access to Psychology Therapies (adults), waiting times for Early Intervention in Psychosis and care packages for people with mental health problems.

Whilst there have been real challenges in achieving and maintaining some of the National Constitutional Standards, the level of performance in the Calderdale system remains strong when compared with others regionally and nationally. There has been a consistent delivery of standards associated with reducing delays in transfers of care (DToC), in Referral to Treatment Times, Cancer Waiting Times and in Diagnostics. We have strengthened the reporting and assurance processes in relation to the delivery of these standards and have improved the links across our local system as well as between the CCG and the arrangements at a West Yorkshire and Harrogate Health and Care Partnership level.

We have also maintained a strong focus on keeping people safe and improving the quality of care, whilst ensuring a strong financial position and achieving financial recovery in a sustainable way. This has resulted in the achievement of our financial plan for 2018-19 and in the achievement of our statutory financial duties.

The Governing Body has been supported in this task by the work of its committees and in particular the work of the Quality, Finance and Performance and Commissioning Primary Medical Services Committees. The fact that we have again been able to land the year-end position favourably, and in particular deliver £7.5m out of a planned £8.1m QIPP saving, says something about the level of focus and grip exerted by the Committee members and staff this year. This is as strong a position as at any point since the inception of the CCG and is a testament to the hard work of everyone involved.

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

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

Partnership working

In my introduction, I have talked about the importance of good partnership working. Our commitment to working collaboratively is reflected in the results of the 2018-19 Ipsos MORI 360 stakeholder survey, in which 94% of respondents rated the effectiveness of their working relationships with the CCG as good, 85% felt that the CCG was an effective local system leader and 91% respondents felt that the CCG worked collaboratively with other system partners on the vision to improve the future health of the population across the whole system. We have:

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

Further information on our activities throughout the year and performance is provided in the Performance Analysis section on page 13.

Key Issues or Risks

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

The financial sustainability of the system continues to be a key challenge to our performance and we continue to work through the System Recovery Group and Partnership Transformation Board to put in place measures to ensure that the local health system model is affordable going forward. The financial plan contains our actions to manage this risk together with the requirement for CCGs to reduce their running costs by 20% from April 2020.

These risks together with the challenges to the resilience of the urgent care system are reflected in the high level risks identified by the CCG in 2018-19 and onward for 2019-20. Other high level risks relate to the delivery of the Avoidable Healthcare Associated Infection targets, an increase in waiting times for children and young people with potential Autism Spectrum Disorder and our ability to achieve the Continuing Health Care assurance targets.

Further detail on our approach to the management of risk and a summary of the in-year risks classed as ‘Serious’ on our Corporate Risk Register can be found in the Governance Statement (see Governance Statement: Appendix 2)

Summary of Performance

Overall the performance of the CCG and the system has been good, with significant reductions in the delays being experienced by patients in the transfer of their care and the delivery of the majority of the NHS Constitution Targets.

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

The level of performance in the Calderdale system remains strong when benchmarked with others nationally. We have strengthened the reporting and assurance processes in relation to the delivery of Cancer standards, and have sought and received assurance about the strength of the locality and West Yorkshire arrangements.

Focus on patients with a length of stay of seven days or more.

Snapshot audits are carried out across a health care setting (for example, an acute trust or whole health system) to find out what patients are waiting for and how many could be treated in a different setting. It identifies the clinical plan for each individual with a hospital length of stay of 7 days or more.

The Emergency Care Improvement Programme

The introduction of the Aligned Incentive Contract between the two CCGs at Calderdale and Greater Huddersfield and Calderdale and Huddersfield NHS Foundation Trust has enabled more collaborative working on joint recovery opportunities.

The Performance Report – Performance Analysis

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

Performance measures

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

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

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

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

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

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

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

CCG Improvement and Assessment Framework (IAF)

Since 2016-17, all CCGs have been assessed against the NHS England CCG IAF. The framework contains indicators aligned to the key priorities in the NHS and covers 4 domains and 6 clinical priority areas.

Calderdale CCG has a rating of **GREEN** for its overall performance against the CCG Improvement and Assessment Framework (2017-18 year end results). The 2018-19 year end results will be available from July 2019 at:
https://www.nhs.uk/service-search/performance/search

Performance against the NHS Constitution standards

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

Accident and Emergency 4 hour waits

Sustaining performance against the A&E 4 hour target continues to prove challenging for our system, with periods of underperformance during the year. Whilst the position compares favourably with the reported performance across the region and nationally (CHFT was the third best performing Trust in the country at the end of the financial year) it remains below the NHS Constitutional Standard. This is reflected in its risk rating on our operational risk register and the close scrutiny by our Finance and Performance Committee, with action being taken forward through the A&E Delivery Board.

Better Care Fund

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

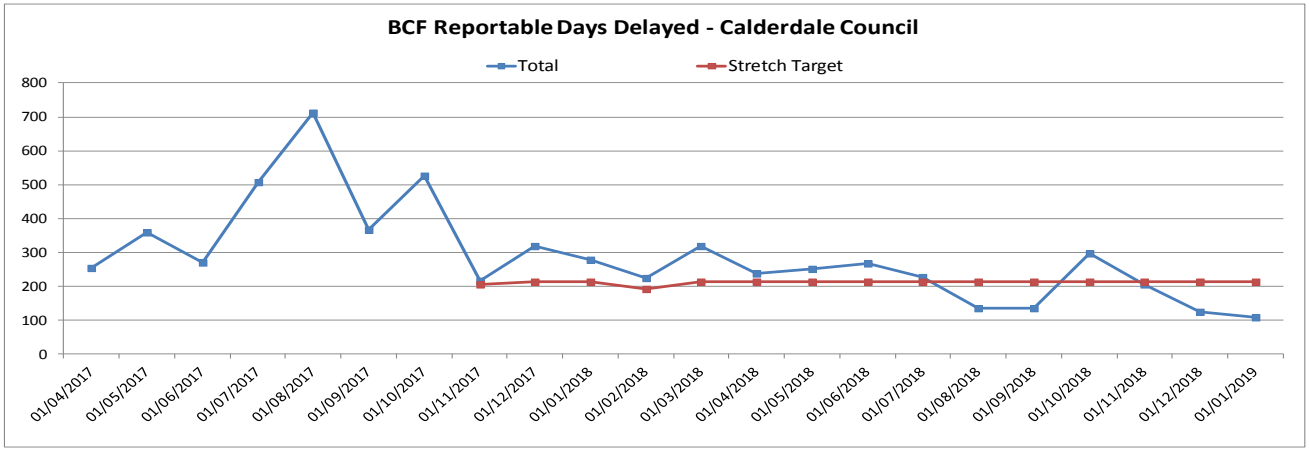
- Number of non-elective admissions compared to target;
- Delayed Transfers of Care - actual days delayed compared to target;
- Permanent admissions of older people (65 and over) to residential and nursing care homes, per 100,000 population;
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

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

Reducing long stays in hospital

Excessive and often unnecessary delays in discharging people from hospital care can have a significant impact on patients' health and wellbeing. These delays, particularly for elderly people, can result in poor outcomes and delay recovery.

We have introduced 'Multi-agency Discharge Events' where all partners come together to plan discharges and overcome barriers when they occur. We have focussed on reducing the numbers of people who are in hospital for longer than 21 days by 30%. Working with partners we have a better understanding of why patients become delayed in our system and what we can do together to improve this.



Quality, Innovation, Productivity and Prevention (QIPP)

Whilst we have continued to work on a set of initiatives which seek to improve patient care and reduce inefficiencies, we have taken a different approach this year, which reflects the new Aligned Incentive Contract with Calderdale and Huddersfield NHS Foundation Trust. The QIPP initiatives that we have focused on during the year include:

- Reducing delays in transfers of care
- Rehabilitation and community beds
- Continuing healthcare
- Frailty and falls
- Outpatient appointments
- Procedures of Limited Clinical Effectiveness

Enhanced reablement service

This new enhanced service started in September and aims to place people in the most appropriate environment to maximise their rehabilitation, with a focus on those who could be supported within the community, closer to home. This is a multi-agency partnership approach led by the CCG with involvement from CHFT and Calderdale Council.

In July 2017 the partnership approved the enhanced step down/up pathway for patients in need of a community based rehabilitation service. The 'recovery at home' community service consists of a redesigned service for falls and frailty fractures. The impact of providing this service in the community has meant that there are 8 fewer beds needed in the hospital. The resources have been reinvested into the community to provide therapy and reablement support for an additional 20 people.

Other measures of performance

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

Quality Premiums

The Quality Premium is an NHS England scheme to reward CCGs for improvements in the quality of services they commission. The quality premium paid to CCGs in 2018-19 reflects the quality of services commissioned in the previous year. The measures cover a combination of national and local priorities, the financial reward available and the achievement in Calderdale. The total reward available to the CCG in 2018-19 was £280k.

Financial Duties

CCGs have a number of financial duties under the NHS Act 2006 (as amended). The CCG's performance against those duties is included in the finance section on page 28.

The Performance Report - Key Activities throughout the year

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

- **Transforming the way that health and care is provided;**
- **Keeping people safe and continually improve the quality of care;**
- **Maintaining system resilience;**
- **Achieving system financial recovery.**

Transforming the way that health and care is provided

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

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

Calderdale as a Place

The CCG is working closely with partners through the Health and Wellbeing Board to achieve its shared vision of a sustainable health and care system for the people of Calderdale that delivers: improved health outcomes, reduced health inequalities, greater independence and a lower need for hospital based care. The Single Plan for Calderdale which will be revised in 2019-20, sets out our strategic direction. Calderdale Cares, led by Calderdale Council represents a place-based approach to the delivery of health and social care and sees the collaboration of a range of organisations that share common resources and deliver shared population health outcomes.

Focus on Frailty

An unnecessary hospital stay for an older or frail person can result in deconditioning very quickly; this reduces life expectancy, quality of life and provides a poor patient experience.

The Frailty Team works in Accident & Emergency, the acute floor and Surgical Assessment Area and carries out rapid assessment of frail, mainly older patients and, where possible, avoids an unnecessary admission to hospital.

Every frail patient referred has a Comprehensive Geriatric Assessment. The team works with social care, community services and the voluntary sector and has a dedicated therapy team to ensure the safe and timely return to the individual's own home rather than admission to hospital.

Over a 100 admissions are being avoided each month.

An important part of Calderdale Cares is the development of 5 localities across Calderdale, based on population sizes of 30-50,000 people.

In 2018-19 we moved forward with the development of an integrated approach to commissioning and to begin to develop a commissioner/provider alliance approach to deliver services and outcomes as set out in the CCG's community prospectus 'Care Closer to Home' in line with the Health and Wellbeing Strategy.

Care Closer to Home (CC2H)

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

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

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

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

Localities and Primary Care Networks

The localities in Calderdale are based around 5 groups of general practices and have been developing organically with people who have the insight, energy and leadership and want to change. Recognising that to be sustainable, practices need to work together and work differently, the CCG has created a collaboration fund to support practices to develop their plans for working over a wider population base. Taking this collaborative approach

Primary Care Workforce Group

A Calderdale Primary Care Workforce Group has been established to bring together primary care stakeholders to support and deliver a resilient workforce, supporting the successful delivery of local priorities, national strategies and targets. These include Care Closer to Home, Calderdale Cares, the NHS England Long Term Plan and the 10 High Impact Changes.

The group which is led by the Pennine GP Alliance and is funded by the Local Workforce Action Board (LWAB), brings together all the key stakeholders in the Primary Care Workforce – CCG; Pennine GP Alliance; Caritas Group Practice (an Advanced Training Practice); CHFT (community division); the Local Medical Committee; Community Pharmacy West Yorkshire and Calderdale based workforce leads (including Calderdale Council).

provides opportunities for general practice to:

- Increase the level of peer support and shared learning
- Support and promote initiatives to share skills across practices
- Reduce pressure on the workforce
- Harness opportunities to reduce the administrative burden and reduce costs

Over the past year Practice Managers, clinical leads, colleagues from Health and Social and the voluntary sector have come together to enhance care for the local community. This has resulted in both the North Halifax and Central Halifax localities agreeing to register as Primary Care Home sites with the National Association of Primary Care.

Five Year Framework for the GP Contract

Towards the end of the year, NHS England and the British Medical Association announced the new 5 year framework for the GP contract which is designed to support delivery of the NHS Long Term Plan. What is clear is that the direction of travel being set out nationally is closely aligned to the journey that we had already embarked on in Calderdale and adds impetus to CCG's work with General Practice in the coming year.

General Practice Forward View

We continue to build on our ambition and vision for primary medical services in Calderdale to 2020. Our member practices continued to develop new ways of working in order to improve access to services not only during winter but across the whole year. Some of these areas are highlighted below:

Good access to general practice

We have continued to invest in improving access to GP services. This has resulted in:

- a consistent approach with all practices opening from 8 am to 6:30 pm Monday to Friday;
- offering at least 70 appointments per 1,000 registered patients per week;
- increasing appointments by a further 5%, which equates to over 17,000 additional appointments to support winter and bank holiday closing;
- enhanced access to GP Services through 'Hubs' across Calderdale; offering primary medical services appointments, Monday to Friday 6:30 pm to 8:00 pm, Saturday and Sunday 10am to 2:00pm and bank holidays 10am to 11:30am, 365 days a year.

International GP Recruitment

The International GP Recruitment Scheme in West Yorkshire and Harrogate was launched in October 2018. The CCG is working with six member practices to recruit seven GPs.

GP Online consultations

Working with our member practices and the Local Medical Committee, we have started the roll out of the GP Online Consultation Services in Calderdale. The benefits expected are:

- Expanded health knowledge and increased ability of patients to make more informed decisions;
- Reduced travel for patients;
- Increased information sharing and improved communication between patients and practices;
- Improved access to care services;
- Increased patient satisfaction and a reduction of DNAs (people who do not attend);
- Reduced administrative workload for practice staff and increased practice efficiency.

Medicines Management

Changing the way you order your prescriptions

A campaign to stop third party ordering repeat prescriptions in Calderdale started on April 1st 2018. This has resulted in a significant reduction in items ordered and cost versus the same period last year. We are on track to save c£400k over the financial year.

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

Prescribing Gain Share Scheme

The aim of this scheme is to encourage practices to work together in their localities to improve the cost effectiveness of their prescribing in line with national and local good prescribing practice and guidelines. Examples include supporting patients to self-care by utilising over-the-counter medications where appropriate, encouraging the use of evidence-based treatments and reducing the use of medications with little evidence of effectiveness. Any resources released would be apportioned 50% for the CCG to contribute to financial sustainability and 50% for the locality to reinvest in patient care. This scheme will run for three years.

Optimise Rx

Optimise Rx is a prescribing tool which is used by all Calderdale practices to promote quality and safety as well as cost effective prescribing. The Medicines Management Team presented its learning on the 'Long Term Engagement with Optimise Rx' at a national conference for Optimise Rx customers. The presentation was well received. Use of the software has generated a significant number of safety and best practice messages which have been used to improve the quality of care in Calderdale as well as delivering over £240,000 savings in 2018-19.

National prescribing guidance

Phase 1 of 'items which should not routinely be prescribed in primary care' has been implemented in the CCG and has gone well – with a significant drop in the cost of prescribing these items. Phase 2 is due in the next financial year.

The NHS England guidance on over the counter items - which should no longer be routinely be prescribed in primary care - was rolled out in August and has saved an estimated £117,000 in August to Dec 2018.

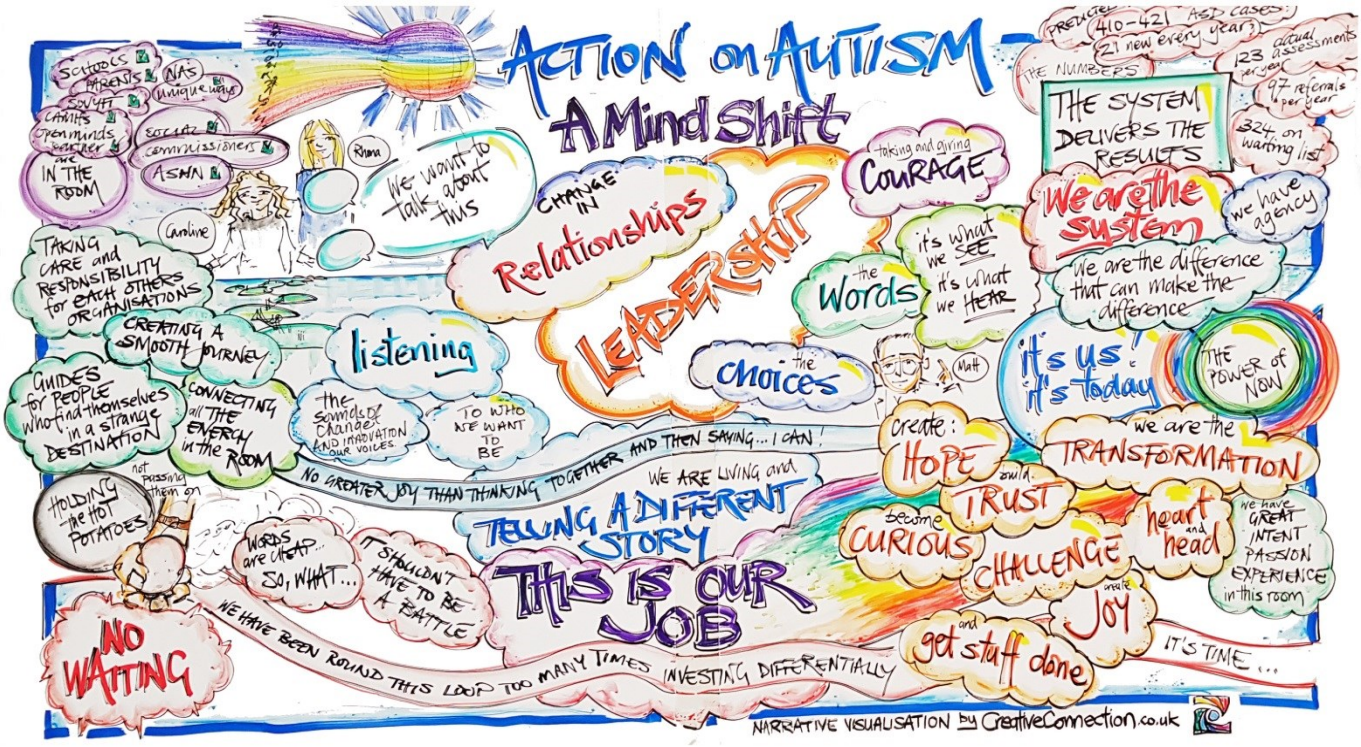
PINCER

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

Transforming mental health services

Improving support for Young People with Autism

Our aim is to develop community services which support young people with Autism by improving access to effective specialist services and preventing unnecessary admissions to hospital. This is in line with our vision for care closer to home.



As part of the Autism Summit held in January, partners made a number of commitments on how they would work to improve care available for children and young people with Autism.

A snapshot video recounting the event can be viewed here: https://youtu.be/hND2hKkgTpk

Five Year Forward View for Mental Health

Throughout the year we have continued to work with our partners at South West Yorkshire Partnership Foundation Trust, Calderdale Council and the voluntary sector, to make progress against the objectives set out in the 'Five Year Forward View for Mental Health' (2016). Specifically in 2018-19:

- We carried out an engagement exercise to find out more about people's views of our adult psychological services and to find out what else would help people with their mental health. The report of the engagement is at the link below: https://www.calderdaleccg.nhs.uk/download/psychological-therapies-engagement-report/
- We worked with Calderdale Council to widen the range of accommodation available to support people living with long-term mental health conditions;
- We have invested in a consultant psychiatrist to work with SWYPFT's Care Home Liaison Team, providing specialist input into the care of older people with mental health problems. This service is able to offer more proactive support to individuals in care homes and seeks to avoid unnecessary admissions to hospital. This is especially important for people with Dementia and mental health problems who may find a hospital admission and the unfamiliar environment particularly stressful.

The NHS Long Term Plan was published in January 2019 and continues with many of the priorities in the Five Year Forward View for Mental Health. The CCG and partners are committed to working together to implement these priorities as well as looking for other ways to make a difference for people in emotional distress.

Working across Calderdale and Greater Huddersfield

Right Care, Right Time, Right Place

In May 2018 the Secretary of State for Health and Social Care requested that the NHS in Calderdale and Greater Huddersfield undertake further work on its proposals for the future of out of hospital care, capacity and the availability of funding required, following recommendations and advice made by the Independent Reconfiguration Panel (IRP)[2].

An enhanced proposal for the future model of care was developed to address the issues identified by the IRP's report. The following areas, which were subject of 2016's public consultation, remain unchanged:

[2] The IRP is an advisory non-departmental public body sponsored by the Department of Health and Social Care. The IRP is established as the independent expert on NHS service change.

• Urgent care	• Acute inpatient medical care
• Maternity and midwifery services	• Critical care
• Paediatrics	• Acute and complex surgery
• Planned surgery	• Outpatient services.

The variations from the original proposals are:

- Huddersfield Royal Infirmary (HRI) is to provide hospital services for the foreseeable future;
- The current number of hospital beds across Calderdale and Greater Huddersfield is to be retained;
- Community services to be developed to demonstrate a reduction in demand for hospital care;
- Calderdale Royal Hospital and Huddersfield Royal Infirmary to provide 24/7 consultant-led A&E services;
- A&E at Calderdale Royal Hospital to receive all blue-light emergency ambulances;
- A&E at Huddersfield Royal Infirmary will be for self-presenting patients;
- Patients requiring care to be transferred by ambulance to Calderdale Royal Hospital and critical care provided at Calderdale Royal Hospital;
- 24/7 anaesthetic cover at Huddersfield Royal Infirmary;
- Physician led step-up and step-down inpatient care at Huddersfield Royal Infirmary;
- Greater use of digital technology across hospital, primary care, community care and mental health services.

In December 2018 the Department of Health and Social Care (DHSC) confirmed that capital funding of £196.5m had been allocated to support implementation of the enhanced proposal and that this was included as part of the Government's major multi-year £2.9 billion funding package of additional capital investment in the NHS to provide better service models for patients, integrate care services and renew aging facilities.

Working across the wider West Yorkshire and Harrogate footprint

West Yorkshire and Harrogate health and care partnership is made up of a wide range of organisations from health, Local Authorities, voluntary and the community sector. The partnership works closely together to plan services and address the challenges that face the health and care sector in the area. The CCG is fully involved in the work to improve the health and care of local people. Some of the priorities being taken forward across the partnership are:

Integrated Urgent Care

A new Integrated Urgent Care service has been procured across Yorkshire and the Humber, re-commissioning NHS111. The contract which went live on the 1st April 2019 is the culmination of a competitive dialogue procurement process lasting 12 months, involving 21 CCGs and NHS England. The new service will help to ensure improved access to clinical advice for patients.

- Ensuring that Hyper Acute Stroke Services are sustainable and fit for the future;
- Healthy Hearts improvement project to identify more people with high blood pressure, helping them to control it better – reducing the risk of heart attacks and stroke;
- Reducing variation in planned care;
- Urgent and Emergency Care – an integrated approach to Urgent care services;
- Cancer services – including a 'whole system' collaboration to reduce smoking prevalence, improve early stage diagnosis and improve support for people living with and beyond cancer.

Detecting Cancer Early

Bowel cancer is the fourth most common cancer in the UK. If it is detected at an early stage, it is easier to treat and there is a better chance of survival. For those people who are displaying early signs and symptoms of possible bowel cancer we have introduced a more effective non-invasive test, known as FIT. This provides a more accurate result to help determine whether further investigation is needed. This means that only those people who need a colonoscopy are referred.

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

Further information on the West Yorkshire and Harrogate Health and Care Partnership and workstreams can be found at: http://www.wyhpartnership.co.uk/our-priorities.

Further information on the Joint Committee of CCGs can be found in the Governance Statement.

Keeping People Safe and Improving Quality of Care

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

- Building on the close working relationships with our providers through, e.g. the Quality Boards.
- Participating in quality visits with colleagues at Calderdale and Huddersfield NHS Foundation Trust, focusing on specific areas of quality and safety. These have tested whether front line staff are aware of and are implementing processes such as learning

Patient Stories

Patient stories enable the governing Body to hear about the experiences and needs of people accessing health services. They also set the tone for a meeting by starting with a patient focus and promoting a position of empathy prior to any decisions being made.

Throughout the year we have heard a number of stories at our Governing Body including the experience of children and their families as well as the impact of developing pressure ulcers: https://youtu.be/OTutrN1jEoY

We also heard staff experience stories in relation to our Mental Health First Aider (MHFA) programme (see also staff report)

from serious incidents, falls and medicines management.

- Participating in quality visits with colleagues at South West Yorkshire Mental Health Partnership NHS Foundation Trust to understand the level of progress made against the latest CQC inspection - identifying those areas where commissioning decisions could assist improvement.
- Working with care home providers to ensure safe delivery of care for clients and, where they are struggling, to support them with the improvements required. In the homes that have been rated inadequate by CQC the input and support provided by the CCG has contributed to an improvement in the CQC ratings.
- Maintaining a rigorous grip on quality performance through the scrutiny of the quality and safety dashboards.
- Encouraging member practices to report incidents, identifying themes and share learning in order to improve safety in the way services are provided.
- Monitoring quality and safety in primary care, through "critical friends" visits where concerns have been raised. We use the NHS England Quality Assurance Process to support this process.
- Embedded the Quality Impact Assessment process within the organisation and working with partners across West Yorkshire and Harrogate Health and Care Partnership to develop a single approach to Quality and Equality Impact Assessment.
- Sharing patient stories at every Governing Body meeting in order to learn about experience of health services and how we can improve those services for our patients.

Quality For Health

Quality For Health (QFH), developed by Voluntary Action in partnership with the CCG, is a quality assurance standard for voluntary and community organisations which enables them to evidence the delivery of high quality outcomes for local people. Over the past 12 months QFH has grown on a local and national scale and now has 20 QFH approved providers in Calderdale, with a further 11 working towards the standard.

The CCG has invested in Quality For Health for 2019/2020 as part of our ambition for a vibrant voluntary and community sector.

Voluntary Action Calderdale is part of a national steering group to develop quality assurance for social prescribing.

(For more information, on QFH, visit https://www.youtube.com/watch?v=FVo0I_O0Bdw)

Some of examples of our work are:

Learning Disability Mortality Riews (LeDeR)

The learning disabilities mortality review programme has been established as a result of one of the key recommendations of the Confidential Enquiry into the premature deaths of people with learning disabilities (CIPOLD). It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England (NHSE) and supports local reviews of deaths of people with learning disabilities aged 4 to 74 across England.

We have learned that care is good when:

- *The learning disability nurse is able to support people in hospital;*
- *The same people support a person and get to know them well;*

- *The hospice is involved in end of life care planning.*

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

- *Planning early about end of life care;*
- *Making documents available and including person's thoughts and wishes;*
- *Support for families after someone dies;*
- *More people having Annual Health Checks.*

We are working hard in Calderdale to improve the outcomes of people with learning disabilities. One example is the introduction of an End of Life Workbook that 'Supported Living' providers have completed to increase their confidence and knowledge in how to look after people at the end of life and what to expect. Screening and health checks for people with learning disabilities are also being improved.

Calderdale, Kirklees and Wakefield have established a 'Learning into Action' Group that includes a self-advocate. The group has committed to an advocate's challenge in each meeting of something to be worked on to improve the lives of people with a learning disability.

Safeguarding Adults and Children

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

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

A notable change in the last year followed a review of the commissioned Children Looked After service (CLA) and Care Leavers. The CCG Designated Nurse for Safeguarding Children has now taken on the role of the Designated Nurse for Children Looked After (CLA) and Care Leavers. This has enabled the provider to develop a full wrap around service for those looked after children in Calderdale who are placed within and outside the district; supporting the delivery of high standard assessments, continuity of care for these children and includes the provision of health passports for all care leavers.

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

This has included:

- Working with health providers to protect people from abuse and neglect;

- Delivering the Health and Wellbeing Board Domestic Abuse Pledge – the team have engaged fully in the work of the partnership and led on the delivering of a single point of contact for all health agencies within the local domestic abuse hub;
- Further development of safeguarding in primary care by facilitating quarterly meetings with safeguarding lead GPs - providing group supervision, training, shared learning from case reviews, template policies and regular safeguarding newsletters.
- Developing CCG systems so that those people whose care and treatment has to be particularly restrictive in order to keep them safe - are also afforded human rights' protections through the Deprivation of Liberty Safeguards;
- Playing a full role on the Local Calderdale Safeguarding Children & Adults Boards. This includes developing the new safeguarding children's partnership arrangements following the publication of the 2018 'Working Together to Safeguard Children'. Work with the Calderdale Safeguarding Adults Board has included the development of a new quality and performance scorecard, new policies and guidance and improving the partnership response to self-neglect.
- The team has continued to provide a health leadership role and be fully engaged in local arrangements for Serious Case Reviews, Safeguarding Adults reviews and Domestic Homicide Reviews.

Ensuring system resilience

The Accident and Emergency Delivery Board plays a key role in ensuring regular dialogue between the CCG, primary and secondary care, social care, the voluntary sector, Healthwatch and Community Pharmacy West Yorkshire in order to maintain good system resilience. The Board keeps under review system performance and identifies mitigating actions. As part of this, it seeks and receives assurance on emergency and business continuity planning. It also provides an opportunity for partners to come together to resolve issues and nurture innovation. In 2018-19, the focus of the A&E Delivery Board has been on:

- Supporting the new Urgent Care System Resilience Group programme;
- Development of winter planning including surge and escalation plans with revised trigger points;
- Providing oversight of the work to achieve the expected reductions in delays in transfer of care and length of stay;
- Ensuring that mental health services are incorporated into any A&E Delivery Board planning;
- Improving access across the 7 day period, including improving access to primary care.
- Seeking assurance on contingency planning across the system as part of the preparations for EU-Exit.

Financial performance and system financial recovery

Financial Performance

The CCG has had a challenging financial year in 2018-19. The financial plan for the year was to deliver an in year breakeven position and maintain an accumulated surplus position of £4.6m.

In order to achieve this plan, the CCG had a QIPP savings target of £8.1m (2.8%). A summary of Calderdale CCG's allocations and expenditure is set out in the table below:

Calderdale CCG: Summary of allocations and expenditure (2018-19)	Allocation £'000	Expenditure £'000	Variance £'000
Accumulated surplus brought forward	-4,552	0	-4,552
Programme allocation	-287,484	287,504	20
Primary medical services allocation	-29,436	29,436	0
Running cost allocation	-4,697	4,677	-20
Total allocation	-326,169	321,617	-4,552
In year surplus	0	0	0
Accumulated surplus	-4,552	0	-4,552

I am pleased to say that the CCG has been able to deliver its financial plan for 2018-19, despite the financial challenges. The CCG successfully delivered £7.5m QIPP savings however the shortfall against the planned £8.1m savings caused a financial pressure during the year. The CCG was able to mitigate this pressure through its contingency budget.

This has been the first year of an Aligned Incentive Contract with our main acute provider (Calderdale and Huddersfield NHS Foundation Trust) which has enabled the CCG to mitigate the usual volatility in acute cost pressures and has developed our partnership working to focus on system sustainability pressures rather than the potential negative effects of Payment by Results contracts. This approach resulted in the CCG being able to manage the fluctuations in its medicines management costs and other contract variations within existing resources and deliver over £2m of system efficiencies.

The CCG has a number of statutory financial duties and targets against which our performance is monitored. Although we have experienced significant financial challenges, I am pleased to be able to report that we have met all our statutory financial duties. The table below shows a summary of the CCGs performance against these targets in 2018-19:

Financial Duty	Achieved / Not Achieved	Performance in 2018-19
Achieve operational financial balance	Achieved	Delivered surplus of £4,552
Revenue administration resource use does not exceed the amount specified in Directions	Achieved	The CCG underspend on its administration by £20k
Maintain capital expenditure within Capital Resources	Achieved	No capital resource limit set in 2018-19
Manage cash within the CCG's Cash Limit	Achieved	Cash balance of £1k
Better Payment Practice Code - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty)	Achieved	99%

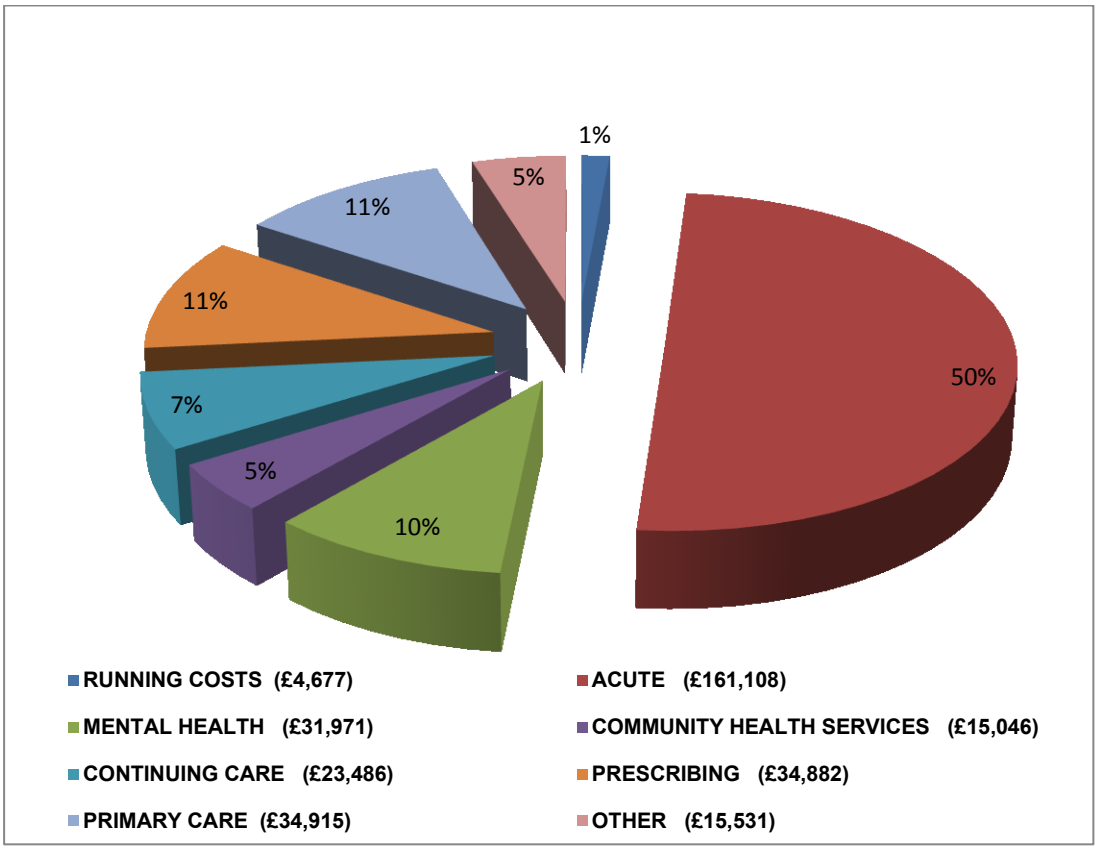
Investments in services

During 2018-19 we invested over £321.6m to improve the health and care of local people through the commissioning of high quality services. The CCG made a number of specific new investments in health care services during the year. These include:

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

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

Net investment by the CCG in 2018-19 (£'000)



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

Financial planning for 2019-20

The plan for 2019-20 is to again deliver an in-year breakeven position and to maintain a cumulative surplus on £4.6m. The CCG has received growth in its allocations which are shown in the table below:

Calderdale CCG 2019-20 allocations	Programme	Delegated Primary Medical	Running Costs	Total
	£'000	£'000	£'000	£'000
Start Allocation	285,433	29,449	4,646	319,528
Growth	15,578	861	18	16,457
Total	301,011	30,310	4,664	335,985
% uplift	5.46%	2.92%	0.39%	

Although the CCG has received a higher uplift than in previous years, much of the uplift has been earmarked to fund changes to national tariffs and also changes in the NHS Agenda for Change pay commitments. The CCG has a QIPP savings target of £6.2m which represents 1.8% of our programme allocation.

The CCG has also included a number of reserves within our financial plan for 2019-20 which reflect NHS England guidance, these include:

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

In addition the CCG has recognised in its financial plan funding to cover investments in areas where there have been significant pressures. These include:

- Investment in NHS 111 and Out of Hours services
- Investment into Yorkshire Ambulance Services (YAS)
- Investment into Continuing Healthcare and Funded Nursing Care

The CCG has continued its aligned incentive contract arrangements with Calderdale Hospital NHS Foundation Trust into the new financial year. The focus will continue on ensuring the financial sustainability of the local health economy through system wide transformation programmes to ensure that health services are delivered in the most effective and efficient way whilst continuing to deliver high quality services.

Running costs

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

The Governing Body has agreed the financial plan for 2019-20 and recognises that the level of savings required to meet our plan is challenging. As part of any investment recognised above the Governing Body has clear expectations of how they will aid our recovery and financial sustainability as well as deliver clear outcomes for patients.

Financial Risk

As part of our planning process the CCG has identified a number of risks that threaten delivery of our 2019-20 financial plan which are reflected on our corporate risk register (see appendix 1: Governance Statement: risks to the CCG), these include:

- That spending in hospitals providing acute services, increases above that currently forecast;
- That prescribing spend is higher than that forecast in plan;
- That continuing care spend continues to grow above the level that we have forecasted in plan;

- That QIPP schemes do not deliver the required level of cash releasing savings.

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

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

The Performance Report – Sustainability Report

This section of the Annual Report contains information about our key activities in relation to sustainable development.

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

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

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

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

Corporate Approach

- As a commissioning organisation and employer, we have a Governing Body lead for sustainable development and have Sustainable Development Management plan which will be refreshed in 2019.

Travel and logistics

- We have assessed our transport and travel and have calculated our carbon footprint (see below);
- Our Expenses Policy sets out our commitment to sustainability;
- We assess the travel, transport and accessibility of locations for engagement and consultation meetings and follow up any events with a questionnaire to participants which informs future choice of venues – Our preferred model is to go where people are, rather than expecting people to come to us. This is supported by working with our engagement champions. (https://www.calderdaleccg.nhs.uk/get_involved/)
- We use technology to reduce the number of journeys being made by our staff – who are increasingly working across West Yorkshire as we develop collaborative working as part of the Health and Care Partnership. Reducing the amount of travelling required contributes to an improvement in staff health and wellbeing, increases efficiency, reduces our impact on the environment and reduces running costs. **This year we have held an estimated 270 teleconferences involving 432 people and 24 videoconferences involving an estimated 42 people.**

Adaptation

Responding to the effects of climate change is embedded in our Emergency Planning, Resilience and Recovery (EPRR) work as part of fulfilling our responsibilities under the Civil Contingencies Act 2004. We work closely with partners across the system on business continuity planning, ensuring that Surge and Escalation Plans as well as heatwave and winter plans are in place. We also take part in flood planning exercises with partners across Calderdale. In October 2018 we self-assessed **'substantial'** compliance against the national EPRR core standards (see also system resilience – performance report).

Sustainable care models

Building sustainable care models is central to all our work with partners across Calderdale as a Place and across West Yorkshire and Harrogate Health and care Partnership. Sustainability principles are embedded in our commissioning plans. Details of our work on Care Closer to Home, Calderdale Cares and the work that is being taken forward in localities we are taking forward, can be found in the Performance Report – Key Activities.

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

Our people – Encouraging a healthy workforce

(*This also supports our contribution to 'Green Space and Biodiversity*)

We are committed to a workplace culture that creates motivated employees who feel valued by the CCG and each other, and whose contributions are celebrated. This promotes overall staff wellbeing and encourages the innovation and continuous improvement needed to benefit the health and lives people living in Calderdale. Our staff forum promotes and leads a wide range of activities that support the physical, social and psychological wellbeing of all staff.

Some examples are:

- Staff volunteering: to benefit the local community and support staff in developing an understanding of our local communities. We have taken part in a scheme in central Halifax to read to care home residents who suffer from Dementia and helped create a wheelchair-accessible garden at a north Halifax community centre;
- Charitable giving: over £180 was raised through the year for national charities and donations made to local food banks and the Women's Shelter;

- Promoting national campaigns, such as Time To Talk Day, Macmillan Cancer Coffee Morning and the NHS' Antibiotic Guardian and Sepsis campaigns;
- Relaunching of the CCG's 'Star Awards' – for staff to recognise each other for 'a job well done' or visibly demonstrating the CGG's values;
- Offering blood pressure monitoring and healthy weight sessions;
- Highly popular, informal "coffee, cake and catch-up" sessions every month to encourage positive relationships across the organisation, with a regular focus on promoting positive mental health (see also the Staff Report).

Sustainable use of resources

At the CCG, we continue to work to reduce our carbon footprint at our headquarters at Dean Clough. In 2018 we:

- Introduced the use of recycling bins in our staff kitchen resulting in the recycling of over **5,500 litres** of rubbish
- Have moved to the use of recycled paper and have **saved 6.5 trees** through recycling shredded paper.

Resource usage in 2018-19

Resource	Quantity (kWh)		tCO2 emissions		Cost (Inc. VAT) (£)	
	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19
Gas (note 1)	36,170	93,531	8	20	1,713	3,746
Electricity	51,109	47449	23	21	9,103	9,061
Water (note 2)	--	--	--	--	--	--
General waste (note 3)	--	--	--	--	--	--
Recycling (including confidential waste)	--	--	--	--	2,191	2,633
	Kg	Kg			Kg	Kg
Composting (Kitchen Waste)	68	0	--	--	--	--
	Miles	Miles				
Business Travel	57,605	55877	20.5	19.91	31,606	37,978
Business Travel – Car Share	3,794	2,600	-	-	190	130

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

The Performance Report – Meeting our Statutory Duties

This section of the Annual report confirms that we are compliant with all our statutory duties and summarises our activities in the four areas below:

Ensuring the Continuous Improvement in Quality

(Section 14R, NHS Act 2006 as amended)

Ensuring patient safety and improving quality is core to the role of the CCG. We work hard to maintain strong relationships with our providers, participating in quality visits at both CHFT and SWYPFT, working with care home providers to ensure safe delivery of care for clients and maintaining a rigorous grip on quality performance through the scrutiny of quality and safety dashboards and monitoring quality and safety in primary care.

Further information on our activity to reduce harm, improve effectiveness and experience throughout the year can be found on page 24.

Serious Incidents and never events

No serious incidents and never events have been reported for 2018-19. We continue to work with Calderdale and Huddersfield NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust on an improvement strategy to learn from serious incidents.

Performance rating

The 2018-19 year-end assessment against the CCG Improvement and Assessment Framework for our CCG will be available from July 2019 on www.nhs.uk/service-search/performance/search

Engaging people and communities

(Section 14Z2 of the NHS Act 2006 (as amended))

Our Public and Patient Involvement and Experience Strategy sets out our approach to involving local people and the legislation that the CCG must work to. The duty to involve local people is set out in Sections 242 and 244 of the Health and Social Care Act 2012, The NHS Constitution and the Equality Act 2010.

The CCG has involved just over **3,000** local people in the year 2018-19 on the following service areas:

- Wheelchair Services Engagement and workshops
- Active Calderdale
- Autism
- A week in the life of A&E
- Equality Delivery System and how we involve children and young people and people who are LGBT

'Couch to 5k' runners at Bankfield Surgery. For more information visit https://youtu.be/sr5606LX97k

A separate engagement annual report (2018-19) provides a full account of this work and will be available on the CCG's website in July 2019. This report provides more information on how both the CCG and the commissioned service providers have involved local people in the development, design and delivery of services throughout the year. The report also sets out who has been involved, what people have told us and what has happened as a result. Each section is a summary account with links to the published reports.

Using the insight we already hold:

Using the information we already hold ensures that we don't ask local people to respond to the same question over and over again. We value the contributions people make and always review the information we hold before we do any further engagement.

This means that the voice of local people is continually being reflected, even years after it was given. Using the information we already hold, we have created two insight reports which will help support the design of community and hospital services. The voice of local people documented in these reports can be found on our website at: www.calderdaleccg.nhs.uk/you-said-we-did/

Giving everyone a voice:

A key focus of work for 2018-19 has been to demonstrate how well we have involved all our local population with a particular focus in our protected groups.

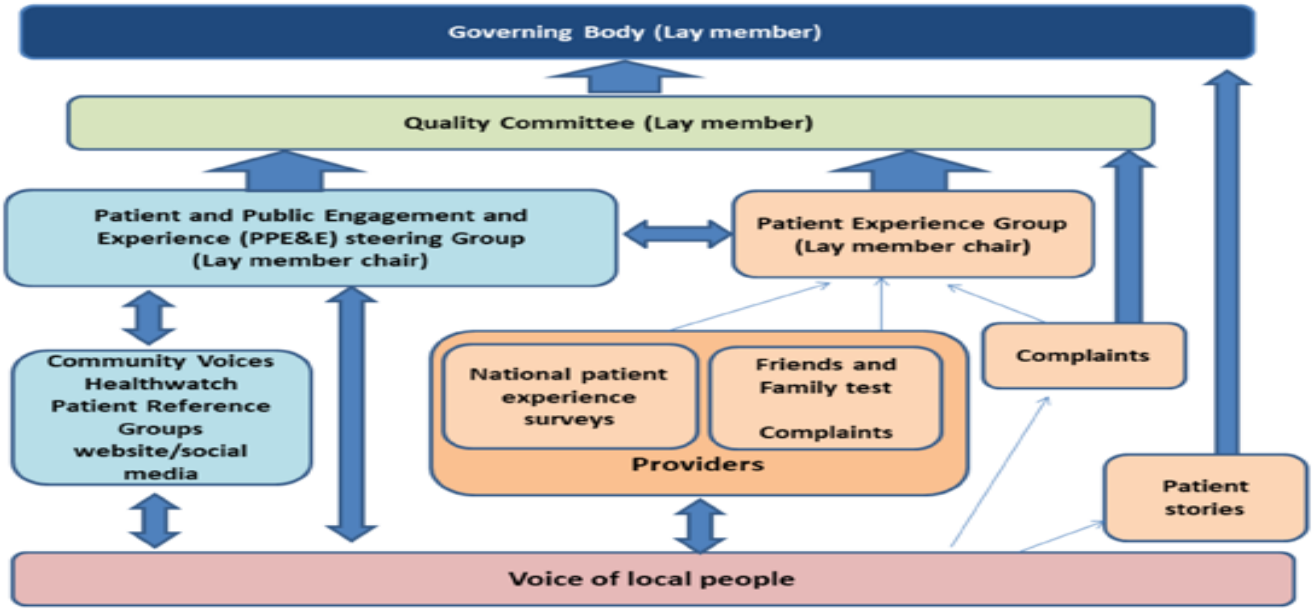
We have reviewed our engagement function using the Equality Delivery System (EDS). This consisted of a panel of diverse local people recruited from the community to rate our engagement function and provide recommendations for improvement. The panel scored Calderdale as '**achieving**' with some suggested improvements which were built into a 2 year action plan. The recommendations were to do more work to strengthen the voice of the LGBT population and of children and young people:

- Created an equality newsletter which describes our progress;
- Conversations with LGBT children and young people has ensured that the equality monitoring form we use in surveys has been adapted to include a wider range of gender and sexual identities;
- We have worked with young people to co-produce a young person friendly survey so we can improve surveys in the future;
- The CCG is now an active member of the LGBTQ+ Partnership Network and are working towards the group aim of '***celebrating an inclusive voice that is visible and has influence'***.

In addition, we have developed our website's '*get involved'* page to demonstrate the support offered to get involved. The website also now has the software 'BrowseAloud' which is another means of ensuring that the website and all publications are fully accessible.

How public and patient involvement influences our commissioning decisions:

The diagram below sets out the governance for involving local people and how the voice of local people is fed into the organisation. We know that everyone wants to be involved in meetings but we want to show how the voice of local people is filtered through the organisation so that local people can be assured that their views are heard.



The results of the Ipsos Mori 360 Stakeholder review in 2019 confirmed support for our approach with 79% of respondents agreeing that when the CCG is commissioning or decommissioning services it:

- demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care;

- engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes;
- asks the right questions at the right time (75% respondents agree);
- Involves the right individuals and organisations (77% respondents agree).

A copy of our Public and Patient Involvement and Experience Strategy can be found at: **https://www.calderdaleccg.nhs.uk/key-documents/)**

Reducing Health Inequalities

(Section 14T NHS Act 2006 (as amended))

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

In response to the delivery of Calderdale Cares, we have worked with our partners across Calderdale to develop five localities. The localities build on formal and informal community networks and groups of general practices seeking to develop the provision of services, based on the specific needs of each locality, thereby tackling the specific health needs of localities and reducing the health inequalities gap. This approach has put us in forefront of national policy and the recently published GP Contract (also see page 19)

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

- Clear collaboration on the content of the Calderdale Joint Strategic Needs Assessments;
- A key focus refreshing the Wellbeing Strategy for Calderdale on tackling the wider determinants of health;
- Delivery of the Triple Aim of Improving Health, Quality and Value;
- The Council's Directors of Public Health and of Adults and Wellbeing are advisors to the CCG's Governing Body;
- The Public Health Consultant attending our Quality Committee and Local Medical Committee Executive;
- A number of joint improvement activities led by ICE, including strengthening our community equipment offers, working together on plans to strengthen personalisation, developing a joint approach to end of live care and also reablement.

Equality and Diversity

We are committed to ensuring that equality and diversity is a priority when planning and commissioning local healthcare. To help us do this we work closely with local communities to

understand their needs and how best to commission the most appropriate services to meet those needs. Our Equality and Diversity Strategy ensures that all activity puts equality at the centre of what we do both as commissioners and employers.

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

- Bespoke training for Governing Body members on equality for decision makers;
- Supporting the Calderdale Equality Health Panel, which provides a platform for community groups to engage in regular dialogue with local healthcare organisations;
- Our work as part of the Equality Delivery System **(**EDS2) outcomes to inform the Equality Objectives for 2018-2022 (see page 37);
- Making sure that equality is embedded into systems and processes to support delivery of system recovery;
- Performance against the delivery of our equality and diversity duties is reported into the Quality Committee on a quarterly basis, with the Annual Report being submitted to the Governing Body.

Case Study: Partnership working

Whilst there is a long history of the NHS working with local authorities and voluntary sector partners to deliver better health and social care services to local communities, there is a renewed emphasis on partnership working to deliver new models of care and support.

In order to deliver our equality objectives we established a multi-agency steering group to oversee the work and support the design and implementation of our action plans. The steering group has broad representation from the CCG, the local authority and voluntary sector partners including Voluntary Action Calderdale, Barnardo's and The Brunswick Centre.

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

Contribution to the delivery of the Health and Wellbeing Strategy

(Section.116B (1)(b) Local Government and Public Involvement in Health Act 2007)

The CCG plays an active role on the Health and Wellbeing Board and the delivery of the Single Plan for Calderdale and Calderdale Cares is one of the key priorities for the CCG. Further information on the work being taken forward across Calderdale can be found in the Performance Report.

The Health and Wellbeing Board is attended by The Chief Officer and Chair of the CCG and oversight of delivery of the plans is provided by the joint officers group. The CCG has taken an active role in developing the new Wellbeing Strategy, which builds on the Single Plan for Calderdale and is aligned to the Inclusive Economy Strategy as well as national policy and

established good practice. The refreshed Strategy will focus on activities that support: starting well, staying and working well, aging well – tackling wider determinants of health, reducing inequalities and improving health life expectancy.

The new Wellbeing Strategy includes a refreshed vision:

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

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

Outcomes	**Improving health (ensuring children have the best start in life, health inequalities are reduced and people are enabled to live independently at home for a long as possible)**
	Improving quality of services and the experiences of those who received them
	Improving efficiency (ensuring services and ways of working are effective, productive and avoid waste)
	Improving the experiences of our staff and volunteers, ensuring they feel valued and get joy from the work that they do.

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

Appendix one: Performance against NHS Constitution

NHS Constitution Rights and Pledges 2018/19 - CCG Level

Reporting Period: Mar-19

NHS CALDERDALE CCG

	Measure	Target / Baseline	Period Actual	Period RAG	YTD	YTD RAG	Direction of travel
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	83.5%	-	80.7%	-	▲
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	90.7%	-	91.9%	-	▼
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	92.0%	●	92.4%	●	▲
	Patients on incomplete pathways waiting more than 52 weeks	0	6	●	108	●	▼
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	87.9%	●	96.7%	●	▼
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	94.5%	●	91.3%	●	▲
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0	●	1	●	↔
Cancer Waits - 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	97.3%	●	98.3%	●	▼
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	96.4%	●	97.8%	●	▼
Cancer Waits - 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	98.9%	●	97.1%	●	▲
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	92.5%	●	95.5%	●	▲
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	●	99.7%	●	↔
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	●	99.4%	●	↔
Cancer Waits - 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	85.4%	●	85.1%	●	▼
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	●	95.7%	●	▲
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	tba	75.0%	tba	75.0%	tba	▼
Ambulance Calls	Category 1 **	00:07:00	00:06:44	●	00:07:21	●	▼
	Category 2 **	00:18:00	00:17:40	●	00:20:26	●	▼
	All handovers between ambulance and A&E must take place within 15 minutes *	95%	78.7%	●	80.2%	●	▼
	All crews should be ready to accept new calls within a further 15 minutes *	95%	70.3%	●	71.3%	●	▲
Mixed Sex Accomodation	Minimise breaches	0	1	●	2	●	▲
MRSA	Number of MRSA reported infections	0	0	●	5	●	▼
C_Diff	Number of C_Diff reported infections	38	2	●	2	●	▲
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	Q4 0	●	1	●	↔
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%	Q3 97.1%	●	96.0%	●	▲

The Accountability Report

Dr Matt Walsh
Accountable Officer

22 May 2019

The Accountability Report

This section of the Annual Report enables the CCG to meet key accountability requirements to Parliament. The Accountability Report is divided into the:

- The Corporate Governance Report – which includes:
  - The Members' Report
  - The Statement of Accountable Officer's Responsibilities
  - The Governance Statement
- The Remuneration and Staff Report
- The Parliamentary Accountability and Audit Report.

The Corporate Governance Report – Members' Report

The CCG is a membership organisation and consists of the 25 practices that are based in Calderdale (see appendix 1 to this Members' Report). The practices work together throughout the year to improve the quality of care, access to services and experience for local people. They do this in a number of ways; through meetings of the Practice Commissioning Leads, Locality meetings, the Medicines Advisory Group and the Practice Managers Action Group. Over the last few months they have been developing plans for the introduction of Primary Care Networks as part of the wider locality working under Calderdale Cares (see Performance Report)

Member Practices

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

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

Releasing Time for Care – Learning in Action

In October 2018, the CCG organised a 'Releasing Time for Care (RTFC)' Event for its member practices, the event was facilitated by the National Programme Team and focussed on the 10 High Impact Actions and what the practices could do to make an impact in their own organisation. The event which was focused on "Demand Management", attracted over 90 general practice delegates.

- incentivise and encourage practices to analyse referrals and own referral behaviour;
- Encourage practices to manage a greater proportion of demand within a primary care/community based setting, where appropriate;
- Reduce variation in referral rates between practices.

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

Practice Commissioning Leads

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

Localities

The member practices are supported by the CCG to meet together in their localities. They worked collaboratively to support the redesign of patient pathways – leading to improved efficiency, effectiveness and patient experience. A significant focus this year has been on prescribing and medicines management (see Performance Report).

Performance of the membership

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

- Attendance at meetings –The CCG held 5 Practice Commissioning Leads' meetings and 5 Protected Learning Time afternoons.
- There has been excellent attendance at the Practice Leads meetings;
- The sharing of peer review of referrals and non-elective admissions and A&E activity at the practice leads events;
- Evaluation of the effectiveness and value of each Practice Leads meeting carried out to inform future planning;
- The end of year collaboration report is used by the CCG to identify any opportunities or

Hospital clinicians and primary care working closer together

Good communication and relationships between clinicians working in primary and secondary care are vital to minimise clinical risks and to deliver the best experience of care and outcomes for patients.

In July, 74 Calderdale GPs and CHFT Consultants came together to hear about the experiences of general practice and hospital consultants in delivering care – particularly in paediatrics and frailty.

Participants agreed to work together on areas such as direct access to consultants on call and duty doctors in GP surgeries, the issuing of fit notes and ways of reducing unnecessary attendances at A&E.

further development as well as assessing the effectiveness of the commissioning engagement scheme and collaboration fund.

Highlights from the work of the practices

Highlights from the work of the practices can be found in the Performance Report.

Chair and Accountable Officer

Dr Steven Cleasby is the CCG's Chair and Dr Matt Walsh is the CCG's Accountable Officer.

Governing Body and its Committees

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

Composition of the Governing Body (2018-19)		
7 GPs as elected by the member practices, including the clinical chair.	Dr Alan Brook	Chair until 30 April 2018
	Dr Steven Cleasby	Chair from 1 May 2018; Clinical Vice Chair until 30 April 2018
	Dr Majid Azeb	Clinical Vice Chair from 1 May 2018
	Dr Helen Davies	
	Dr James Gray	GP Member from 28 June 2018
	Dr Farrukh Javid	
	Dr Caroline Taylor	
	Dr Nigel Taylor	
Three lay members (including the deputy chair)	David Longstaff	Deputy Chair (Audit, Conflicts of Interest Guardian and Freedom to Speak Up Guardian)
	John Mallalieu	Lay Member (Finance and Performance)
	Kate Smyth	Lay Member (Patient and Public Involvement) until 31st January 2019
Secondary Care Specialist and Registered Nurse	Dr Robert Atkinson	Secondary Care Specialist
	Professor Rob McSherry	Registered Nurse (from 1 August 2018)
Accountable Officer	Dr Matt Walsh	
Chief Finance Officer/ Deputy Chief Officer	Neil Smurthwaite	
Chief Quality and Nursing Officer	Penny Woodhead	(from 2 August 2018); Advisor to the Governing Body until 1 August 2018
Invitations to assist the Governing Body		
Director of Adult Services or another Director that holds a health and social care portfolio (Calderdale Council)	Stuart Smith	Director of Adults and Children's Health and Social Care Services (until 9 August 2018)
	Ian Baines	Director of Adult Health and Wellbeing (from 11 October 2018)
Director of Public Health (Calderdale Council)	Paul Butcher	Director of Public Health

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

Register of Interests

Clinical Commissioning Groups are required to make arrangements to manage actual or potential conflicts of interest so that decisions by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest[3]. The CCG has a number of systems and processes in place to manage conflicts of interests. These are set out in the CCG's Constitution, our Policy on the Management of Conflicts of Interest and our Standards of Business Conduct.

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

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

Personal Data Related Incidents

During 2018-19, there were no personal data-related incidents that met the required threshold for notification to the information Commissioner's Officer. Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject).

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

Statement of Disclosure to Auditors

Each individual who is a member of the CCG's Audit Committee at the time that the Members' Report is approved confirms:

- **So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report;**

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

- **The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.**

Modern Slavery Act

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

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

GP practices are regularly briefed by the CCG's safeguarding team about local modern slavery figures, local and national campaigns and partnership initiatives. All safeguarding training delivered by the team to GP practices includes modern slavery and human trafficking.

E-learning training is available via West Yorkshire Police free of charge for health partners.

The main focus for health partners (as part of Calderdale's partnership Modern Slavery Action Plan 2018-19) is to improve the skills and knowledge for all frontline health professionals who have face to face contact with victims.

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

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List of Member Practices and Practice Commissioning Leads

Locality	Practice	Practice Commissioning Lead
Group 1 Upper Valley	Hebden Bridge Group Practice	Dr K Moore
	Todmorden Group Practice	Dr Suki Vivekanathan
Group 2 Lower Valley	Church Lane	Dr Sajid Khan
	Longroyde Surgery	Dr Jill Grant
	Northolme & Kos	Dr S Santhanam
	Rastrick Health Centre	Dr F Javid
	Rydings Hall	Dr A Wilkinson
Group 3 South Halifax	Bankfield Surgery	Dr J Gray
	Brig Royd Surgery	Dr L Pickles
	Meadow Dale Group Practice	Dr T Draghici
	Stainland Road	Dr F Azam
	Station Road Surgery	Dr Arif Kazi
Group 4 North Halifax	Beechwood Surgery	Dr Louise King
	Caritas Woodside Surgery	Wendy Iles
	Keighley Road Surgery	Dr K Simpson
	Lister Lane Surgery	Dr K Kumar
	Plane Trees Group Practice	Dr Dinesh Kumar
Group 5 Central Halifax	Boulevard Medical Practice	Dr P Rajeswari
	Horne Street Surgery	Dr Muhammed Niazi
	King Cross Surgery	Dr Helen Bolland
	Rosegarth Surgery	Dr Paul Sawczyn
	Queens Road Surgery	Dr A Jagota
	Park Community Practice	Vacancy
	Spring Hall Surgery	Dr Felicity Price
	Southowram Surgery	Dr Majid Azeb

The Corporate Governance Report – Statement of Accountable Officer's Responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- 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);
- Safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006);
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

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

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

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

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

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

I also confirm that:

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

The Corporate Governance Report – Governance Statement

Introduction and context

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

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

As at 1 April 2018; the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

Governance Framework

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

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

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

Responsibilities of the CCG membership body

The CCG is a membership body which consists of the 25 general practices in Calderdale. The member practices are responsible for agreeing the vision and values and overall strategic direction of the CCG. A number of decisions are reserved to the membership and these are set out in the CCG's Scheme of Reservation and Delegation, including approval of:

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

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

Responsibilities of the Governing Body

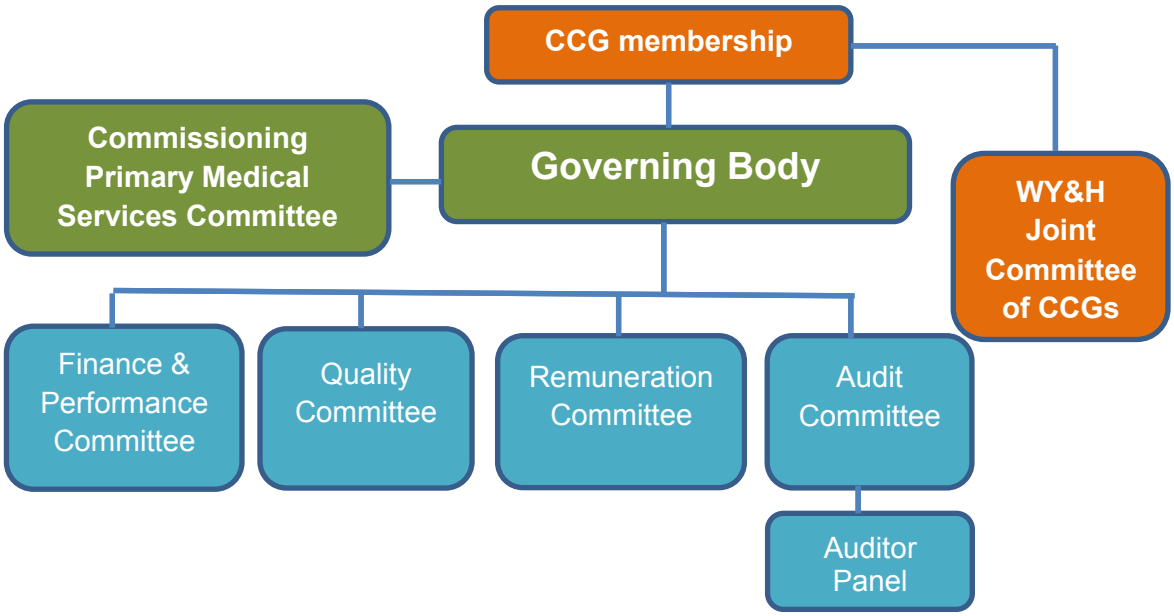
The CCG's Scheme of Reservation and Delegation sets out those decisions that are delegated by the membership to the Governing Body and its committees. These include approval of:

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

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

The governance structure of the CCG is set out below.

Governance Structure of the CCG



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

Work of the Governing Body

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

Governing Body key activities in 2018-19

The Governing Body is actively involved in the formulation of the CCG's strategic priorities and ensuring their delivery. Supported by the management team, this activity is taken forward by the Governing Body's clinical leads, through our Clinical Development Forum and the Governing Body Development workshops and through the business of our formal Governing Body meetings held in public. Key areas of activity this year have been:

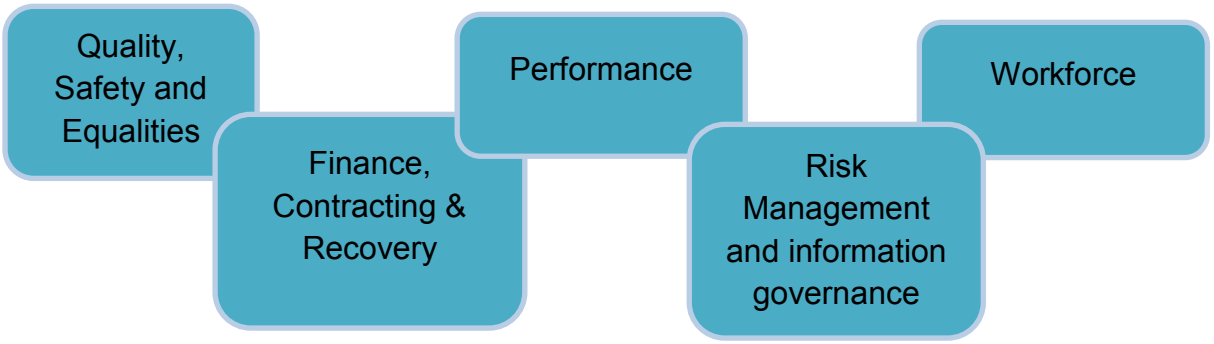
Strategy

- Working with the Health and Wellbeing Board on the delivery of the Single Plan for Calderdale through the mechanism of Calderdale Cares;

- Developing primary and community care;
- Approved the commissioning of the prescribing gainshare scheme – which seeks to drive improvements in performance through locality working (see Performance Report).
- Transforming mental health services across Calderdale including care for adults, children and young people with Autism;
- Right Care, Right Time, Right Place – hospital service change
- Signed up to the Health and Wellbeing Board Domestic Abuse Pledge and six commitments.

Performance management and compliance with statutory and regulatory duties

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



The Governing Body has received the Annual Statement of Public and Patient Engagement, the Joint Safeguarding Annual Report and the Annual Report on our Emergency Preparedness, Resilience and Recovery (EPRR) together with the self- assessment of **'substantial'** compliance against the national core standards.

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

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

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

Governing Body Performance

Under the leadership and oversight of the Governing Body, the CCG has delivered its financial plan and has met all its statutory financial duties. whilst there have continued to be

real challenges in terms of performance on some of the National Constitutional Standards, the level of performance in the Calderdale system remains strong when benchmarked with others nationally.

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

The clear focus of the Finance and Performance Committee this year has been upon financial recovery and a number of key performance issues, such as reducing delays in the transfer of care. The Quality Committee has been presented with a clear view of the quality and safety issues that are being addressed by our providers and with actions being undertaken to support an improvement in these areas. The Commissioning Primary Medical Services Committee has made a number of important decisions about GP practice contracts demonstrating a high level of scrutiny and commitment to ensuring that patients are receiving good quality care.

The Audit Committee has continued to provide important assurance to the Governing Body about the robust risk management arrangements and systems of internal control that are in place. This assurance is supported by the independent audit reports produced by Audit Yorkshire. Finally, the Remuneration Committee has considered and made determinations on Governing Body remuneration as well as taking forward a full programme of reviewing and approving 19 workforce policies.

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

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

Governing Body and Committee effectiveness

The Governing Body and its committees carried out their annual self-assessment between January and March 2019. Compliance with committee terms of reference was reviewed as well as Governing Body and committee culture and effectiveness. The outcome of the assessment demonstrated that appropriate governance arrangements were in place and that

the responsibilities of the committees as set out in the terms of reference were being discharged appropriately.

Actions identified for 2019-20

- The Governing Body has agreed to focus on streamlining the formal governance arrangements to improve the balance between routine and exception reporting and release capacity to focus on the strategic priorities of the CCG, particularly in the light of the need to reduce running costs by 20%. This approach is linked to the discussions by the Governing Body on risk appetite.

Work of the Governing Body committees

➢ Quality Committee

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

- Effective quality arrangements underpin all services provided and commissioned by the CCG, including general practice;
- Statutory and regulatory requirements are met;
- Patient safety is continually improved to deliver a better patient experience.

Work of the Quality Committee: Highlights

- Approved 9 service specifications including those for the Rehabilitation and Recovery Model (Mental Health), early intervention in Psychosis, for people with Autistic Spectrum Disorder and for Tuberculosis.
- Continued to seek and receive assurance that all providers had considered relevant national audit recommendations and NICE guidance – putting in place actions plans as needed.

➢ Finance and Performance Committee

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

This year, the committee has overseen the further development of our approach to the internal governance of the QIPP and Financial Recovery Plan and has been assured about the process operating within the CCG in relation to financial recovery.

Finance and Performance Committee: Highlights

- Worked with partners to achieve a further improvement of the Delayed Transfer of Care (DTOC) position in Calderdale, which currently ranks as one of the strongest nationally.
- Strengthened the reporting and assurance processes in relation to the delivery of Cancer standards.

Commissioning Primary Medical Services Committee

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

Work of the CPMSC: Highlights

- Investment of PMS premium funding
- Reviewed and approved policies and procedures for General Practice Boundary Change applications and discretionary financial assistance to practices impacted as a result of list dispersal; change of contract holder and procurement appetite; and contract options for issuing Prior Information Notice (PIN) to procure APMS contracts
- Implementation of the Improved Access service.
- Approval of the Primary Medical Services Emergency Contract Framework

Remuneration Committee

In 2018-19, under delegated authority from the Governing Body, the Remuneration Committee reviewed and made decisions on the remuneration of the Governing Body, Very Senior managers and Associates, whilst ensuring the robust management of conflicts of interest. From April 2019, the Remuneration Committee will make recommendations to the Governing Body on these matters in line with the provisions of the new Model Constitution for CCGs. The Remuneration Committee also has responsibility for reviewing and approving Human Resources Policies.

Work of the Remuneration Committee: Highlights

Reviewed and approved 19 workforce policies to ensure a consistent approach across Calderdale, Greater Huddersfield and North Kirklees CCGs to support shared staff.

Audit Committee

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

Work of the Audit Committee: Highlights

Sought and received assurance on:

- the preparations for the implementation of the General Data Protection Regulation 2018
- the progress towards achieving compliance with the new Data Security and protection Toolkit.
- the systems of internal control in place, as part of the internal audit programme of work.

West Yorkshire and Harrogate (WY&H) Joint Committee of CCGs

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

The Committee is made up of 2 representatives from each of the WY&H CCGs – usually the Clinical Chair and the Accountable Officer. To make sure that decision making is open and transparent; the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the Partnership team and NHS England also attend.

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

Work of the Joint Committee: Highlights

The Committee has:

- Agreed improvements in the vital care that people receive in the first 72 hours after having a stroke;
- Led work to better identify and treat high blood pressure and reduce the risk of people having heart attacks and strokes;
- Agreed policies which help reduce health inequalities and avoid the 'postcode lottery' ;
- Agreed new ways of providing integrated urgent care services;
- Supported work to reduce smoking prevalence, increase early stage diagnosis and improve support for people living with and beyond cancer.

Compliance with the UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, as the UK Code is based on the underlying principles of good governance (accountability, transparency, probity and sustainability of the organisation over the longer term) we have undertaken a self-assessment of the CCG's systems and processes against those principles that are relevant to the CCG. We have identified one area where we have developed in 2018-19 and continue to do so into 2019-20. This relates to the expansion of the role of the Remuneration Committee to take on the functions of a Nomination Committee whilst continuing to comply with the statutory requirements on Remuneration Committee membership.

Standard 3: Composition, succession and evaluation

This standard contains three principles relating to:

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

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

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

CCG Action:

We have developed the role of the Remuneration Committee to include the functions of a Nomination Committee as recommended by the UK Code. This will enable the Governing Body to take a more systematic and formalised approach to:

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

The terms of reference for the Remuneration and Nomination Committee were approved by the Governing Body in April 2019.

An important aspect of our annual self-assessment was the focus on the balance of the Governing Body and committee membership, how effectively the committee members were working together and how effectively the values of the organisation were being demonstrated to staff. This review is being used to inform the development discussions of our Governing Body.

Discharge of statutory functions

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

Responsibility for each duty and power has been clearly allocated to the appropriate member of the Senior Management Team. The members of the Senior Management Team have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Further information on how the CCG has fulfilled its statutory duties can be found in the Performance Report (page 35). This includes compliance with the duty to consult the Health and Wellbeing Board when reviewing the extent to which the CCG has contributed to the delivery of the joint Health and Wellbeing Strategy.

Risk management arrangements and effectiveness

The CCG's Integrated Risk Management Framework (IRMF) describes our approach to managing risk:

https://www.calderdaleccg.nhs.uk/wp-content/uploads/2018/01/Integrated-Risk-Management-FrameworkFeb-2017_FINAL-Uploaded-09.01.18.pdf.

The CCG manages and reports on risk in two ways:

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

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

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

➢ **Risk Identification**

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

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

Table 1: Risk Matrix

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

Risk assessment and risk rating

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

Risk Recording, Reviewing and Monitoring

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

Once every risk cycle, the Senior Management Team (SMT) reviews all the risks on the register, identifies any new risks; assesses the actions to manage/mitigate the risk and the risk rating. Each of the Governing Body committees review those risks relating to their remit. Risks rated as 'Serious' i.e. at 15 or above are submitted to each of the Governing Body meetings. Commissioning Primary Medical Services risks rated 15 or above are also reported

into the CPMS Committee. A 'Critical Risk' report, with an associated action plan is produced for risks rated 20 or above.

Risk Appetite

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

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

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

Embedding risk management in the CCG's Activity

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

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

Incident reporting

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

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

GP Practices are actively encouraged to report all incidents on DATIX. The more incidents that are reported the more information the CCG has to act upon in order to learn from incidents and consequently prevent recurrence. A quarterly GP incident report is provided to the Quality Committee for review and identification of themes. More detailed data is provided on those themes relating to patient safety and medication incidents. Feedback is provided to member practices in an anonymised form through the CCG's quarterly Safety Bulletin.

Patient Safety Bulletins

CCG patient safety bulletins provided to practices highlight learning from incidents to share good practice and encourage further reporting. Examples include recommendations relating to:

- Putting processes in place so that practices are informed if health partners make amendments to shared patient records;
- Practices reminding patients that they don't need a 'flu vaccination from elsewhere if they have already had one in that season.
- Recommendation that practices have written procedures in place for the receipt and processing of vaccine deliveries, this reduces the likelihood of stocks of vaccines, such as the flu' vaccine' being left unrefrigerated and having to be destroyed as a result.

Involving partners and other stakeholders

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

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

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

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

This is achieved by the following:

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

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

Capacity to Handle Risk

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

Effectiveness of Governance Structures

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

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

Responsibilities of the Senior Management Team and Committees

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

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

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

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

The Audit Committee has the responsibility for providing assurance to the Governing Body on the effectiveness of the CCG's governance and risk management systems and processes.
It is supported in fulfilling its responsibilities by our internal audit providers (Audit Yorkshire) who report on the findings of the annual mandated audit of governance and risk management.

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

The assessment of risks is a continuous process informed by:

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

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

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

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

Staff and Governing Body training

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

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

Learning from good practice

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

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

Risk Assessment

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

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

Major Risks to Governance, Risk Management and Internal Control

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

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

Each of the committees maintains a robust grip on the relevant risks through regular finance, performance and contract; quality and safety, primary medical commissioning reports and the review of the risk register.

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

Other sources of assurance

Internal Control Framework

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

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

Governing Body Assurance Framework (GBAF)

The GBAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the CCG. The GBAF deals with

strategic and long term risks / threats whereas the Risk Register is used to identify and manage performance based (operational) risks that may rise and fall within relatively short term periods. A summary of the principal risks to the CCG's licence and delivery of its strategic objectives is set out in appendix 3 to this governance statement.

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

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

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

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

Annual Audit of Conflicts of Interest Management

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

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

The CCG should ensure that the information contained within the Declaration of Interest Forms matches up with the information published on the Register.

Data Quality

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

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

SNOMED CT ®

This provides a clinical language which facilitates electronic communication between healthcare professionals in clear and unambiguous terms. It can be used to code, retrieve and analyse clinical data. The data quality team is the NHS Digital point of contact for this system. They provide training and support to GP practices to enable a seamless transition to using this system. GPs will need ongoing support from the team to fully realise the benefits – including regular reviews & risk assessments of local templates / reports.

The CCG's data quality team supports GP practices and the CCGs in Calderdale, Greater Huddersfield, North Kirklees and Wakefield. The role of the team is to promote the correct use of the Electronic Patient Record, provide training in completing records, offering advice and guidance for Data Quality queries around QOF (Quality Outcomes Framework), Disease Register Validation, Enhanced Service recording and reporting, Data Entry Templates, and clinical communications including standardised referral letters and forms. They also provide support to the CCGs with data production and data assurance and the data they provide feeds into many dashboards and monitoring reports.

The Governing Body confirms that it finds the quality of data provided, to be acceptable.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect personal and corporate information. I am pleased to be able to report that the CCG has self-assessed as meeting all of the DSPT mandatory standards with an overall published grade of 'Standards met'. This position is supported by

the independent audit (Audit Yorkshire) of the evidence submitted as part of our self-assessment.

We have an information governance management framework in place and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have a robust annual IG work programme and work to ensure that all staff and Governing Body members complete the Data Security Awareness training. The information governance handbook is available to all staff so that they are aware of their information governance roles and responsibilities. I am pleased to be able to report over 95% compliance with the mandatory training.

As referred to earlier in this report, there are processes in place for incident reporting and investigation of serious incidents. We have developed our information risk assessment and management procedures and a programme is in place to fully embed the information risk culture throughout the organisation against identified risks. Assurance is provided through the Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving personal data security) on a routine basis, together with any learning points.

All our information governance systems and processes have been updated to ensure compliance with the General Data Protection Regulation and new Data Protection Act both introduced in 2018.

Business Critical Models

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

Third Party Assurances

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

Control Issues

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

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

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

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

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

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

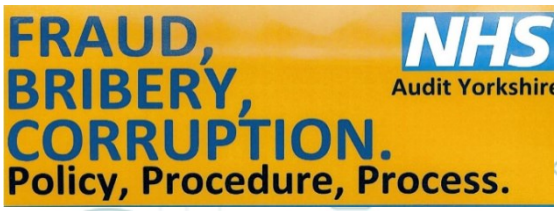
Calderdale CCG has a rating of **GREEN** for the Quality of Leadership indicator on latest available results on MyNHS (2017-18). The year end results for the Quality of Leadership – Well Led Indicator (CCG Improvement and Assessment Framework) will be available from July 2019 at: **https://www.nhs.uk/service-search/performance/search**

Delegation of Functions

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

The minutes and reports of key decisions taken by the committee are received by the Governing Body. Further information on the role of the joint committee and highlights of its work during 2018-19 can be found on pages 24 and 59 above.

Counter Fraud/Anti-Crime Arrangements



The CCG's counter fraud arrangements are compliant with NHS Counter Fraud Authorities' Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the engagement of a qualified Local

Counter Fraud Specialist (LCFS) from Audit Yorkshire under a formal Service Level Agreement. (the current LCFS was nominated, trained and approved by NHS Protect and accredited by the Counter Fraud Professional Board in 2016); the implementation of a CCG-wide countering fraud and corruption policy. All fraud matters are overseen by the Chief Finance Officer/Deputy Chief Officer as Executive Lead and a member of the Governing Body.

Anti-Crime work is based on an annual risk assessment which identifies fraud risk areas for the CCG using local and national fraud intelligence. Risks areas are included within the annual Anti-Crime work plan.

An annual work plan together with the annual report of fraud, bribery and corruption work is submitted to the Audit Committee for approval. The LCFS reports on the progress of counter fraud work to the Chief Finance Officer/Deputy Chief Officer and the Audit Committee. The annual assessment (self-review tool – SRT) of the CCG's compliance with the NHS CFA's Standards for Commissioners: Fraud, Bribery and Corruption was completed by the LCFS and approved by the Chief Finance Officer/Deputy Chief Officer. The self-review tool demonstrates compliance with the NHS Standards for Commissioners. The reports comply with NHSCFA guidelines and provide a summary of the year's activity matched against the standards. The organisation was subject to a NHSCFA quality assessment in March 2019, the CCG and the LCFS has taken appropriate action as recommended by the assessor.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. See Appendix 4: Governance Statement, Summary Head of Internal Audit Opinion.

The Head of Internal Audit concluded that:

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

During the year, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Policies and procedures	High
De-commissioning Arrangements	Significant
Transformation of Commissioning	Significant
Data Security and Protection Toolkit	High
Conflicts of Interest	High
Financial Transactions	Significant
QIPP	Significant
Governance arrangements	Significant
Well-Led	High
CQUINS	High
Performance Management	Report in draft (Significant)

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

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

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

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

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

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

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

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

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

- The Local Counter Fraud self-assessment was subject to a NHSCFA quality assessment in March 2019, the CCG and the LCFS has taken appropriate action as recommended by the assessor.

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

Conclusion

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

Dr Matt Walsh
Accountable Officer

22 May 2019

Governance Statement Appendix 1

CCG Governing Body and Committee Membership and Attendance (as at 16 May 2019)

Governing Body		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair and GP member [4] (until 30 April 2018)	1/1
Dr Steven Cleasby	Chair (from 1 May 2018) and GP Member	6/6
Dr Steven Cleasby	Clinical Vice Chair (until 30 April 2018) and GP Member	1/1
Dr Matt Walsh	Chief Officer (Accountable Officer)	7/7
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	6/7
David Longstaff	Lay Member (Audit) and Deputy Chair	7/7
Dr Rob Atkinson	Secondary Care Specialist	6/7
Dr Majid Azeb	GP Member (Clinical Vice Chair from 1 May 2018)	7/7
Dr Helen Davies	GP Member	7/7
Dr James Gray	GP Member (from 28 June 2018)	4/5
Dr Farrukh Javid	GP Member	5/7
Professor Rob McSherry	Registered Nurse (from 1 August 2018)	4/5
John Mallalieu	Lay Member (Finance and Performance)	7/7
Kate Smyth	Lay Member (Patient and Public Involvement) (until 31 January 2019)	5/5
Dr Nigel Taylor	GP Member	6/7
Dr Caroline Taylor	GP Member	6/7
Penny Woodhead	Chief Quality & Nursing Officer (from 2 August 2018)	5/5
Advisors to the Governing Body		
Penny Woodhead	Chief Quality & Nursing Officer (until 1 August 2018)	2/2
Paul Butcher	Director of Public Health (Calderdale Council)	7/7
Stuart Smith	Director of Adult and Children's Health and Social Care Services (Calderdale Council) (until 9 August 2018)	2/3
Ian Baines	Director of Adults and Wellbeing (Calderdale Council) (from 11 October 2018)	3/4

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

Finance and Performance Committee (as at 16 May 2019)		
Member	**Role**	**Attendance**
Dr Nigel Taylor	Committee Chair and GP Member	11/13
Dr Matt Walsh	Chief Officer (Accountable Officer)	11/13
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	11/13
Dr Steven Cleasby	GP Member (Deputised as GP Member at August 2018 Meeting)	2/2
John Mallalieu	Lay Member (Finance and Performance)	11/13
Dr Farrukh Javid	GP Member	10/12
Kate Smyth	Lay Member (PPI) - Deputy for the Lay Member (Finance and Performance)	1/1
Quality Committee (as at 16 May 2019)		
Dr Majid Azeb	Committee Chair and GP Member	11/13
Dr Caroline Taylor	GP Member and Vice Chair of the Committee	10/13
Dr Nigel Taylor	GP Member (Deputised for GP Member)	1/1
Dr Helen Davies	GP Member (Deputised for GP Member)	3/3
Kate Smyth	Lay Member (Patient and Public Involvement)	9/10
John Mallalieu	Lay Member (Finance and Performance) deputised for Lay Member (Patient and Public Involvement)	1/1
	Lay Member (Finance and Performance)	3/3
Penny Woodhead	Chief Quality & Nursing Officer	11/13
Emma Bownas	Quality Manager (Designated deputy for Head of Quality)	2/2
Commissioning Primary Medical Services Committee (as at 16 May 2019)		
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	5/5
Dr Matt Walsh	Chief Officer (Accountable Officer)	4/5
Kate Smyth	Lay Member (Patient and Public Involvement) (Vice Chair of the Committee)	3/3
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	4/5
Dr Steven Cleasby	GP Member	5/5
Dr Helen Davies	GP Member	4/5
Dr Rob Atkinson	Secondary Care Specialist	5/5

Audit Committee (as at 16 May 2019)		
Member	**Role**	**Attendance**
David Longstaff	Lay Member (Audit) and Chair	5/5
John Mallalieu	Lay Member (Finance and Performance)	5/5
Kate Smyth	Lay Member (Patient and Public Involvement)	4/4
Professor Rob McSherry	Registered Nurse	3/3
Dr Caroline Taylor	GP Member	1/2
Dr Nigel Taylor	Deputised as GP Member at meeting on 17 May 2018	1/1
Dr Farrukh Javid	GP Member	3/3

West Yorkshire and Harrogate Joint Committee of CCGs (as at 16 May 2019)		
Calderdale CCG Member	**Role**	**Attendance**
Dr Steven Cleasby	Governing Body Chair	6/7
Matt Walsh	Chief Officer	5/7
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	2/2

Attendance at the Remuneration Committee can be found in the Remuneration Report on page 87.

Summary of major risks to the CCG's governance, risk management and internal control (2018-19)

Risk No.	Risk Summary	Action to manage the risk	Means to assess outcomes
In-year major risks that have a reduced risk rating at the end of March 2019			
62 Reduced from RR 20 to 15	Risk that the system will not deliver the NHS Constitution 4-hour A&E target due to demand, capacity and patient flow.	- Non-recurrent West Yorkshire A&E Acceleration Zone funding to improve capacity and access. - A&E/primary care streaming services, social work assessment and home-care capacity. - Trialing new primary care service at A&E. - Surge and Escalation and Winter Plans	- Monthly A&E Delivery Board reviews system capacity, demand issues and potential solutions. - Critical Risk Reports with management actions reviewed by F&P Committee and Governing Body.
1177 (984) RR 16	Avoidable Health Care Associated Infections (HCAI) not prevented due to omissions in care provision resulting in avoidable patient harm. Risk further increased due to the lack of Infection Prevention and Control function capacity (IPC - Calderdale Council)	- Post Infection Reviews (PIR) undertaken on all Clostridium difficile infection and E Coli cases, outbreaks and associated deaths and shared for learning. - Antibiotic prescribing monitored & benchmarked against national figures. - Public Health England aware of IPC team capacity issues. - System wide approach from 2019.	- CHFT HCAI board reports received at the HCAI Group, incl. assurance on training, audit and high impact intervention compliance. - HCAI group monitors progress of plans, no. of avoidable/ unavoidable cases. - Performance and HCAI Improvement Plan progress reported to Quality Committee.
1172 RR reduced from 16 to 8	The CCG may not have the sufficient or appropriate QIPP schemes to ensure that its contribution to the health system model is affordable. May result in the non-achievement of control total through non achievement of QIPP targets.	- Monthly QIPP, financial and contract reporting through Senior Management Team and governance arrangements. - System Recovery Group focussed on delivering savings across the system. - Clinical engagement in QIPP programmes - System financial recovery plan developed with CHFT & GHCCG - savings required and models for sustainability - System Recovery Group.	- Internal audit reports. - Finance, contracting and QIPP reports. - Area Team assurance role.

		- STP Financial strategy being developed for consistent approach across WY&H.	
1113 RR reduced from 16 to 6	Risk that the 2 national Continuing Healthcare (CHC) assurance targets will not be achieved due to delays in allocation of social workers. This means that the CCG will not achieve the quality premium and will be identified as underperforming and subject to scrutiny from NHSE	- Work with key stakeholders to agree new ways of working and gain cooperation. - Improvement plan and monthly trajectory submitted to NHSE. - Clinical lead and Operations manager in CHC team working with Calderdale Council and CHFT to deliver new ways of working/monitor all parts of the process and escalate and manage delays.	- New senior management in place at Calderdale Council working in a positive manner to implement discharge to assess.
709 RR reduced from 16 to 8	Risk of delays in patient transfer of care (TOC) due to (a) a lack of NHS capacity non-NHS services outside hospital, and (b) health and social care systems and processes not currently being optimised.	- TOC Improvement Plan; visibility and commitment across A&E Delivery Board. - Providers share data on delays and mitigating actions; - System engaged in national Ambulatory Care and Frailty programmes; - Developing new means of improving patient flow and patient experience.	- TOC real-time dashboard for system overview of patients on discharge pathway with aggregated version for Commissioners enabling progress to be assessed; - Finance and Performance Committee review performance against the TOC Improvement Plan.
515 RR reduced from 15 to 12	Continuing Healthcare/Specialist Care team may not be able to deliver the CCG performance and recovery plan due to difficulties recruiting clinical staff and long term sickness in the nursing team.	- Regular update and notification of pressures by Head of Service to the Head of Contracting. - Continue to rationalise workload by identification of key priorities and reallocation of work. - Processes to identify and escalate concerns to the manager. - External and internal review of CHC structure agreed.	- Work prioritised on clinical care to ensure patient safety. - Clear team objectives to deliver NHSE assurance and CCG financial recovery targets (within the scope of the National Framework). - Interim clinical lead in place with team supervision of activity and performance. - Head of Service oversight
1173 RR reduced from 15 to 4	Risk CCG fails to manage running cost spend within the ring fenced allocation (£4.6m). Increased risk annual pay award could place pressure on the CCG's ability to manage costs. The CCG not yet able to quantify impact	- Budgets approved by Governing Body (April '18). - Vacancy and budgetary control process in place. - Small reserve budget available. - Several scenarios planned to quantify impact of various levels of pay award and t impact on future running costs. - Full budget review process instigated with	- Monthly Financial Reporting systems. - Internal Audit reviews on financial systems and processes. - Regular budget holder meetings to review running cost budgets. - Discussion of risk and position in monthly F&P Committee.

	of the new proposed pay deal or had confirmation if its running cost allocation will be increased.	CFO/budget holder meetings to assess risks and savings for 2018-19 onwards. - Work undertaken to mitigate impacts.	- Detailed review of impact of pay review scenarios.
821 RR reduced from 16 to 8	The Full Business Case does not secure the funding required, due to inability to deliver financial sustainability, resulting in the implementation of the transformation changes required to address the Financial and Quality and Safety case for change being stopped and whole system becoming financially unsustainable.	- The Full Business Case has been produced in line with Treasury guidance with support in specific areas from NHSI and assurance from NHSE's clinical Director. The FBC has been submitted by CHFT to NHS Improvement. - Partnership transformation Board (PTB) established, supported by a System Recovery Group. One of PTB's responsibilities is delivery of System Financial Sustainability	- Proposals referred to the Secretary of State by the Joint Health Overview and Scrutiny Committee (JHOSC). - The Partnership Transformation Board has completed a development session to identify how the partners could work together more effectively.
1200 RR 16 Reduced to 12	Risk that increase in waiting times for children and young people (CYP) with potential autism spectrum disorder (ASD) to access services will have a negative impact on their care, resulting in potential harm to patients and their families.	- Implementation of the recommendations received from the independent review will positively impact on the waiting times. - Reporting through SMT, CCG Governance and Safeguarding Board (June, August, Sept 2018) to provide assurance, information on processes and next steps. - Media and communications provided externally. - Additional funding identified to manage the increased backlog. - CCG working with existing providers to develop a plan and agree proposal - Oct/Nov 2018.	- Waiting list initiative to enable those currently waiting to be assessed and diagnosed in a timely manner. - Two workshops held with key partners and parent/carer representatives to develop an agreed pathway. - System leaders' summit (Jan 2019) to own the risk and help implement the future pathway.
major risks that have closed in 2018-19			
1116 Met target risk rating	Risk of not sustaining delivery of the new target for reportable delayed transfers of care (DTOC) set by NHSE, due to technical difficulties associated with the trajectory construction, resulting in Calderdale potentially losing control on the way BCF and IBCF funding in allocated locally.	- Joint (CCG, CMBC) executive representation at a meeting with NHSE in London; - DTOC Delivery Plan Developed and shared with NHSE;	- Joint (CCG, CMBC) executive representation at a meeting with NHSE in London. - DTOC Delivery Plan Developed and shared with NHSE.

Governance Statement Appendix 3

Governing Body Assurance Framework: principal risks to the achievement of the strategic objectives and compliance with the CCG's licence and actions identified to mitigate these risks in 2018-19

Strategic Objective	Summary of Principal Risks	Mitigation
1. Achieving the agreed strategic direction for Calderdale	We do not deliver our strategic outcomes because we have not integrated our commissioning activities with Calderdale Council.	▪ Chief Officer, Chair and Clinical Vice Chair members of the Health and Wellbeing Board supporting effective partnership working. ▪ Single Plan for Calderdale (SPFC) - a single strategic direction
	We do not deliver our strategic outcomes because we have not tackled the wider determinants of health.	▪ Intelligence Sharing: New Business Intelligence model in place and creating links with Public Health intelligence. ▪ SPFC confirms actions to tackle wider determinants of health.
	We do not delivery our strategic outcomes because we have not implemented new models of primary care and community services	▪ SPFC sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. CCG Operational plan sets the strategic direction aligned to the SPFC. ▪ Prospect for Care Closer to Home containing timeline and scoping.
	We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire and Harrogate footprint.	▪ Annual workplan agreed by Health Futures Joint Committee and approved by CCG member practices.
	We do not deliver our strategic outcomes because we have not delivered the proposed clinical model of hospital and community services as set out in the public consultation.	▪ Process developed between CCG and CHFT in regards to managing interim service changes ▪ We completed consultation on 21st June 2016 on proposed future arrangements for hospital and community health services ▪ Interim service changes to cardiology, respiratory and frail elderly services have been put in place ▪ Working with the Independent Reconfiguration Panel (IRP) to mitigate any risks from the referral to the Secretary of State ▪ Regular reporting through the Clinical Quality Board to Quality Committee ▪

2. **Improving Quality**	We do not deliver our strategic outcomes because we have not fully developed and optimised system working on enabling functions, such as workforce, estates, digitisation and communications.	▪ **Workforce:** System forum to understand and develop workforce plans to deliver new models of care. ▪ **Estates:** System forum to understand and develop plans to digitise in order to deliver new models of care building on BCF work ▪ **Digitisation:** System forum to understand and develop Estate plans to deliver new models of care. ▪ **Communications:** Clear integrated plans to ensure high quality communications in order to share the CCG narrative with stakeholders and the public.
	We are unable to deliver our strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.	▪ Engagement of practices through the Commissioning Engagement Scheme ▪ Practice Managers' Action Group inputs to clinical commissioning and shares information with member practices on behalf of the CCG
	We do not improve patient experience in line with our plans due to a failure to use appropriate patient and public engagement intelligence to support service improvement and plans to change service models	▪ Patient and Public Engagement and Experience Strategy (2013-18) and annual improvement plan (2016-17) in place. ▪ Patient and Public Experience and Engagement Steering Group (including partners) and Patient Experience Group.
	We are unable to commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans – thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire STP	
	We do not maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients	▪ Quality outcome standards, quality schedule, patient safety and relevant targets within service specifications
	We are unable to provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding	▪ Safeguarding policies and procedures in place ▪ Annual section 11 audits scrutinise provider safeguarding arrangements (policies, procedures and training)

		arrangements, resulting in harm to children and adults.	▪ Collaborative working through provider safeguarding committees
3.	**Improving value**	We do not deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable.	▪ Development and delivery of short/medium term financial recovery plan ▪ 5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting planned community services, reducing financial risk ▪ Development of Closer to Home model to reduce increasing demand on acute services (CC2H)
4	**Improving governance**	We don't comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.	▪ Compliance with the provisions of the CCG's Constitution which has been reviewed by NHS England ▪ Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework
		We don't have effective governance and risk management processes in place due to not having the right structures, capacity and capability	▪ Robust governance structure, integrated risk management framework and systems of internal control in place ▪ Process for regular review of governance and risk management part of internal audit annual work plan

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS CALDERDALE CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 2019

Roles and Responsibilities

On behalf of the Clinical Commissioning Group the Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

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

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Governing Body 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 Governing Body Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

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

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. As such, it is one component that the Clinical Commissioning Group and Governing Body take into account in making its Annual Governance Statement.

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that:

- **Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses 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 Governing Body Assurance Framework and supporting processes; and

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

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

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

The review has confirmed that the CCG's governance structure and reporting lines enable the CCG to effectively discharge its duties and responsibilities in full. The majority of governance controls reviewed were found to be operating satisfactorily.

Whilst the Governing Body Assurance Framework was found to be effectively utilised and reviewed within the organisation, the CCG should consider refreshing its structure and content to ensure that it fully captures all relevant information and to strengthen the link, where relevant, with the Corporate Risk Register. It would also be beneficial to place a greater emphasis on the assurances and controls in place by periodically validating these.

The CCG has a development session planned for the Governing Body to review the content and utilisation of the Governing Body Assurance Framework in September, which will further strengthen the existing document and supporting arrangements.

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

The 2018/19 Internal Audit Plan was approved by the Audit Committee on 15 March 2018. The work of Internal Audit continues to focus on the design and embedding of core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

- Governance
- Information and Performance Management
- Quality
- Integration and Business Development
- Commissioning and Contract Management
- Financial Assurance

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

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

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

The outcome of the assurance audit reports as at 22 May 2019 from the 2018/19 audit plan are summarised below. Those audit areas in italics will be completed by 31 May 2019.

Audit Area	Assurance Level
Policies and Procedures	High
De-commissioning Arrangements	Significant
Transformation of Commissioning	Significant
Data Security and Protection Toolkit	High
Conflicts of Interest	High
Financial Transactions	Significant
QIPP	Significant
Governance Arrangements	Significant
Well Led	High
CQUINs	High
Performance Management	*Report in Draft (Significant)*

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

Helen Kemp-Taylor
Managing Director and Head of Internal Audit
Audit Yorkshire
22 May 2019

The Accountability Report – Remuneration and Staff Report

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

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 (Patient and Public Involvement) and Chair of the Committee (until 31st January 2019)	2/2
John Mallalieu	Lay Member (Finance and Performance); Deputy Chair of the Committee	2/2
Rob Atkinson	Secondary Care Specialist	2/2
Dr Alan Brook	GP Member and Governing Body Chair (until 30th April 2018)	0/0
Dr Steven Cleasby	GP Member and Governing Body Chair (from 1st May 2018)	1/2
Dr Nigel Taylor	GP Member	2/2

The Remuneration Committee is supported in its considerations by the Human Resources/Organisational Development Manager (the HR and Learning and Development service is commissioned from Calderdale and Huddersfield Foundation Trust), the CCG Chief Finance Officer/Deputy Chair as required and the Head of Corporate Affairs and Governance.

The Governance Statement contains further details about the role and work of the Remuneration Committee in 2018-19.

Policy on Remuneration of Senior Managers

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

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

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

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

- Remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate executive of sufficient calibre;
- Organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;
- Remuneration must be set through a process that is based on a consistent framework and independent decision making based on accurate assessments of the weight of roles and individuals' performance in them;
- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay are being set, and who are qualified or experienced in the field of remuneration.
- No individual should be involved in deciding his or her own pay;
- Remuneration must be based on the principle of equal pay for work of equal value.

GP Members of the Governing Body

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

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

Registered Nurse and Secondary Care Specialist

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

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

Lay Members

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

Remuneration of Very Senior Managers (VSMs)

The posts of Accountable Officer and the Chief Finance Officer/Deputy Chief Officer are subject to VSM terms and conditions at Calderdale CCG. In considering the remuneration for these posts the Remuneration Committee takes account of the following factors:

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

Consideration of the reasonableness of the remuneration

In taking account of the factors set out above, the Remuneration Committee confirms that the remuneration received by the Governing Body members is considered reasonable.

Table 1 (a): Senior manager remuneration (including salary and pension entitlements) 2018-19

Name & Title	Salary (bands of £5,000)	Expense payments (taxable)	Performance Pay & Bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total
	£000	To nearest £100	£000	£000	£000	
Dr. Alan Brook, Chair (note2)	5-10	0	0	0	0	5-10
Dr. Steven Cleasby, Chair (note3)	65-70	0	0	0	0	65-70
Dr. Majid Azeb	45 - 50	0	0	0	0	45 - 50
Dr. Nigel Taylor	45-50	0	0	0	0	45-50
Dr. Caroline Taylor	55-60	0	0	0	0	55-60
Dr. Farrukh Javid	30-35	0	0	0	0	30-35
Dr. Helen Davies	40-45	0	0	0	0	40-45
Dr Rob Atkinson - Secondary Care Specialist	15-20	0	0	0	0	15-20
Dr. James Gray (note4)	20-25	0	0	0	0	20-25
Rob McSherry - Registered Nurse (note5)	5-10	0	0	0	0	5-10
Kate Smyth, Lay Member (note6)	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	5-10	0	0	0	0	5-10
Penny Woodhead, Chief Quality & Nursing Officer (note7)	30-35	0	0	0	20.0 - 22.5	50-55
Matt Walsh - Accountable Officer	135-140	0	0	0	10 – 12.5	145 - 150
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	105-110	0	0	0	22.5 - 25	125 - 130

Note 1: The information in Table 1 above is subject to audit by our external auditors, KPMG
Note 2: Dr A Brook, was Chair of the Governing Body until 30 April 2018
Note 3: Dr S Cleasby became Chair of the Governing Body, 1 May 2018. He was the Assistant Clinical Chair prior to that.
Note 4: Dr J Gray joined the Governing Body, 28 June 2018
Note 5: Rob McSherry joined the Governing Body, 1 August 2018
Note 6: Kate Smyth left the Governing Body, 31st January 2019
Note 7: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £90k - 95k; however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Table 1 (b): Senior manager remuneration (including salary and pension entitlements) 2017-18

Name & Title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000)	Long term performance pay & bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total
	£000		£000	£000	£000	£000
Dr. Alan Brook, Clinical Chair	60-65	0	0	0	0	60-65
Dr. Steven Cleasby, Assistant Clinical Chair	65-70	0	0	0	0	65-70
Dr. Majid Azeb GP Member	45-50	0	0	0	0	45-50
Dr. Nigel Taylor GP Member	45-50	0	0	0	0	45-50
Dr. Caroline Taylor GP Member	45-50	0	0	0	0	45-50
Dr. Farrukh Javid GP Member	30-35	0	0	0	0	30-35
Dr. Helen Davies GP Member	30-35	0	0	0	0	30-35
Dr. Rob Atkinson Secondary Care Specialist	10-15	0	0	0	0	10-15
Jackie Bird, Registered Nurse	15-20	0	0	0	0	15-20
Kate Smyth, Lay Member	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member(1)	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	5-10	0	0	0	0	5-10
Matt Walsh - Accountable Officer	135-140	0	0	0	50.0 - 52.5	185-190
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	105-110	0	0	0	45.0 - 47.5	150-155

Note 1: John Mallalieu was a Lay Advisor to the Governing Body until 31st May 2017, when he became a Lay Member of the Governing Body

Table 2: Pension benefits as at 31 March 2019

Name & Title	Real increase in pension at pension age. (Bands of £2,500)	Real increase in lump sum at age 60. (Bands of £2,500)	Total accrued pension at age 60 as at 31/03/19 (Bands of £5,000)	Lump sum at age 60 related to accrued pension as at 31/03/19. (Bands of £5,000)	CETV at 1/04/18	CETV at 31/03/19	Real Increase in CETV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Matt Walsh - Accountable Officer	0 - 2.5	2.5 - 5	25 - 30	85 - 90	561	667	69
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	0 - 2.5	0 – 2.5	15 - 20	0 - 5	161	217	37
Penny Woodhead - Chief Quality & Nursing Officer	0 - 2.5	0 - 2.5	0 – 5	0 – 5	13	36	10

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

Note 2: For GP members the NHS Pensions Agency is not able to disaggregate the pensions.

Note 3: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 4: The information in table 2 above is subject to audit by our external auditors, KPMG

Cash Equivalent Transfer Values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation for Early Retirement or Loss of Office

No payment has been made in compensation for loss of office or early retirement during 2018-19.

Payments to Past Senior Managers

No payment has been made to past senior managers.

Fair Pay Disclosure – Pay Multiples

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

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

The banded remuneration of the highest paid Director/Member in NHS Calderdale CCG in the financial year 2018-19 was £155-160K (2017-18: £155-160k). This was 4.3 times (2017-18: 4.65) the median remuneration of the workforce, which was £36,644 (2017-18: £33,895).

In 2018-19, 0 (2017-18, 0) employees received remuneration in excess of the highest-paid Director/Member. Remuneration ranged from £14k - £157k (2017-18: £13k to £155k).

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

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

CCG Workforce profile

The CCG's workforce profile is shown below and the information is based on the directly employed staff of the CCG as at 31st March 2019. Information relating to the Governing Body is reported separately.

Information relating to individuals classed as senior managers for the purposes of this annual report can be found on page 88.

Staff numbers and costs

Table 3: Average Number of People Employed over the period 1st April 2018 – 31 March 2019

	2018-19			2017-18		
	Permanent Employees	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Total CCG	67	16	83	70	15	85

Note1: The information in the above table is subject to audit by our external auditors, KPMG

The staff costs and employee benefits as at 31st March 2019 are set out as in the table below:

Table 4 (a): 2018-19 Staff costs and employee benefits

	2018-2019								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,585	2,973	612	2,126	2,051	75	1,459	922	537
Social security costs	320	319	1	225	224	1	95	95	0
Employer contributions to the NHS Pension Scheme	433	432	1	312	311	1	121	121	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	6	6	0	6	6	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**4,344**	**3,730**	**614**	**2,669**	**2,592**	**77**	**1,675**	**1,138**	**537**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(24)	(24)	0	(24)	(24)	0	0	0	0
Net employee benefits expenditure including capitalised costs	**4,320**	**3,706**	**614**	**2,645**	**2,568**	**77**	**1,675**	**1,138**	**537**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**4,320**	**3,706**	**614**	**2,645**	**2,568**	**77**	**1,675**	**1,138**	**537**

Table 4 (b): 2017-18 Staff costs and employee benefits

2017-18	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
Salaries and wages	4,199	3,234	965	2,581	2,020	561	1,618	1,214	404
Social security costs	393	342	51	254	215	39	139	127	12
Employer contributions to the NHS Pension Scheme	482	419	63	302	255	47	180	164	16
Gross Employee Benefits Expenditure	**5,074**	**3,995**	**1,079**	**3,137**	**2,490**	**647**	**1,937**	**1,505**	**432**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(770)	(770)	0	(395)	(395)	0	(375)	(375)	0
Net employee benefits expenditure including capitalised costs	**4,304**	**3,225**	**1,079**	**2,742**	**2,095**	**647**	**1,562**	**1,130**	**432**
Net employee benefits expenditure excluding capitalised costs	**4,304**	**3,225**	**1,079**	**2,742**	**2,095**	**647**	**1,562**	**1,130**	**432**

Note1: The information in Table 4 (a & b) above is subject to audit by our external auditors, KPMG

Staff Composition

As at 31st March 2019, the CCG directly employed 91 staff (excluding the Governing Body, but including the 2 Very Senior Managers (VSM). This equates to 82.61 whole time equivalents (WTE).

Gender profile

The following table sets out the gender profile of the organisation as at 31 March 2019.

Table 6: Gender profile of the organisation

Staff and Governing Body numbers by gender				
	Governing Body (excl. Very Senior Managers)	Very Senior Managers (VSM)	Staff Excl. Governing Body and VSMs	Total
Female	3	0	78	81
Male	9	2	25	36
Total(1)	**12**	**2**	**103**	**117**

Note1: Currently a vacancy for the Lay Member (PPI)

Note2: Our Chief Nursing and Quality Officer is a Governing Body member and a shared member of staff (Calderdale, Greater Huddersfield and North Kirklees CCGs), employed by Greater Huddersfield CCG.

Note3: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay gap report.

Sickness Absence

The yearly average sickness figures for the CCG between 1st April 2018 and 31st March 2019 are:

Table 7: Sickness absence data (1st January 2018 – 31st December 2018)

Total Days Sick (Full Time Equivalent):	1005
Total Days Available (Full Time Equivalent)	32,406
Average Annual Sick Days per Full Time Equivalent:	7.00

We continue to have a clear focus on the health and wellbeing of our staff and work hard to promote a healthy working environment. 69% of those responding to the 2018-19 staff survey, felt that we took positive action on health and wellbeing, compared to the national CCG average of 33%. The CCG's Staff Forum has been incredibly proactive throughout the year in carrying out a number of initiatives in support of this (See the Sustainability Report).

The CCG also has a number policies and procedures in place to support staff through periods of sickness absence or difficult periods in their lives. We have a positive and pro-active approach to reducing the levels of sickness absence through a number of support mechanisms including:

- Improvement plans;
- Putting in place support mechanisms for staff through periods of long term sickness;
- Provision of the Employee Assistance Programme (EAP) to support the needs of staff. This service is also available to staff at our member practices;
- Offering workplace 'Flu vaccinations to all staff in order to support the resilience of the workforce and the community;
- The provision of a comprehensive Occupational Health service, providing expert advice on the management of health conditions at work.

We have also supported a number **mental health and wellbeing** initiatives, including:

- Time for regular mindfulness and Wellbeing Half Hour sessions; investment in Mental Health First Aiders;
- "Walk and talk" walking group that encourages staff to take a break, participate in physical activity, and build relationships;
- Publicising local groups, support and activities around Calderdale, such as 'Active Calderdale' and the Bike Library.

Staff Policies

The CCG has a suite of staff policies providing clarity on the CCG's vision, values and expectations. These include policies on health and safety, trade union recognition and time off for representation, whistleblowing and flexible working. All the CCG's policies can be found on our website.

The implementation of these policies together with occupational health input supports the recruitment of disabled people and ensures all CCG employees; including disabled people have access to training, career development and promotion opportunities. We will continue to work to make this a welcoming and accessible place for people with a disability. In particular, our policies cover:

Requirement	Policy or procedure
Giving full and fair consideration to applications for employment by the CCG made by disabled persons, having regard to their particular aptitudes and abilities.	• Equality and Diversity Policy; • Recruitment and Selection Policy
Continuing the employment of, and arranging appropriate training for, employees of the CCG who have become disabled persons during the period when they were employed by the CCG.	• Equality and Diversity Policy; • Managing Sickness Absence Policy; • Flexible Working Policy; • Learning and Development Policy.
Training, career development and promotion of disabled people employed by the CCG.	• Equality and Diversity Policy; • Recruitment and Selection Policy • Pay Progression Policy • Appraisal Paperwork

Other employee matters

Equality and diversity

Our approach to maintaining equal opportunities in the workplace flows through all our systems and processes from recruitment, the equality impact assessments, the requirement that all staff complete their Equality and Diversity training and in regular monitoring to ensure that there is no detrimental effect on CCG staff as a result of implementing our policies and that we continue to proactively identify and addressed any inequalities. We work closely with our trade union representatives and our staff forum to seek views of our staff in terms of our approach to equality and diversity.

The CCG's approach to staff management is supported by a robust set of policies and procedures, which underpin the full employee cycle. This includes a fair and transparent approach to recruitment and learning, and a well-embedded appraisal process, to assist individuals and teams with career management in support of the strategic aims of the CCG and the health and care system. The CCG is an active participant in a Calderdale-wide Future Leaders programme. This is a new venture in partnership with public and private sector employers across Calderdale. It provides existing managers with the opportunity to develop leadership skills and gain a qualification, and contributes to human capital management and employability across the CCG's local area.

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

Employee consultation and/or participation

We engage with our staff through a variety of mechanisms, including an active staff forum, monthly staff workshops, and through a staff intranet, which includes discussion forums and regular news. The CCG participates annually in the national NHS Staff Survey in order to gain feedback and understand how the CCG benchmarks against the other CCGs taking part nationally. 79% of staff responded to the survey in 2018. Overall, the CCG's results were positive. Particular highlights related to the organisation taking positive action on health and wellbeing, communication between senior managers and staff, clarity of responsibilities, and a focus on organisational values in appraisal conversations. The results will be discussed with staff in order to build on the CCG's ongoing staff engagement plan, focusing on strengths and areas for improvement.

NHS Staff survey (2018-19)

- 86% felt that the care of patients/service users was our top priority
- 91% feel that we take action to ensure errors are not repeated
- 76% would recommend the CCG as a place to work
- 75% were often/always enthusiastic about their job
- 88% felt that we act fairly on career progression or opportunities

Health and safety at work

Ensuring the health and safety of our staff, Governing Body members and visitors to the CCG is a high priority for us. We work to keep people safe through a variety of mechanisms including mandatory health and safety training, reporting and learning from incidents or near misses, regular awareness raising sessions and amendment of policies and procedures. This year our Lone Worker Procedure was updated for staff visiting clients in their own homes.

Health and Safety at work

Whilst CCG staff work in a low risk environment, there are risks as in any workplace. One of the risks for our staff is exposure to upper limb disorders. All new staff complete a Display Screen Equipment (DSE) assessment as part of their induction. This helps to ensure that the workstation is set up to meet their needs including the provision of more specialist work equipment e.g. a bespoke operator's chair as required.

Trade Union relations and representation

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

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974. During 2018-19, there were 4 members of staff, who were accredited Trade Union representatives. These representatives provided a service across the three CCGs at Calderdale, Greater Huddersfield and North Kirklees. One of these representatives is employed by Calderdale CCG.

Table 8: Relevant union officials during 2018-19

Total number of employees who were relevant union officials during the period of 1st April 2018 to 31st March 2019 (note1) (FTE)	**4**

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

Table 8 below, contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union

duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Table 9: Percentage time spent on facility time

Percentage of time spent	No. of Employees
0%	
1-50%	4
51-99%	
100%	

Table 10: Percentage of pay bill spent on facility time

	£
Total cost of facility time (note1)	5,358
Total pay bill (note2)	12,753,000
% of total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.04%

Note1: This is based on actual salary of the 4 trade union representatives
Note2: This is the combined total pay bill for Calderdale, Greater Huddersfield and North Kirklees CCGs

The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2018-19, on paid trade union activities.

Table 11: Paid Trade Union activities

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

Expenditure on consultancy (2018-19)

Table 12: Expenditure on consultancy (2018-19)

Description	Costs(£)
No expenditure on consultancy in 2018-19	0
TOTAL	0

External Audit

NHS Calderdale CCG appointed KPMG as their external auditor from 1st April 2017. The cost of the work performed by the auditor in respect of the reporting period (2018-19 is £49,200 (including VAT).

Table 12: Services from KPMG (2018-19)

Services from KPMG	£
Audit Services	
Statutory audit and services carried out in relation to the statutory audit, e.g. reports to the Secretary of State	**49,200**
Further assurance services - Compliance with the requirements of the Mental Health Investment Standard (Note1).	**10,000**
Other Services	**0**
TOTAL	**59,200**

Note1: The CCG has received £10,000 of resource allocation in relation to this work. The final fee is not yet confirmed.

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

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, Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.

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

Table 13: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2019	4
Of which the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	2
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

We can confirm that all existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary that assurance has been sought.

Table 14: New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months are as follows:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	2
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	2
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 15: Off-payroll Governing Body member/senior official engagements

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

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

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

Exit Packages, including special (non-contractual) payments

There has been one exit package or other departure, requiring exit packages or severance payments during 2018-19 (see table 16).

Table 16: Exit Packages including special (non-contractual) payments (2018-19)

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

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

Note: The information in Table 16 is subject to audit by our external auditors KPMG.

The Accountability Report – Parliamentary Accountability and Audit Report

NHS Calderdale CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities (see Financial Statements note 31), losses and special payments, gifts, and fees and charges (see Financial Statements note 40). An audit certificate and report is also included in this Annual Report at page 143.

Glossary of Terms

A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
AQP	Any Qualified Provider
ASD	Autism Spectrum Disorder
BCF/iBCF	Better Care Fund/improved Better Care Fund
CAMHS	Child and Adolescent Mental Health Service
CC2H	Care Closer to Home
CCG	Clinical Commissioning Group
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CIP	Cost Improvement Plan
CPMSC	Commissioning Primary Medical Services Committee
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
DoLS	Deprivation of Liberty Safeguards
FFT	Friends and Family Test
GMS	General Medical Services
GH CCG	NHS Greater Huddersfield Clinical Commissioning Group
HCAI	Health Care Associated Infection
HMRC	Her Majesty's Revenue and Customs
HWB	Health and Wellbeing Board
ICS	Integrated Care Partnership
LGBT	Lesbian, Gay, Bisexual and Transgender
LTC	Long Term Condition
MCA	Mental Capacity Act
MSK	Musculoskeletal Services
NHSE	NHS England
NK CCG	North Kirklees Clinical Commissioning Group
NICE	National Institute of Clinical Excellence
PCN	Primary Care Network
PMS	Primary Medical Services
PPEE	Patient and Public Engagement and Experience
PPI	Patient and Public Involvement
QIPP	Quality, Innovation, Productivity and Prevention
RCRTRP	Right Care, Right Time, Right Place
SCR	Serious Case Review
SDMP	Sustainable Development Management Plan
SI	Serious Incident
SMT	Senior Management Team
STP	Sustainability and Transformation Partnership
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
VSM	Very Senior Manager
VAC	Voluntary Action Calderdale
W CCG	NHS Wakefield Clinical Commissioning Group
WY&H STP	West Yorkshire and Harrogate Sustainability and Transformation Partnership (now known as the Health and Care Partnership

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2018-2019

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2019 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 2018-19

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(1,208)	(2,281)
Other operating income	2	-	(751)
Total operating income		**(1,208)**	**(3,032)**
Staff costs	4	4,344	5,074
Purchase of goods and services	5	317,603	312,886
Depreciation and impairment charges	5	424	82
Provision expense	5	-	-
Other Operating Expenditure	5	455	437
Total operating expenditure		**322,825**	**318,479**
Net Operating Expenditure		**321,617**	**315,447**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**321,617**	**315,447**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**321,617**	**315,447**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**321,617**	**315,447**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	13	-	423
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		-	423
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	595	1,500
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	1	83
Total current assets		**596**	1,583
Non-current assets held for sale	21	-	-
Total current assets		**596**	1,583
Total assets		**596**	2,006
Current liabilities			
Trade and other payables	23	(27,700)	(23,791)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total current liabilities		**(27,700)**	(23,791)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(27,104)**	(21,785)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(27,104)**	(21,785)
Financed by Taxpayers' Equity			
General fund		(27,104)	(21,785)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(27,104)**	(21,785)

The notes on pages 114 to 141 form part of this statement

The financial statements on pages 110 to 113 were approved by the Audit Committee on 16th May 2019 under delegated authority from the Governing Body and signed on its behalf by

Chief Accountable Officer
Dr. Matt Walsh

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(17,475)	0	0	**(17,475)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(17,475)**	**0**	**0**	**(17,475)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(315,447)	0	0	(315,447)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(315,447)**	**0**	**0**	**(315,447)**
Net funding	311,137	0	0	311,137
Balance at 31 March 2018	**(21,785)**	**0**	**0**	**(21,785)**

The notes on pages 114 to 141 form part of this statement

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(321,617)	(315,447)
Depreciation and amortisation	5	76	82
Impairments and reversals	5	348	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	904	574
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,909	3,692
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(316,380)**	(311,099)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(316,380)**	(311,099)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		316,298	311,137
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**316,298**	311,137
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(82)**	38
Cash & Cash Equivalents at the Beginning of the Financial Year		**83**	45
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**1**	83

The notes on pages 114 to 141 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They

1.1 **Going Concern**

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

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. The accounts for 2018/19 have been calculated under a net accounting basis.

1.3 **Movement of Assets within the Department of Health and Social Care 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 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 and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Subsidiaries**

The clinical commissioning group has no subsidiaries.

1.5 **Associates**

The clinical commissioning group has no associates.

1.6 **Joint arrangements**

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

1.7 **Pooled Budgets**

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

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and,
- The clinical commissioning group’s share of the expenses jointly incurred.

1.8 **Operating Segments**

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

1.9 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Notes to the financial statements

Payment terms are standard reflecting cross government principles.

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

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

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

1.10.2 **Retirement Benefit Costs**

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

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

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

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within

1.11 **Other Expenses**

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

1.12 **Grants Payable**

clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.13 **Property, Plant & Equipment**

1.13.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.13.2 **Measurement**

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

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

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

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

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

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

Notes to the financial statements

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

1.13.3 **Subsequent Expenditure**

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

1.14 **Intangible Assets**

1.14.1 **Recognition**

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

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

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

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

1.14.2 **Measurement**

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

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

1.14.3 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.15 **Donated Assets**

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

1.16 **Government grant funded assets**

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

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

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

Notes to the financial statements

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.18 **Leases**

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

1.18.1 **The Clinical Commissioning Group as Lessee**

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.19 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.
The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

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

1.19.1 **Services Received**

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

1.19.2 **PFI Asset**

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

1.19.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.
The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.19.4 **Lifecycle Replacement**

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

Notes to the financial statements

1.19.5 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

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

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

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

1.22 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

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

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

1.26 **Contingent liabilities and contingent assets**

Notes to the financial statements

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 **Financial Assets**

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

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

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

1.27.1 **Financial Assets at Amortised cost**

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

1.27.2 **Financial assets at fair value through other comprehensive income**

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

1.27.3 **Financial assets at fair value through profit and loss**

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

1.27.4 **Impairment**

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

1.28 **Financial Liabilities**

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

Notes to the financial statements

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

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

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

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

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

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

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

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

1.33.1 **Critical accounting judgements in applying accounting policies**
process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.33.2 **Sources of estimation uncertainty**
The clinical commissioning group has made no assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

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

1.35 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies ***1**	**1,047**	1,510
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	**137**	-
Recoveries in respect of employee benefits	**24**	771
Total Income from sale of goods and services	**1,208**	**2,281**
Other operating income		
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Receipt of donations (capital/cash)	-	-
Receipt of Government grants for capital acquisitions	-	-
Continuing Health Care risk pool contributions	-	-
Non cash apprenticeship training grants revenue	-	-
Other non contract revenue	-	751
Total Other operating income	**-**	**751**
Total Operating Income	**1,208**	**3,032**

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

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

***1 -** Non patient care services to other NHS bodiesd includes £158k revenue received from GHCCG for 2018/19. (£0.3m 2017/18)

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	661	-	-	-	-	137	24
Non NHS	-	386	-	-	-	-	-	-
Total	**-**	**1,047**	**-**	**-**	**-**	**-**	**137**	**24**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	1,047	-	-	-	-	137	24
Over time	-	-	-	-	-	-	-	-
Total	**-**	**1,047**	**-**	**-**	**-**	**-**	**137**	**24**

3.2 Transaction price to remaining contract performance obligations

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

	2018-19 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

Total 2018-19

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

4.1.1 Employee benefits

Total 2017-18

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,234	964	4,198
Social security costs	342	51	393
Employer Contributions to NHS Pension scheme	420	63	483
Other pension costs	-	-	-
Apprenticeship Levy	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	**3,996**	**1,078**	**5,074**
Less recoveries in respect of employee benefits (note 4.1.2)	(771)	-	(771)
Total - Net admin employee benefits including capitalised costs	**3,225**	**1,078**	**4,303**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**3,225**	**1,078**	**4,303**

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(18)	-	(18)	(624)
Social security costs	(3)	-	(3)	(65)
Employer contributions to the NHS Pension Scheme	(3)	-	(3)	(82)
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	**(24)**	**-**	**(24)**	**(771)**

A change in accounting policy of gross to net staff recharges between neighbouring Clinical Commissioning Groups has resulted in a reduction of other employee benefits costs in 2018-19.

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**67.00**	**16.00**	**83.00**	**70.00**	**15.00**	**85.00**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

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

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	1	22,236	1	22,236
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**22,236**	**1**	**22,236**

	2018-19 Departures where special payments have been made		2017-18 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	1	22,236
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	1	13,500	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**13,500**	**1**	**22,236**

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

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

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

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

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the

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

4.5.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The latest actuarial valuation was carried out as at 31 March 2016. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member

For 2018-19, employers' contributions of £433k were payable to the NHS Pensions Scheme (2017-18: £421k were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	407	280
Services from foundation trusts *(1)	169,026	166,760
Services from other NHS trusts	21,694	19,980
Provider Sustainability Fund (Sustainability Transformation Fund 1718)	-	-
Services from Other WGA bodies	0	-
Purchase of healthcare from non-NHS bodies	58,732	54,361
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	34,246	37,447
Pharmaceutical services	-	-
General Ophthalmic services	231	170
GPMS/APMS and PCTMS *(2)	29,719	29,961
Supplies and services – clinical	42	4
Supplies and services – general	553	352
Consultancy services	-	36
Establishment	1,038	1,375
Transport	3	1
Premises	1,720	1,936
Audit fees	49	52
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services *(3)	10	-
Other professional fees	79	41
Legal fees	33	93
Education, training and conferences	20	36
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**317,603**	**312,886**
Depreciation and impairment charges		
Depreciation	76	82
Amortisation	-	-
Impairments and reversals of property, plant and equipment	348	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets		
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**424**	**82**
Provision expense		
Change in discount rate	-	-
Provisions	-	-
Total Provision expense	**-**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	455	437
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Non cash apprenticeship training grants	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**455**	**437**
Total operating expenditure	**318,482**	**313,405**

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

***1** Internal Audit Fee's of £39K 2018-19 (2017-18 £41k) are included in Services from Foundation Trusts.

***2** GPMS/APMS and PCTMS included £28.073m for delegated responsibility for commissioning Primary Medical Services for 2018/19 (£27.946m in 2017/18).

***3** The CCG will be required to obtain assurance from the external auditors over reported compliance with the requirements of the Mental Health Investment Standard. The CCG has received £10k of resource allocation in relation to this work. The final fee is not yet confirmed.

6.1 Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,748	90,988	9,128	83,830
Total Non-NHS Trade Invoices paid within target	9,619	88,191	9,084	82,903
Percentage of Non-NHS Trade invoices paid within target	**98.68%**	**96.93%**	**99.52%**	**98.89%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,525	192,179	2,618	190,444
Total NHS Trade Invoices Paid within target	2,417	190,806	2,575	190,431
Percentage of NHS Trade Invoices paid within target	**95.72%**	**99.29%**	**98.36%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2018-19 £'000**	2017-18 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

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

8. Investment revenue

The Clinical Commissioning Group does not have any investment revenue.

9. Other gains and losses

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

10. Finance costs

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

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

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

12. Operating Leases

12.1 As lessee

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

12.1.1 Payments recognised as an Expense

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	1,085	0	**1,085**	-	1,318	-	1,318
Contingent rents	-	-	-	**-**	-	-	-	-
Sub-lease payments	-	-	-	**-**	-	-	-	-
Total	**-**	**1,085**	**0**	**1,085**	-	1,318	-	1,318

The lease payment above include £341k for NHS Property Services, in 2017/18 the equivalent amount was £216k.

12.1.2 Future minimum lease payments

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	737	-	**737**	-	736	-	736
Between one and five years	-	2,947	-	**2,947**	-	2,947	-	2,947
After five years	-	4,183	-	**4,183**	-	4,914	-	4,914
Total	**-**	**7,867**	**-**	**7,867**	-	8,597	-	8,597

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

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

12.2 As lessor

12.2.1 Rental revenue

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

12.2.2 Future minimum rental value

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

13 Property, plant and equipment

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

Revaluation Reserve Balance for Property, Plant & Equipment

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

2017-18	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	0	0	0	0	0	0	138	700	837
Addition of assets under construction and payments on account				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
Cost/Valuation at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**138**	**700**	**837**
Depreciation 01 April 2017	0	0	0	0	0	0	85	247	332
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	25	57	82
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**110**	**305**	**414**
Net Book Value at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**395**	**423**
Purchased	0	0	0	0	0	0	29	395	424
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**395**	**424**
Asset financing:									
Owned	0	0	0	0	0	0	29	395	424
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**395**	**424**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2017	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Balance at 31 March 2018	**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 any assets under construction.

13.2 Donated assets

The Clinical Commissioning Group do not have donated assets.

13.3 Government granted assets

The Clinical Commissioning Group do not have government granted assets.

13.4 Property revaluation

The Clinical Commissioning Group do not have any properties.

13.5 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

13.6 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

13.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

13.8 Cost or valuation of fully depreciated assets

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

	2018-19 £'000	2017-18 £'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	139	78
Furniture & fittings	700	-
Total	**839**	**78**

13.9 Economic lives

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

14 Intangible non-current assets

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

14.1 Donated assets

The Clinical Commissioning Group do not have any donated assets.

14.2 Government granted assets

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

14.3 Revaluation

The Clinical Commissioning Group do not have any properties.

14.4 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

14.5 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

14.6 Non-capitalised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

14.8 Cost or valuation of fully amortised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.9 Economic lives

Not applicable to Calderdale Clinical Commissioning Group.

15 Investment property

The Clinical Commissioning Group has no investment property at 31st March 2019.

16 Inventories

The Clinical Commissioning Group has no inventories at 31st March 2019.

17.1 Trade and other receivables

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue	399	-	539	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	-	-	41	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	157	-	744	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	-	-	163	-
Non-NHS and Other WGA accrued income	-	-	-	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	39	-	13	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**595**	**-**	**1,500**	**-**
Total current and non current	**595**		**1,500**	
Included above:				
Prepaid pensions contributions	-		-	

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

17.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	394	149	532	86
By three to six months	6	40	7	-
By more than six months	-	7	-	-
Total	**400**	**196**	**539**	**86**

£355k of the amount above has subsequently been recovered post the statement of financial position date 18.04.19.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2019.

17.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Cash and cash equivalents £000s	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - other DHSC group bodies £000s	Trade and other receivables - external £000s	Other financial assets £000s	Total £000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-	-	**-**
Financial Assets held at Amortised cost	82	580	-	744	-	**1,406**
Financial assets held at FVOCI	-	-	-	-	-	**-**
Total at 31st March 2018	**82**	**580**	**-**	**744**	**-**	**1,406**
Classification under IFRS 9 as at 1st April 2018						
Financial Assts designated to FVTPL	-	-	-	-	-	**-**
Financial Assets mandated to FVTPL	-	-	-	-	-	**-**
Financial Assets measured at amortised cost	82	580	-	744	-	**1,406**
Financial Assets measured at FVOCI	-	-	-	-	-	**-**
Total at 1st April 2018	82	580	-	744	-	**1,406**
Changes due to change in measurement attribute	-	-	-	-	-	**-**
Other changes	-	-	-	-	-	**-**
Change in carrying amount	-	-	-	-	-	**-**

17.4 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - other DHSC group bodies £000s	Trade and other receivables - external £000s	Other financial assets £000s	Total £000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018						
Financial Assets held at Amortised cost (ie the 1718 Closing Provision)	-	-	-	-	-	**-**
Financial assets held at FVOCI	-	-	-	-	-	**-**
Total at 31st March 2018	**-**	**-**	**-**	**-**	**-**	**-**
Loss allowance under IFRS 9 as at 1st April 2018						
Financial Assets measured at amortised cost	-	-	-	-	-	**-**
Financial Assets measured at FVOCI	-	-	-	-	-	**-**
Total at 1st April 2018	**-**	**-**	**-**	**-**	**-**	**-**
Change in loss allowance arising from application of IFRS 9	**-**	**-**	**-**	**-**	**-**	**-**

18 Other financial assets

18.1 Current
The Clinical Commissioning Group has no current assets as at 31st March 2019.

18.2 Non-current
The Clinical Commissioning Group has no non-current assets as at 31st March 2019.

18.3 Non-current: capital analysis
The Clinical Commissioning Group has no non-current capital as at 31st March 2019.

19 Other Current assets
The Clinical Commissioning Group have no other current assets as at 31st March 2019.

20 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	83	45
Net change in year	(82)	38
Balance at 31 March 2019	**1**	**83**
Made up of:		
Cash with the Government Banking Service	1	83
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**1**	**83**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**1**	**83**
Patients' money held by the clinical commissioning group, not included above	-	-

The Clinical Commissioning Group have no bank overdraft as at 31 March 2019.

21 Non-current assets held for sale
The Clinical Commissioning Group does not have any non current assets held for sale during the period.

22.1 Analysis of impairments and reversals: property, plant and equipment

	2018-19 £'000	2017-18 £'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Loss or damage resulting from normal operations	-	-
Over-specification of assets	-	-
Abandonment of assets in the course of construction	-	-
Total charged to departmental expenditure limit	**-**	**-**
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Other	(348)	-
Change in market price	-	-
Total charged to annually managed expenditure	**(348)**	**-**
Total impairments and reversals charged to the statement of comprehensive net expenditure	**(348)**	**-**
Impairments and Reversals charged to the revaluation reserve		
Loss or damage resulting from normal operations	-	-
Over-specification of assets	-	-
Abandonment of assets in the course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Other	-	-
Change in market price	-	-
Total Impairments and reversals charged to the revaluation reserve	**-**	**-**
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	**-**	**-**
Total impairments and reversals of property, plant and equipment	**(348)**	**-**

The Clinical Commissioning Group does not has had no imapirments of intangible fixed assets..

23 Trade and other payables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	3,126	-	706	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,454	-	1,548	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	14,258	-	11,672	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	8,572	-	9,481	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	58	-	58	-
VAT	-	-	-	-
Tax	46	-	42	-
Payments received on account	-	-	-	-
Other payables and accruals	186	-	284	-
Total Trade & Other Payables	**27,700**	**-**	**23,791**	**-**
Total current and non-current	**27,700**		**23,791**	

The CCG has no liabilities for early retirement.

Other payables include 65£k outstanding pension contributions at 31 March 2019

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31st March 2019.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31st March 2019.

26 Borrowings

The Clinical Commissioning Group has no borrowings as at 31st March 2018.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group has no private finance initiative, LIFT or other service concession arrangements as at 31st March 2019.

28 Finance lease obligations

The Clinical Commissioning Group has no financial lease obligations as at 31st March 2019.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31st March 2019.

30 Provisions

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	-	-
Other	-	-	-	-
Total	**-**	**-**	**-**	**-**
Total current and non-current	**-**		**-**	

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However , the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2019 is £99,615. (2017/18 £75,811).

The clinical commissioning group has no provisions balances transferred to it as a result of the 1st April 2013 transition and has no provisions arising during the period.

31 Contingent Liabilities

	2018-19 £'000	2017-18 £'000
Contingent liabilities		
Equal Pay	-	-
NHS Resolution Legal Claims	-	-
Employment Tribunal	-	-
NHS Resolution employee liability claim	-	-
Redundancy	-	-
Continuing Healthcare	-	-
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	**0**	**0**
Contingent assets		
Amount Payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

	2018-19 £'000	2017-18 £'000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

32.2 Other financial commitments

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

	2018-19 £'000	2017-18 £'000
In not more than one year	-	-
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**-**	**-**

33 Financial instruments

33.1 Financial risk management

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

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

33.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

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

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Equity investment in group bodies	-	-	-
Equity investment in external bodies	-	-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	-	-	-
Trade and other receivables with NHSE bodies	254	-	254
Trade and other receivables with other DHSC group bodies	145	-	145
Trade and other receivables with external bodies	157	-	157
Other financial assets	-	-	-
Cash and cash equivalents	1	-	1
Total at 31 March 2019	**557**	**-**	**557**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	-	-	**-**
Loans with external bodies	-	-	**-**
Trade and other payables with NHSE bodies	379	-	**379**
Trade and other payables with other DHSC group bodies	11,779	-	**11,779**
Trade and other payables with external bodies	15,252	-	**15,252**
Other financial liabilities	186	-	**186**
Private Finance Initiative and finance lease obligations	-	-	**-**
Total at 31 March 2019	**27,595**	**-**	**27,595**

34 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2018-19 £'000	2017-18 £'000
Total net expenditure reported for operating segments	321,617	315,447
Reconciling items:		
Total net expenditure per the Statement of Comprehensive Net Expenditure	321,617	315,447

34.2 Reconciliation between Operating Assets and SoFP

	2018-19 £'000	2017-18 £'000
Total assets reported for operating segments	596	2,007
Reconciling items:		
Total assets per the Statement of Financial Position	596	2,007

34.3 Reconciliation between Operating Liabilities and SoFP

	2018-19 £'000	2017-18 £'000
Total liabilities reported for operating segments	(27,700)	(23,791)
Reconciling items:		
Total liabilities per Statement of Financial Position	(27,700)	(23,791)

35 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2018-19				Amounts recognised in Entities books ONLY 2017-18			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Better Care Fund	NHS calderdale CCG & CMBC	Reduction of DTOC and Emergancy Re admissions	0	0	0	14,239	0	0	0	13,973

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Metropolitan Borough Council in relation to the Better Care Fund.
The Better Care Fund (BCF) is a mandatory policy to facilitate integration of service provision between Health and Social Care.

The schemes managed through the BCF include: Disabled Facilities Grants, carers services, supporting social care, reablement and recovery services. Under the policy we have to report on a number of metrics which include delayed discharges from hospital and levels of emergency admissions.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budget is jointly controlled between the CCG and Calderdale Metropolitan Borough Council.

The NHS Clinical Commissioning Group has £317k of payables relating to the Better Care Fund as at 31st March 2019.

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

Name of entity	**Description of principal activities**	**Basis for treatment eg materiality**

The CCG has no interests not accounted for under IFRS 10 or IFRS 11.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health.
During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practise for which Governing Body members have a relationship have been disclosed below. In 2016/17 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

	2018-19				2017-18			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Longroyde Surgery (Dr Alan Brook)	450	0	0	0	428	0	0	0
Spring Hall Group Practice (Dr Steven Cleasby)	1119	0	0	0	1,213	0	0	0
Southowram Surgery (Dr Majid Azeb)	364	0	0	0	369	0	0	0
Hebden Bridge Group Practice (Dr Nigel Taylor & Dr H Davies)	2577	0	0	0	2,483	0	0	0
Beechwood Medical Centre (Dr Caroline Taylor)	1114	0	0	0	1,136	0	0	0
Rastrick Health centre (Dr F Javid)	593	0	0	0	573	0	0	0
Bankfield Surgery (Dr J Gray)	700	0	0	0	0	0	0	0

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

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

David Longstaff is the audit lay member for Calderdale CCG, Greater Huddersfield CCG and North Kirklees CCG , but had no material transactions.

In addition the executive Governing Body members have relatives or interests with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Bradford Teaching Hospitals NHS FT
East Lancashire NHS T
Pennine Acute NHST.
Leeds Teaching Hospitals NHS Trust
Insight
Age UK
Rosegarth Surgery

Two Governing Body members also have material transactions with:
Barnsley Hospital NHS FT
The Christie NHS FT

And material transactions are detailed below :

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

	2018/19 £000	2017/18 £000
Calderdale and Huddersfield NHSFT	142,081	139,434
South West Yorkshire Partnership NHSFT	21,793	20,687
Yorkshire Ambulance NHS Trust	12,438	11,945
Leeds Teachings Hospitals NHST	6,842	5,763
Bradford Teachings Hospitals NHSFT	3,706	3,661
NHS Greater Huddersfield CCG	0	674
Pennine Acute NHST	418	637
East Lancashire Hospital NHS Trust	695	650
Mid Yorkshire Hospitals NHS Trust	759	600
Central Manchester University NHS FT	510	209
CSU	225	253
The Christie NHS FT	53	67
Calderdale Local Medical Committee	69	77
NHS North Kirklees CCG	0	19

In addition the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies.

	2018/19 £000	2017/18 £000
Calderdale Metropolitan Borough Council	18,512	17,200

38 Events after the end of the reporting period

The Clinical Commissioning Group has no post balance sheet events which will have a material effect on the financial statements.

39 Third party assets

The Clinical Commissioning Group held no cash and cash equivalents which relate to monies held by the Clinical Commissioning Group.

40 Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Cash and other losses (including overpayments, physical losses, unvouched payments and theft) **(1)**	1	348	0	0
Fruitless payments and constructive losses	0	0	0	0
Claims waived or abandoned (excluding cases between DH group bodies)	0	0	0	0
Store losses and damage to property	0	0	0	0
Total	**1**	**348**	0	0

Details of cases individually over £300,000:

• **[1]** The Administrative write off relates to the impairment of the CCGs fixtures and fittings and IT assets following a management review of the carrying value of assets, totalling £348k. These have been recognised and accounted for in 2018/19.

Special payments
The CCG has had no special payments during the period.

41 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2018-19 Target £'000	**2018-19 Performance £'000**	**2018-19 Duty Achieved**	2017-18 Target £'000	2017-18 Performance £'000	2017-18 Duty Achieved
Expenditure not to exceed income	322,825	322,825	Yes	318,479	318,479	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	321,617	321,617	Yes	315,447	315,447	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,697	4,677	Yes	4,666	4,474	Yes

The CCG received total revenue resource allocation of £326,169K and had net expenditure of £321,617K delivering an agreed surplus of £4,552K.

42 Impact of IFRS

Not applicable to Calderdale Clinical Commissioning Group.

43 Analysis of charitable reserves

Not applicable to Calderdale Clinical Commissioning Group.

44 Effect of application of IFRS 15 on current year closing balances

There is no material impact of IFRS 15 on the clinical commissioning groups financial statements for 2018-19.

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group ("the CCG") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations, including the impact of Brexit, and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the

other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 51, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 51, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Calderdale CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

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

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

24 May 2019

NHS Calderdale Clinical Commissioning Group, 5th Floor, F Mill, Dean Clough, HX3 5AX