NHS
Calderdale
Clinical Commissioning Group

annual report
2014/15

OUR LOGO EMBRACES ALL OUR VALUES

LONG LIFE
Preventing people from dying prematurely

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

INDEPENDENCE
Helping people to recover and maintain their independence

CARE
Ensuring people have a positive experience of care

PROTECTION
Ensuring a safe environment and protecting people from harm

EQUALITY
Reducing inequalities

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

The Annual Report and Accounts consists of three sections:

Annual Report, which must consist of:

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

Statements by the Accountable Officer, which are:

- Statement of Accountable Officer's Responsibilities
- Governance Statement

Annual Accounts, which must consist of:

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

The Annual Report and Accounts 2014/15 for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on 21st May 2015 under delegated authority from the Governing Body

Dr Matt Walsh, Accountable Officer

27th May 2015

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PART THREE – ANNUAL ACCOUNTS

Annual Accounts

Glossary

AQP	Any Qualified Provider
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Service
CC2H	Care Closer to Home
CCG	Clinical Commissioning Group
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CIC	Community Interest Company
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
GH CCG	Greater Huddersfield Clinical Commissioning Group
HCAI	Hospital Acquired Infections
HPMO	High Performing Membership Organisation
LTC	Long Term Condition
MBC	Metropolitan Borough Council
NHSE	NHS England
NK CCG	North Kirklees Clinical Commissioning Group
NICE	National Institute of Clinical Excellence
PDR	Performance and Development Review
PICU	Paediatric Intensive Care Unit
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
SIGN	Scottish Intercollegiate Guidelines Network
SMT	Senior Management Team
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
VAC	Voluntary Action Calderdale
W CCG	Wakefield Clinical Commissioning Group
YPHO	Yorkshire Public Health Observatory

Chair's Introduction

It gives me real pleasure to be able to present our second Annual Report. It has been an exciting year for the Clinical Commissioning Group in which we have made significant progress in shaping the future for NHS services in Calderdale. We began the year by developing our 5 Year Strategic Plan. With the involvement of the public and partners we set out our ambition on the level of transformational change that is needed to ensure that people in Calderdale are able to live healthy and independent lives secure in the knowledge that if they need them, the services will be there to keep them safe, supported and cared for.

Key to the delivery of this ambition is the work that we have been taking forward with partners as part of the Right Care, Right Time, Right Place, Programme. We have focused on development in phases to ensure that we maintain high quality services for local people - strengthening existing community services; further enhancing them and bringing care closer to home; and developing proposals for the future of hospital care. In 2014/15 we produced a new community service specification and development of our Care Closer to Home model with partners, part of which includes the launch of our programme to develop new ways of working in the Upper Valley. We have also worked closely with the Calderdale Council on identifying integrated health and social care services as part of the Better Care Fund.

This year has not been without its challenges. These include the financial pressures being experienced throughout the NHS and the pressures on our urgent care system. We have continued to keep a tight grip on our financial position and performance which is reflected in achievement of our QIPP (Quality, Innovation, Productivity and Prevention) target and financial balance at the end of the year.

Throughout the year we have carried out a significant programme of engagement activity, have listened to what the public has said and have taken on board the recommendations of the Calderdale People's Commission- established to give local people further opportunity to have their say. This has all helped us to be clear about our future direction of travel.

All this work culminated in March 2015 when we were successful in becoming one of only 29 sites nationally to be selected as part of the *Vanguard* programme. The aim of *Vanguard* is to support a transformation in the way that care is delivered locally. As a *Vanguard* site, Calderdale will be able to draw on national expertise as well as the knowledge from other sites in the scheme. This will help us to develop new ways of working to address some of the challenges we face and to strengthen our ability to deliver our Care Closer to Home programme.

As a CCG, we are clear that we can only be successful by working collaboratively with our partners and in the past year have demonstrated our commitment to strengthening our relationships through our work on the Health and Wellbeing Board, with Calderdale Council, our main providers, the voluntary and community sector and the CCGs across West Yorkshire.

The CCG is in part a membership organisation which delivers the commissioning responsibilities of all Calderdale GP practices. We have continued excellent engagement with them through the HPMO programme (High Performing Membership Organisation) with actively involved representative leads from each practice as well as two meetings for all GPs. These sessions have received good feedback. We have also had great success dividing practices into five localities to test initiatives to address our seven clinical priority areas, allowing them to share best practice and learn from each other. As well as providing essential engagement, HPMO and Practice Leads provide a developmental route for interested clinicians to either take responsibility for a specific topic as an Associate, or to ultimately become a new Governing Body member, providing essential resilience and succession planning for the CCG.

In 2014/15 we recruited two replacement Governing Body members, a GP and a Hospital Consultant. Both have had a successful induction to the organisation and bring renewed vigour to our activities.

Each year we carry out a self-assessment of Governing Body and sub-committee effectiveness and have summarised our work in this area in the Governance Report. I would however like to take this opportunity to thank the staff, governing body and the member practices for their commitment to achieving all that we have during the year.

Turning towards the next year, our main priorities in 2015/16 are:

- delivering the health outcomes outlined in the Five Year Forward View and our own one year plan – to reduce health inequalities, reduce preventable deaths, improve quality of life and patient experience, maximise independence, and ensure services are safe;
- working with public health colleagues at Calderdale Council to promote good health through healthy lifestyles;
- improving health outcomes through local initiatives including the Calderdale Food for Life Partnership as part of our sustainability plan
- increase our efficiency by being more joined-up and reducing duplication; and
- bringing care closer to home and out of a hospital setting where clinically appropriate, which is what people have told us that they want;
- Developing our role as part of the co-commissioning of primary medical services.

We have some big ambitions for health and social care services in Calderdale, and I am confident that we will continue to make progress on these during 2015/16 and make a real difference to the health and wellbeing of local people.

Dr Alan Brook, Chair

STRATEGIC REPORT

1. Who we are

NHS Calderdale Clinical Commissioning Group was licenced to operate from 1 April 2013 under the NHS Reforms that were brought in by the Health & Social Care Act 2012, which amended the National Health Service Act 2006. This was without conditions.

Calderdale CCG is a membership organisation consisting of 26 general practices that look after the health needs of the estimated 213,000 people who live in Calderdale and/or are registered with a Calderdale GP. This means that local clinicians – who have a good understanding about the needs of their population – are responsible for commissioning the health services used by local people.

2. How the CCG is organised

The practices that make up the CCG have delegated authority to the Governing Body to oversee the work of the organisation.

Governing Body and sub-committees

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

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

The Governing Body makes decisions in line with those outlined in the CCG Constitution, Standing Orders, Standing Financial Instructions and Standards of Business Conduct.

Since its establishment in 2013, the Governing Body has been supported in its work by four sub committees: Finance and Performance, Quality, Remuneration and Audit. In February 2015, the CCG was granted full delegated responsibility for the commissioning of specified primary medical services. In order to effectively manage any actual or potential conflicts of interest for our GP Governing Body members, a new sub-committee has been established with decision making responsibilities for primary medical services. This committee has a lay and executive majority. The new committee will begin operating in the new financial year.

Associates

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

Practice Commissioning Leads

Each practice has nominated a Practice Commissioning Lead (see the Members' Report). The role of this clinical lead is to be a two way conduit between the practices and the Governing Body. This includes sharing information about issues for local people at practice level, representing practice views and acting on behalf of the practice in matters relating to the CCG – including shaping the priorities of the CCG, testing plans and proposals. They also disseminate information to the practices from the Governing Body on strategies and potential developments. More information on the work of the member practices is contained within the Governance Statement.

CCG staff

The CCG is based at Dean Clough Mills in Halifax and has 45.8 whole time equivalent (WTE) staff who commission services on

Diabetes engagement work

In 2014, Calderdale and Greater Huddersfield Diabetes Network brought together local people at two events to talk about how diabetes care and support could be improved.

The resulting strategy - which outlined new/improved models of care and support - was published during Diabetes Awareness Week in June 2014.

In October 2014, a second event focused on the models to make sure they were fit for purpose and on supported self –care.

The strategy and outputs from the events, which evaluated well, are being used by the Network to drive improvements for local people with diabetes and their families.

behalf of the local population. Some of these staff work in shared posts with Greater Huddersfield CCG and with North Kirklees CCG.

Our vision, aims and values

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

Our Aims

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

Our Values

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

3. The national and local context

Calderdale is located in Pennine West Yorkshire and is part of Leeds City Region. The area also borders the Manchester and Central Lancashire City Regions. Calderdale is placed within the M62 corridor, on the main trans-pennine rail route between two expanding and prosperous city regions, Leeds and Manchester. Calderdale's location allows quick and easy access to a population of 5.5 million providing significant economic opportunities.

There are over 200,000 residents in Calderdale, with over 8,000 businesses. The area is home to a number of major companies: HBOS/Lloyds; Nestle; Marshalls; Crosslee and Eureka! Calderdale's high value sectors are manufacturing and finance, with high growth sectors being creative and digital industries, tourism and leisure. Calderdale has a large number of employment sites; however these are often constrained - making development difficult. The proportion of residents with a qualification of NVQ level 4 or above is below the national average, which may be due in part to young people leaving the district to attend higher education establishments elsewhere nationally and not returning.'

The Gross Value Added (GVA) per head of population is a good indicator of productivity. In 2013, the provisional per head of population figure was £16,812, which is an increase on previous years. However, in common with other districts in West Yorkshire, Calderdale still suffers from a net low GVA compared with the national average of £23,755[1].

[1] Economy and Enterprise Strategy 2010 – 2020, Calderdale Council; Workplace based GVA1 per head NUTS3 at current basic prices; Business and Economy Department, Calderdale Council.

Staying Well

Preventing and alleviating loneliness is vital to enabling older people to remain as independent as possible. A main aim of Staying Well is to have a positive impact on isolated individuals in relation to their overall health and well-being, as well as reducing health inequalities. Another focus of the project is to create more connected local communities so addressing social isolation-contributing to the Sustainability agenda. The project:

- Enhances bespoke activities in local communities;
- Builds on existing local voluntary sector and neighbourhood initiatives.
- Has 4 community 'hubs' (North Halifax Health Alliance, Halifax Opportunities Trust, Elland & District Partnership and Hebden Bridge Community Association)
- Will support local community workers, voluntary groups, health and council partners to deliver the project aims.
- Is council-led with CCG support – main focus relies on voluntary and community sector.
- Is a key priority for the Health and Well-being Board; links to the Better Care Fund, part of wider Care Closer to Home Strategy, links to sustainability agenda.

Staying Well will:

- Help us demonstrate the positive impact of community based initiatives.
- Impact positively on GP attendances.
- Reduce avoidable admissions for planned, unplanned and long term care.
- Be externally evaluated on its cost-benefit.

The district faces a number of challenges; whilst there have been significant improvements in terms of unemployment and in the recovery of key industries post-recession, there continues to be the need to increase the investment in commerce and industry and increase the skills-base of the local population. There is also need to reduce the congestion on our roads and reduce the impact of air pollution on the health of local people.

Furthermore, a number of our neighbourhoods have particular long term challenges which have prevented them achieving their full potential so there is a need to assist these communities enabling them to achieve similar levels of economic development to that enjoyed by the higher performing neighbourhoods.

Meeting the challenges facing the health and social care system

Throughout 2014/15 we have continued to work to manage the challenges faced by the health and care system locally and nationally. These include an increasing population, particularly in the numbers of people aged over 65 years and in children.

Whilst improvements have been made in key population outcomes such as life expectancy, when we compare ourselves with similar districts in England, there are still major improvements that can be made in the key disease groups such as respiratory disease, cardiovascular disease and cancer. At the same time, we also recognise that the overall picture of health in Calderdale can disguise some wide variations in outcomes that are linked to the mix of urban and rural geography in the area, deprivation or ethnicity.

All these factors have implications for our strategic direction and the types of services we need to commission.

We are working with partners at Calderdale Council, our main providers and the third sector to:

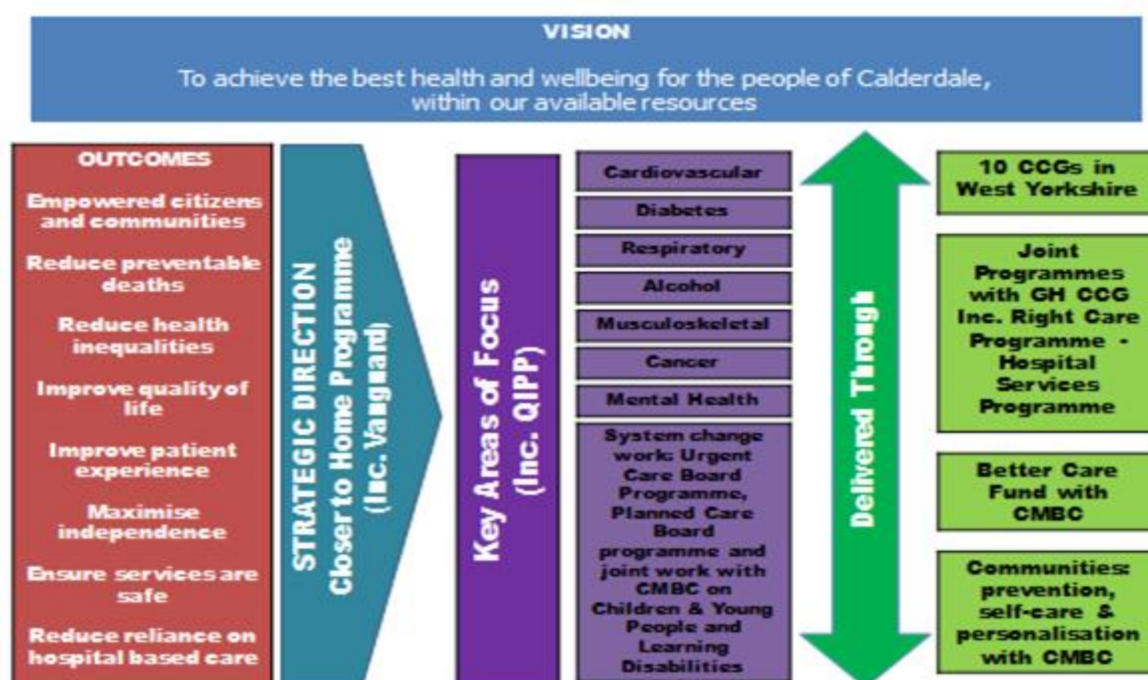
- Deliver the strategic priorities set out in the local Wellbeing Strategy;
- Respond to the recommendations contained within the Francis and Winterbourne reviews as well as the Kirkup Report;
- Continue to develop strategies for meeting the workforce issues faced locally and nationally;
- Manage in a positive way, the continued pressure on the urgent care system;
- Respond to the wider fiscal pressures;
- Meet the needs and aspirations expressed by local communities, patients, service users and carers.

All these challenges mean that our responses must continue to be strategic and system-wide to deliver the scale of benefits and the sustainable impact required. Our approach is set out below:

4. Our Commissioning Activities

Whilst 2014/15 has been a challenging year in many ways, it has been an extremely positive year in which we have made real progress towards achieving our strategic objectives.

The commissioning activities of the CCG and our contribution to the delivery of the system-wide programme *Right Care, Right Time and Right Place* were set out at the beginning of the year in our 5 Year Strategic Plan which be found at: www.calderdaleccg.nhs.uk/documents.



Throughout the year we have focused on the two major transformational components of *Right Care, Right Time, Right Place:*

- Care Closer to Home (CC2H) Programme
- Hospital Services Programme

We also focused on the delivery of our QIPP (quality, innovation, productivity and prevention) targets. Other key activities have centred on the development of the Better Care Fund Plan for 2015/16.

Supporting all this work has been an ambitious and successful public and community engagement programme, which has generated a wealth of valuable information on the shape of support and services that local people want to see.

Underpinning all our commissioning activity is our quality governance and focus on continuous quality improvement. Much of this work is driven through the quality team and the quality committee as well as the quality boards at Calderdale and Huddersfield NHS Foundation Trust (CHFT) and SWYPFT (South West Yorkshire Partnership NHS Foundation Trust).

5. The Provider Landscape

As a CCG, we are clear about both our regulatory and social responsibilities when it comes to the provider landscape within which we operate. We seek to use our spending power to good effect over and above the commissioning of high quality, safe, effective services that deliver value for money for our population.

Type of Provider	% By Value
NHS	81.0%
Independent Sector – Continuing Healthcare / Funded Nursing Care / Mental Health / Learning Disabilities	8.3%
Local Authority	3.9%
Independent Sector – Primary Care (including GP Practices)	2.9%
Independent Sector - Elective & Diagnostics	2.0%
Not for Profit	1.9%

Calderdale CCG's provider landscape consists of a number of distinct footprints. These footprints are shared with key commissioning partners and can be described as:

- Acute;
- Community and primary care;
- Mental health and learning disabilities;
- Continuing health care;
- Local authority and third sector.

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

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

Any Qualified Provider (AQP) is a mechanism for allowing service users a choice of provider for specific services. There are currently a number of AQP services in place across Calderdale covering services closer to home: Adult Hearing; Non Obstetric Ultrasound; and MRI.

The mental health footprint is shared with Calderdale Council, but the provider landscape is dominated by one main provider covering South West Yorkshire. Our CCG, together with the CCGs across Kirklees and Wakefield contracts jointly for core mental health services from SWYPFT. The CCG also leads a jointly commissioned contract with SWYPFT for the provision of Child and Adolescent Mental Health Services (CAMHS).

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

The continuing health care footprint is shared with Calderdale Council and is characterised by a broad range of providers, contracted either directly or through a framework agreement covering domiciliary care. These

Many people told us that communication with and from Learning Disability services was a real problem. In October, the CCG and Calderdale Council commissioned '**Lead the Way'** (Cloverleaf):

- To ensure all vulnerable adults with a Learning Disability, family and carers can locally access and benefit from quality statutory/voluntary services whilst maintaining an 'Ordinary Life'.
- Provides personalised support to individuals and their families and carers.
- E.g. A carers support group;
  All inclusive mixed ability sports sessions; Life coaching/ healthy lifestyles

Very positive feedback about this service from individuals and their families. It is making a difference for them.

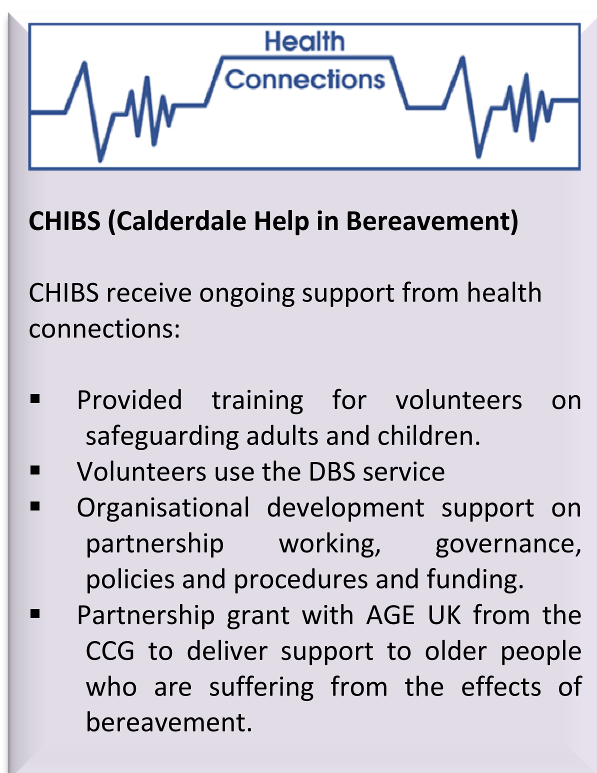
providers work mainly across the Calderdale district but with patient placements outside of the local area.

Third sector (not-for profit organisations)

The CCG has a shared footprint with Calderdale Council and the third sector with a range of funding agreements in to support provision across the district. We have also worked jointly on a range of procurements led by the Council.

In addition, we have developed a supportive approach to working with the third sector in Calderdale with the emphasis being on building future capacity and capability. This work contributes to our sustainable development agenda.

Third sector (not-for profit organisations)
Health Connections



CHIBS (Calderdale Help in Bereavement)

CHIBS receive ongoing support from health connections:

- Provided training for volunteers on safeguarding adults and children.
- Volunteers use the DBS service
- Organisational development support on partnership working, governance, policies and procedures and funding.
- Partnership grant with AGE UK from the CCG to deliver support to older people who are suffering from the effects of bereavement.

The Health Connections Programme has been commissioned by the CCG from Voluntary Action- Calderdale to provide support to the third sector on:

- **Capacity Building** – organisational development and resilience.
- **Safeguarding and Equalities** – policy development and implementation; ongoing professional development of staff.
- **Partnership working** – facilitation of partnerships, networking to encourage partnerships.
- **Engagement** – building community assets (engagement champions), undertaking engagement, supporting network development.
- **Grants** – small and partnership grants via Calderdale Community Foundation, large grants directly from Calderdale CCG.
- **Patient Reference Group (PRG) development** – support for practice managers and PRG members.

In 2014/15 this has delivered:

- Increased levels of quality in frontline organisations particularly around safeguarding and equalities.

- Clear demonstrations of the value that the Voluntary and Community Sector (VCS) can bring to improving health outcomes.
- Increased delivery of health outcomes via grant investment, particularly around mental health, drugs and alcohol, obesity and diabetes.
- Increased partnership working between VCS groups – particularly around older people, BME, mental health and dementia.
- Increased number of PRGs operating effectively in Calderdale
- Improved reach into local communities.
- Increased and more effective engagement with local people in local communities.

The CCG's Contracts Register can be found on the CCG's website www.Calderdaleccg.nhs.uk

6. Strategic Objectives of the CCG

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

In 2014/15 we reviewed our strategic objectives as part of the development of the 5 Year Strategic Plan. The following strategic objectives are set out in our Governing Body Assurance Framework:

Strategic Objectives
1. Improving health outcomes
2. Improving service user experience of care
3. Maximise independence and recovery
4. Ensuring services we commission are safe
5. CCG exercises its functions effectively, efficiently and economically in a way that provides good value for money
6. Empower citizens and resilient communities
7. An organisation that is fit for purpose

The strategic objectives fall into three main categories:

- Achieving strong financial control and best value for money
- Clinical commissioning priorities
- Ensuring that the organisation is fit for purpose. Information on how we have implemented this can be found within the Equality Report, Members' Report, Remuneration Report and the Governance Statement.

6.1 Achieving strong financial control and best value for money

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

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

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

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

The CCG fulfilled all these financial duties in 2014/15. Further information can be found in the Accounts section of the Annual Report.

6.2 Clinical commissioning priorities

Our proactive collaboration in the Calderdale and Greater Huddersfield Health and Social Care *Right Care, Right Time, Right Place* Programme set the vision for our system. This programme played a pivotal role in bringing together the seven partners to develop proposals for transformational change. At the beginning of 2014/15, we set out our contribution to the achievement of this system-wide vision in our 5 Year Strategic Plan.

The focus of the commissioning priorities set out in our 5 Year Strategic Plan continues the shift of services and resources to the delivery of care through integrated health and social care models - delivered in community and primary care settings. This forms the basis for our major programmes: Closer to Home Programme (including integrated health and social care provision through the Better Care Fund programme) and the Hospital Services Programme.

This work also ensures that the resources invested in planned care are effective and are provided in the most suitable setting – whether in hospital or closer to home.

This will transform the way our system currently works so that empowered citizens can access integrated community, social and primary care services that are connected by effective pathways into acute settings. This will ensure people can receive the right care at the right time in the right place.

Strategies for achieving our clinical commissioning priorities

We are clear about the strategies that we have employed to put us in a strong position to achieve our clinical commissioning priorities. We have:

- Built on the work of the Right Care, Right Time, Right Place Programme and the Wellbeing Strategic Priorities.
- Set our ambitions by developing eight challenging strategic outcomes which are aligned to those set out in Everyone Counts: Planning for Patients 2014/15 – 2018/19 (NHS England) and used these to describe our priority programmes.
- Used indicative data and insights from our public and patient engagement to identify the areas where there is the largest potential for gain in terms of improved outcomes and value from the money invested in healthcare.

- Ensured the plan promotes the delivery the NHS Constitution.
- Aligned our plans with the work being developed by the 10 West Yorkshire CCGs.
- Used Right-Care methodology to guide our business processes.
- Initiated an improvement journey that will ensure the services we commission are high quality, placing safety at the heart of all we do.
- Established a financial envelope that will ensure delivery is affordable.
- Strengthened our organisational development plans to ensure we have the capacity and capability required to deliver the plan.
- Built on the trajectories submitted to NHS England who provide assurance that our plans are robust. They will also provide the basis to assure our Governing Body on the progress being made with delivery.

Delivery of this plan will be guided by the design principles we have adopted for our organisation (see the aims of the CCG on page 8).

Delivery of the priorities is monitored using the key performance indicators set out in Everyone Counts: planning for patients 2014/15[2] (NHS England). This ensures a consistent approach that can be benchmarked locally, regionally and nationally.

Key performance indicators used by NHS Calderdale CCG.

NHS Constitution rights and pledges: outcome measures

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

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

Quality premiums

Quality premiums are intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – is based on six measures that cover a combination of national and local priorities. These are:

- reducing potential years of lives lost (PYLL) through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15% of quality premium);
- improving access to psychological therapies (15% of quality premium);

[2] NHS England, Everyone Counts: Planning for Patients 2014/15

- reducing avoidable emergency admissions (25% of quality premium);
- addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15% of quality premium);
- improving the reporting of medication-related safety incidents based on a locally selected measure (15% of quality premium);
- emergency admissions for alcohol liver related disease (a local measure based on a local priority (15% of quality premium).

In 2014/15 we have worked with partners to achieve the quality standards. Details on the progress made to date can be located in appendix 1 (b)

The CCG has a rigorous approach to the monitoring of performance against delivery of the programmes through its internal governance processes. This approach has led to the achievement of most of our key NHS Constitution duties including:

- Referral to treatment times for admitted, non-admitted patients;
- Waiting times for diagnostic tests;
- Cancer waiting times;
- Non elective admissions;
- Avoidable admissions

The areas of challenge on performance this year largely relate to the resilience of our urgent care system. This has been an exceptional year nationally in terms of pressure on urgent care services, and it is worth noting that the position for Calderdale has not been unusual when compared with other systems locally and nationally.

In 2014 we worked with partners to introduce the Strategic Resilience Group (SRG)[3] in order to bring together the commissioning and delivery elements of planned and urgent care across the CHFT footprint. This change ensures that capacity planning and operational delivery across the health and social care system is coordinated. A further aim of this approach is to make use of the Better Care Fund to generate additional opportunities for working across health and social care (see Better Care Fund page 23).

The CCG monitors performance against delivery of the programmes through our robust internal governance processes. Where there is in-year variation, this is reported and performance managed through the monthly QIPP meetings and Finance and Performance Committee. Issues regarding variation are escalated through the appropriate governance structures such as the Planned Care Board, The Urgent Care Board and the Partnership Steering Group.

Further information on our internal governance arrangements can be found in our Governance Statement.

[3] NHSE, Operational Resilience and Capacity Planning Guidance (13 June 2014).

Future targets

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

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

In terms of CQUINS, we will be using local indicators in the following areas for 2015/16:

Calderdale and Huddersfield NHS Foundation Trust

- Respiratory- Asthma and pneumonia as in 2014/15
- Diabetes – Inpatient self-management care bundle
- Medicines Safety- accuracy of information on discharge
- End of Life – staff training and numbers of patients on care of the dying care plan
- Nutrition- patient experience and reducing food waste

South and West Yorkshire Partnership NHS Foundation Trust

- Care Plan audit to improve quality of care plans
- Early Intervention in Psychosis
- Learning Disabilities
- mental health safety thermometer, reduce number of harms caused by medication omissions

Further information on our strategies for achieving the Objectives of "strong financial control and best value for money" and "an organisation that is fit for purpose" are contained in section 9.1 Levels of Investment and in the Governance Statement.

Respiratory service

The fully integrated service aims to improve outcomes for people with respiratory disease and reduce avoidable hospital attendances and admissions. It will be managed through a single point of access. Key features include:

- 7 day service
- Nurse-led community clinics
- Multi –disciplinary teams
- 'Hot Clinics' - daily specialist clinics
- Post-discharge home visits and regular contact with the patient to monitor their condition

The CCG will measure the impact of this new service and will continue to seek new ways to improve care and support.

Children's Asthma

- Personalised supported self-management plan that is developed with the child and their family – shared with their school and/or nurseries. We are aiming to expand this approach to include activity clubs.

7 Significant features of the development and performance in the year

As a CCG, we have been successful in building on the developments of previous years and delivering the first year of our transformational 5 Year Strategic Plan. This

has culminated in the awarding of Vanguard Status in March 2015. The significant features are set out below:

7.1 Right Care, Right Time, Right Place

The *Right Care, Right Time, Right Place* Programme (formerly known as the Strategic Review Programme) introduced new programme arrangements in June 2014 in response to a number of recommendations presented by the Health Gateway review.

The programme is the Commissioners' response to a Case for Change that was developed as part of the system-wide Strategic Review and consists of three interlinked pieces of work: Calderdale Care Closer to Home Programme; Kirklees Care Closer to Home Programme; and the joint Hospital Services Programme[4].

The programme is being taken forward in three phases over the next five years:

Phase 1 - Strengthen Community Services in line with the new model of care (in Calderdale and in Kirklees).
Phase 2 - Enhance Community Services
Phase 3 - Hospital Services Programme (Calderdale and Greater Huddersfield)

The development of our care closer to home programme (phase 1) has been one of our key areas for delivery in 2014/15.

Care Closer to Home (CC2H) Programme

We have:

- Produced a CC2H Specification and set this within provider contracts for 2015/16 - with clear links to delivery of our Better Care Fund (BCF) Plans.
- Seen our acute provider (CHFT) develop a new clinically-led division within its structure to oversee and drive forward the delivery of Care Closer to Home – with strong links to the work of the new GP Federation.
- Strengthened relationships with 128 health-related providers in the third sector.
- Brought together providers within a new CC2H Implementation & Innovation Hub.
- Implemented new models of care such as the Quest for Quality in Care Homes; a new model of respiratory care; a multi-agency Staying Well programme for older people in Calderdale to tackle social isolation and loneliness; a new Palliative Care Collaboration between Health, Marie Curie and Overgate Hospice

- providing out-of-hours support and care to people with palliative care needs; a new Child Health Care Closer to Home pilot in North East Halifax –bringing together; CHFT, GPs, and Children's Community Nurses delivering paediatric clinics in the community at a Children's Centre.

- Worked with our third sector providers to deliver new models of Social Prescribing – supporting health and social care to access a different menu of support for patients.

- Continued to strengthen current integrated health & social care intermediate care services.

Palliative care Pilot (Commenced April 2014):

A number of challenges were identified in the end of life care pathway in Calderdale, which needed to be addressed to improve the patient experience and enhance the palliative care pathway. They included:

- A need for more comprehensive advanced care planning and early identification of patients at the end of life;
- Better care coordination across the pathway;
- Better planning to prepare for discharge and organise appropriate packages of care within the community; and
- Increased support to help people stay at home and avoid admissions to hospital, particularly out of normal working hours.

Four partner organisations –Calderdale CCG, Marie Curie Cancer Care, Overgate Hospice and CHFT – have launched a new service to address some of these challenges by introducing a responsive and effective out of hours specialist palliative care service in Calderdale. The team have saved 84 avoidable admissions equating to £50,400 so far (Feb.2015)

Case Study: Multi-disciplinary team working

A young patient with pancreatic cancer was visited by the team one evening to help them to manage their symptoms of uncontrolled nausea and vomiting. The out of hours palliative care team supported an out of hours GP by advising on the appropriate type and course of anti-sickness medication based on the patient's condition and the medicines they were already taking. The palliative care team and GP agreed to make a joint visit to the patient's house so the GP could prescribe and provide the medication with the additional support of the expert team. The treatment worked and the patient's symptoms quickly settled so they were able to feel more comfortable.

- Continued to build on examples of integration between general practice and social work.

Children's Health Care Closer to Home (C^3)

Six partners from across Calderdale and Huddersfield (GH CCG), Calderdale CCG, CHFT, Locala CIC, Kirklees MBC and Calderdale MBC have come together to

design and test a model of healthcare that brings professionals from primary and secondary care together to work collaboratively in the interests of children and families.

The aim of the C^3 service is to develop provision and expertise in children's health care closer to the child, young person or families' home. The foundations of C^3 lie in self-management, empowering families to have the confidence to manage their own health conditions and also when to escalate appropriately.

This model delivers a multi-professional clinic at the Innovations Children Centre in the North East Halifax area made up of a Paediatric Consultant, Advanced Paediatric Nurse Practitioner, General Practitioner, and Community Children's Nurse. This clinic is offering family friendly hours and accepts referrals from pre-selected pilot GP practices.

We are currently undertaking an initial six month review with a full evaluation planned at twelve months. There has been excellent feedback received from patients and the clinicians involved.

There are clear improvements in communication between secondary and primary care and clear opportunities of education of primary care clinicians and in supported self-management of children, young people and families with long term conditions.

General Practice

General Practice is at the heart of a wider system of integrated out-of-hospital care, working on a more systematic collaborative basis with Community Health Services, Social Care, third sector organisations, Community Pharmacist West Yorkshire and other partners. In recognition of this we have begun a dialogue with our member practices about the opportunities for operating at greater scale. This has been supported by the establishment of the GP Federation in Calderdale (the Pennine GP Alliance) which represents 23 out of 26 practices in Calderdale and 95% of the local population and the full delegation of commissioning certain primary medical services to the CCG in February. This will be taken forward through the development of a Primary Care Strategy in 2015/16 and a greater alignment with the work of the 10 CCGs across West Yorkshire.

Better Care Fund Programme

The Better Care Fund is a national initiative to promote integrated out of hospital care. The CCG has continued to work closely with Calderdale Council, since the introduction of the guidance in August 2013 and has strengthened its governance arrangements for the programme in 2014/15. The Better Care Fund Plan for Calderdale was approved in December 2014 and a Section 75 Legal Agreement between the Clinical Commissioning Group and the Council will be in place from 1 April 2015.

The Better Care Fund Plan for 2015/6 is fully aligned with CC2H Programme and includes schemes aimed at reducing avoidable emergency admissions to hospital

and permanent admissions to residential care. The plan also aims to reduce delayed transfers of care and improvements in the outcomes of rehabilitation.

Hospital services programme

We are clear that transformational change is necessary in our hospital services to meet current and future healthcare needs. The aim of the Hospital Services Programme is to enable us to define and commission the future model of hospital services for Calderdale and Greater Huddersfield. The key elements of the programme are quality and safety, workforce, estates, IT and finance.

We need to be able to demonstrate to the public and ourselves that the enhanced and integrated community services being established will meet local needs. It is important that collectively we are confident that community services are working well before we consider changes to the hospital. We expect to have that degree of confidence and be in a position to demonstrate readiness for consultation during 2015.

7.2 QIPP (Quality, Innovation, Productivity and Prevention)

The aim of QIPP is to improve quality whilst delivering efficiency savings. In 2014/15 we achieved £4m of QIPP savings. This has been achieved in part through the delivery of a range of QIPP schemes, which were identified through our prioritisation process at the beginning of the financial year. These schemes have included work on; respiratory, diabetes, MSK, mental health, and cancer services. During this year work has also taken place to plan for 2015/16 QIPP, which will also include alcohol and Cardiovascular services. A significant scheme this year has continued to be the Quest for Quality in Care Homes:

- **Quest for Quality in Care Homes**

The Quest for Quality in Care Homes' initiative began in 2013/14 and has now been fully implemented across 24 Calderdale Care Homes. We now have:

- **Telecare in care homes** – care home staff request equipment that they feel would benefit residents. Largest deployment of telecare into care homes in the UK, supporting safety - wireless sensors around the home which detect risks e.g. falls.

- **Telehealth** monitoring in the care homes – testing vital signs of residents in the care homes (up to 500 people)

- Invested in an integrated social and clinical approach to support anticipatory care planning (Multi-disciplinary team - MDT):

  - Supports care homes to treat non-urgent illnesses and manage long-term conditions;
  - Clinicians able to access shared information through IT system in care home;

- 7 day working;
- Enhances quality of care;
- Maximises independence and dignity;
- Enhances end of life care;
- Reduces unplanned demand on GPs;
- Reduces avoidable hospital attendances, admissions and readmissions;
- Reduces the number of avoidable ambulance call-outs

7.3 Engagement work carried out in 2014/15

NHS Calderdale CCG has a published strategy which sets out our approach to engagement, our legal obligations and the processes we use to govern these arrangements and provide assurance. This strategy describes what the public can reasonably expect our organisation to deliver and informs staff of our approach.

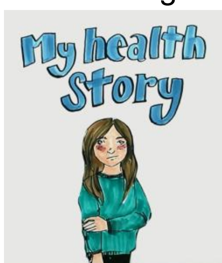
In developing its vision and model, the *Right Care, Right Time, Right Place* Programme directly engaged with over 2,500 people across Calderdale and Greater Huddersfield. This insight was used to inform our 5 Year Strategic Plan, particularly in relation to: Long-Term Care, Planned Care, Unplanned Care and Children's Services

These views gathered over three years of engagement were also used to develop the CC2H specification.

With the support of our communications and engagement team, we have carried out a fantastic engagement programme this year. Our main focus has been on the development of care closer to home

Local people and staff have been engaged in two stakeholder events this year to further inform these plans. Over 200 people have been directly engaged on the model.

We have used the experiences of people living across Calderdale to test out our ideas. Megan's story has been brought to life as a cartoon. We also commissioned an animation which describes the compelling story of our strategic journey – Care Closer to Home – its impact on our population and our partners. We will build on the success of this approach by bringing different elements of the work to life through animations.



Calderdale has a thriving community asset based approach to engagement which has resulted in training 90 community champions across Calderdale who deliver engagement activity across the district reaching grass roots communities. NHS Calderdale CCG also has relationship matrix which helps us to reach groups which represent our most diverse communities. GP Practice 'Patient Reference Groups' continue to be actively engaged through a quarterly Health Forum.

From all the engagement activity which has taken place over the previous year local people have told us what is important to them. People want to see:

- Improved access to health services
- More services in the community
- All agencies working together to deliver Health and Social Care
- Improved Discharge planning and better resourced hospitals.
- Staff Training to improve communication and transparency
- Regular check-ups for people with chronic conditions
- Improved management of risk and safeguarding when people are unwell
- More education and information
- Support for Self Care, and
- Investment in technology

In addition to the engagement activity we deliver there are a number of mechanisms which support us to engage people, these are:

- A dedicated website which contains information on how to contact the CCG and updates people on our engagement activity. This includes the use of social media such as Twitter to gather views.

- PALS and complaints service which capture public views as part of their customer facing role, which we use to inform our engagement approach.

- Close working relationship with Healthwatch colleagues to ensure we listen to people's views through consumer champions.

- Existing consumer websites are reviewed including those attached to the local media, patient opinion and NHS Choices to gather feedback.

- A variety of communication channels are used to disseminate information and provide opportunities for patients and the public to give their views. Including third sector networks.

We have also engaged with our member practices, the Health and Wellbeing Board and our partners:

- Ensured support from the CCG's GP membership in all 26 practices through regular updates and engagement in design and prioritisation.
- Delivered significant engagement with our communities on our future direction of travel – resulting in a clear set of themes which have shaped our plans.
- Entered into on-going dialogue with Health and Well-being Board and Overview and Scrutiny Committee about the plans and their impact locally.
- Engaged with Public Health, Children and Young Peoples Directorate and Adult Health and Social Care.
- Created communication channels with a wide-range of third sector providers, though Voluntary Action Calderdale, and North Bank Forum.
- Created new multi-agency Improvement Hubs for CC2H and Mental Health to support innovation and change outside contracting environments.

8. Our Statutory Duties

The CCG is required to comply with a number of statutory duties. Whilst we have complied with all the statutory duties, we have summarised our activities in some of the areas below.

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

Ensuring patient safety and improving quality is core to our business. The relationship between the CCG as commissioners and our providers is critical in taking forward the learning from national reviews such as Francis and Winterbourne and more recently the Kirkup[5] report.

We are working closely with partners to further enhance a strong quality record across Calderdale. Our focus on reducing harm, improving effectiveness and experience includes:

- Local CQUIN(Commission for Quality and Innovation) targets
- Supporting incident reporting
- Sharing lessons learned
- Members of the Local Patient Safety Improvement Collaborative
- Development and use of quality impact assessments
- Members of the Local Patient Experience network

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

The CCG has carried out a number of activities to promote education and training. Specifically a Vocational General Practice Nurse Training Scheme and a Non-Medical Clinical Workforce Mentor Development Scheme were supported through our Innovation Grants scheme. We also support our primary care teams in development and training activities throughout the year. This is through CCG funded

[5] Morecambe Bay Investigation Report, Dr Bill Kirkup CBE, March 2015

dedicated practice time to attend central events and in-practice training. The central events focus on the clinical priorities of the CCG.

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

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

- Active membership of the Health and Wellbeing Board;
- Active engagement in the development of the Joint Wellbeing Strategy
- Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions;
- Testing the 5 year Strategic Plan and one year operational plans against the Joint Strategic Needs Assessments and the wellbeing priority outcomes (Joint Wellbeing Strategy)

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

As set out earlier in this Strategic Report, the strategic priorities of the CCG were developed in discussion with the Health and Wellbeing Board and contribute to the delivery of a number of the priority outcomes contained in the Joint Wellbeing Strategy. They have been reviewed as part of the development of the 5 Year Strategic Plan which was presented to the Health and Wellbeing Board for comment in March 2015.

Joint Wellbeing Strategy: Priority Outcomes

Calderdale is a place…

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

NHS Calderdale CCG Strategic Priorities – contribution to delivery of Joint Wellbeing Priority Outcomes in 2014/15 and continuing into 2015/16		
CCG – Clinical commissioning Outcomes	**CCG –Change Programmes***	**Alignment with Wellbeing Priorities**
Empowered Citizens & resilient communities	- Call to Action Initiatives - Better Care Fund Initiatives - PPI initiatives (Appendix B) - £2m investment in third sector capacity and capability building on 13/14 investment - Loneliness prevention programme	5, 6
Reduced Preventable deaths	- Respiratory Programme - Cancer Programme - CVD Programme - Mental Health Programme - Alcohol programme	1,5
Reduced health inequalities	- Respiratory Programme - Cancer Programme - CVD Programme - Mental Health Programme - Alcohol programme (linked to reduction in domestic violence)MSK programme (inc. prevention/obesity) - Partnership working to reduce infant mortality - Focus on childhood asthma (training delivered to all practices)	4,5
Improved Quality of life of patients with a long-term condition or illness	- Better Care Fund – Scheme 3 (Integrated, community based health and social care teams) - New community/frailty model being commissioned (started 13/14 Strategic Review - Primary Care Strategy - CVD programme - Diabetes programme - Respiratory programme - Mental Health programme (inc. RAID programme– started 13/14) - MSK programme (inc. prevention/obesity) - Alcohol programme (linked to reduction in domestic violence) - Cancer programme - Local Contract procurement (started 13/14) - Loneliness prevention programme - Detailed review – children & maternity (started 13/14) - End of Life Care model (procured in 13/14)	1, 4,5

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

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

9. Trends and factors likely to impact on the future

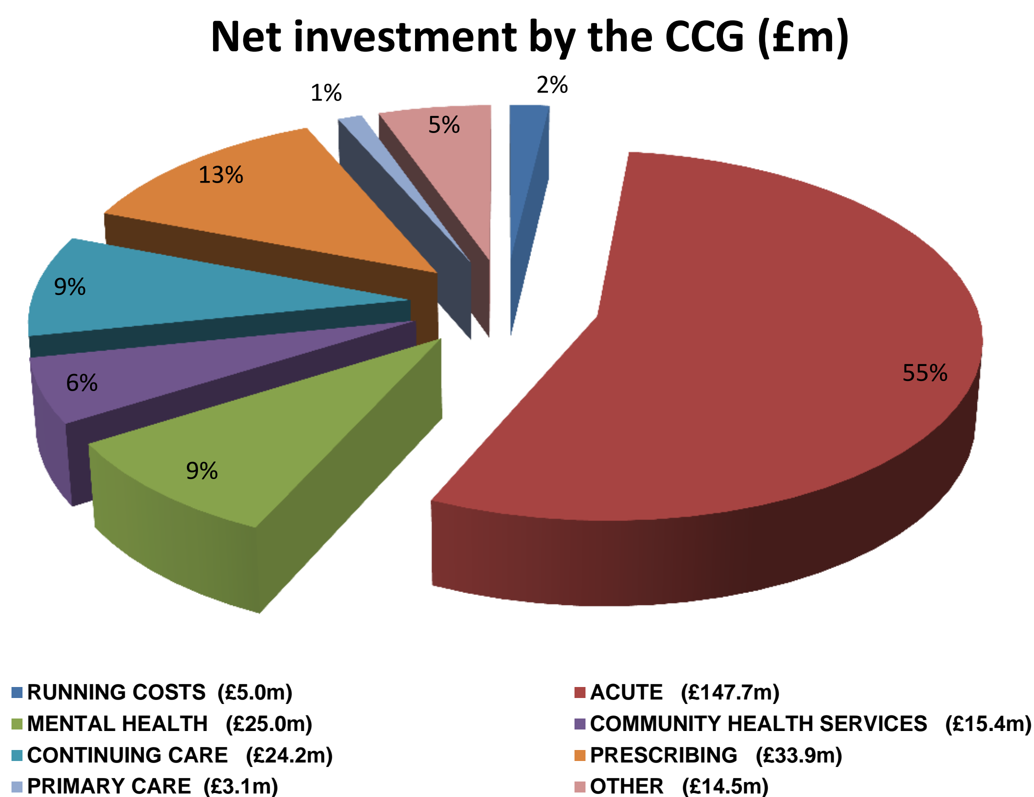
The CCG will continue to work with partners to deliver the transformational change required to meet the challenges set out earlier in this report, manage any impact of the recent general election and the need to prepare for the transition of commissioning support arrangements to alternative providers.

The main focus for the CCG in 2015/16 and beyond will be:

- The implementation of year two of our 5 Year Strategic Plan supported by the achievement of Vanguard status for the CCG. Part of our strategic plans include the creation of an environment that enables general practice to play a much stronger role in the integrated system of out of hospital care.
- The development of integrated out-of-hospital care through our Care Closer to Home and Better Care Fund Plans.
- Develop our capacity and capability to deliver whole system transformational change and common approaches to improvement.
- Respond to the changing political landscape.
- Continued rigorous performance management of the delivery of the CCG's priorities.

9.1 Level of Investment expenditure

During 2014/15 we invested over £268m to improve the health of local people through the commissioning of high quality services.



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

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

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

- **Hospice Care**- significant increase in funding for Overgate Hospice.

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

- **Child and Adolescent Mental Health Service (CAMHS)** – Additional investment to support the service.

- **Respiratory** – investment of 6 specialist respiratory nurses in the community as part of Care Closer to Home.

- **Wheelchair services** – additional funding to support wheelchair service provision.

- **Children's Asthma service** – Funding invested into staff training to help them better support children with asthma and to produce integrated care plans.

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

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

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

The accounts for the Clinical Commissioning Group in respect of 2014/15 have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

In order that we continue to deliver the transformational and service change set out in our strategic plan, a number of Investment Funds have been created within our financial plan for 2015/16, these include:

- Non Recurrent Investment Fund
- Better Care Fund
- Contingency

Financial Risk

There are a number of risks that threaten delivery of our 15/16 financial plan, these include:

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

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

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

- Effective processes identify and realise opportunities for disinvestment and reinvestment in healthcare, to improve outcomes and ensure that the money is directed where it can do most good; and

- We continue to adopt a collaborative approach with partners to ensure that resources are deployed effectively.

9.2 Resources

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

a) Financial

The focus of the CCG is to ensure that we continue to achieve the most effective use of our £268m resource and deliver best value for money.

b) Governing Body, Lay Advisor and CCG Members

One of the most important assets of the CCG is clinical leadership that it brings. Without this level of clinical knowledge and understanding of local people's concerns and issues we would be unable to achieve the degree of transformational change required. Some of our most important resources for the CCG are the members of the Governing Body, the Associates, Practice Commissioning Leads and the Practice Managers as well as the member practices. Details of these roles are set out in the section on Structures.

c) Staff

The CCG has a total of 45.8 WTE staff, some of whom are in shared posts with Greater Huddersfield CCG and across the three CCGs in Calderdale and Kirklees. Looking forward, we will continue to implement our organisational development plan to ensure that we have the capacity and capability to deliver our strategic objectives.

d) Commissioning Support

The CCG currently contracts with the Yorkshire and Humber Commissioning Support Unit (YHCSU) for the provision of commissioning support in areas such as service improvement, business intelligence, communications and engagement, human resources and information governance.

Unfortunately the CSU was unsuccessful in its bid to achieve a place on the Lead Provider framework at the end of 2014/15. This is disappointing news for all Yorkshire and Humber CCGs and marks a requirement to move to new arrangements for support to our commissioning functions. We will be working with NHS England and CCGs in Yorkshire and Humber to manage the transition and the risks associated with this, over the next year.

e) Working with commissioners and providers

We are clear that we would not be able to achieve the scope of transformational change required without close partnership working with other CCG and local authority commissioners, NHS England and with local providers. Over the next few years we anticipate closer partnership working arrangements through the Better Care Fund Programme, the co-commissioning of primary medical services, with the 10 CCGs. We will also continue to have joint contracting arrangements with commissioner colleagues in the local authority and neighbouring CCGs.

We are committed to continuing with our close partnership working with our providers through the transformational programmes, the system resilience arrangements, work with the voluntary, community and third sector as well as supporting the development of the newly formed GP Federation.

f) Professional, regulatory, legal advice

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

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

g) Public and local communities

We recognised the pivotal role that our communities will play in the successful delivery of our Strategic Plan. As a CCG, we have made significant efforts to engage with our population throughout the year and our ambition will see this dialogue continue as we work with local communities across Calderdale to generate a dynamic conversation that will ultimately drive the changes required.

9.3 Risks to the achievement of our strategic objectives in 2015/16

There are a number of risks to the delivery of our strategic objectives which are set out in the Governing Body Assurance Framework (see appendix 2)

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

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

9.4 Relationships with key stakeholders

Critical to the success of the CCG in delivering the strategic objectives are the relationships that have developed with key stakeholders through collaborative working and other mechanisms. Our work with a number of these partners has already been referred to earlier in this report – namely through working with our member practices, the commissioning support unit, patient and the public, Calderdale Council, the Health and Wellbeing Board, Healthwatch, partner agencies as part of the Right Care, Right Time, Right Place programme; neighbouring CCGs and the 10 CCGs across the wider West Yorkshire footprint.

The CCG takes seriously its responsibilities in terms of its impact on local communities and wider society. Some of the ways in which we address this, including our approach to community engagement and working with partners on tackling inequalities are set out earlier in the Strategic Report. Further information on our approach is contained in the Sustainability Management Development Plan (see Sustainable Development Report).

Dr Matt Walsh, Accountable Officer

27th May 2015

Appendix 1 (a)

NHS Constitution Rights and Pledges 2014/15

	Outcome/Measure	Target/ Baseline	Apr	May	Jun	Qtr 1	Jul	Aug	Sep	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	Mar	Qtr 4	YTD
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	92.7%	91.5%	93.1%	92.4%	92.7%	91.0%	90.9%	91.5%	92.7%	92.9%	92.6%	92.7%	91.5%	91.4%		91.5%	92.1%
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	98.5%	98.7%	98.8%	98.7%	98.3%	97.6%	98.0%	98.0%	98.1%	98.5%	98.6%	98.4%	98.6%	98.3%		98.5%	98.4%
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	95.8%	95.5%	95.3%	95.5%	95.1%	94.7%	95.3%	95.0%	95.0%	95.4%	94.7%	95.0%	94.1%	94.4%		94.2%	95.0%
	Patients on incomplete pathways waiting more than 52 weeks	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0		0	1
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99.3%	99.2%	99.5%	99.3%	98.5%	97.8%	97.9%	98.1%	99.7%	99.2%	99.2%	99.4%	96.8%	99.2%		98.1%	98.8%
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (Week Ending 29/03/2015)	95%	94.9%	94.7%	97.6%	95.7%	96.7%	95.8%	95.9%	96.1%	93.8%	94.7%	90.2%	93.0%	91.4%	93.8%	94.8%	93.3%	94.5%
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	98.0%	97.0%	99.5%	98.2%	95.8%	96.9%	99.4%	97.3%	99.1%	97.5%	99.1%	98.5%	97.0%	99.7%			98.1%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	97.7%	97.2%	97.1%	97.3%	100.0%	100.0%	95.3%	98.3%	98.3%	96.5%	88.2%	94.6%	95.8%	100.0%			97.0%
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	97.6%	100.0%	97.3%	98.3%	98.9%	95.1%	98.6%	97.8%	96.3%	100.0%	100.0%	98.6%	96.1%	98.6%			98.1%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%	100.0%	95.0%	98.2%	100.0%	100.0%	94.4%	98.1%	96.0%	100.0%	92.3%	96.4%	100.0%	89.5%			97.0%
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%

Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	87.9%	88.2%	85.7%	87.3%	95.7%	85.7%	86.5%	90.2%	92.7%	92.3%	87.8%	90.2%	88.1%	69.7%			87.6%
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	85.7%	100.0%	96.0%	100.0%	100.0%	66.7%	90.9%	0.0%	100.0%	100.0%	75.0%		100.0%			92.9%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	N/A	100.0%		75.0%	83.3%	100.0%		100.0%	100.0%	0.0%		100.0%	50.0%	100.0%	0.0%			80.0%
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	72.6%	70.3%	76.6%	72.7%	65.2%	76.6%	59.2%	67.6%	74.6%	78.5%	71.0%	74.2%	76.7%	73.5%		75.2%	72.3%
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	75.5%	72.8%	73.2%	73.8%	69.5%	72.7%	66.9%	69.7%	74.9%	78.2%	59.1%	70.1%	65.8%	72.8%		69.1%	70.8%
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	97.0%	96.5%	96.1%	96.5%	94.4%	96.2%	94.6%	95.1%	96.5%	97.0%	90.6%	94.5%	93.5%	95.8%		94.6%	95.2%
	All handovers between ambulance and A&E must take place within 15 minutes	95%	91.5%	91.2%	91.4%	91.4%	91.2%	92.0%	91.7%	91.7%	87.7%	88.9%	84.8%	87.0%	87.0%	86.1%		86.6%	89.4%
	All crews should be ready to accept new calls within a further 15 minutes	95%	84.2%	83.5%	81.4%	83.0%	81.5%	80.6%	79.0%	80.4%	78.0%	77.4%	75.9%	77.0%	76.8%	76.5%		76.7%	79.5%
Mixed Sex Accommodation	Minimise breaches	0	0	0	0	0	0	0	0	0	3	0	0	3	0			0	3
MRSA	Number of MRSA reported infections	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0		0	1
C_Diff	Number of C-Diff blood stream infections	3.9	4	6	5	15	5	3	2	10	1	1	2	4	4	3		7	36

Appendix 1 (b)

Quality Premiums 2014/15

National Measures		Target/Baseline	2009	2010	2011	2012	2013
Domain 1: Preventing People from dying prematurely	Potential years of life lost from causes considered amenable to health care: adults, children and young people	3.2% reduction between 2013 and 2014 based on DSR	2333.2	2591.2	2259.9	2419.3	2177.2

National Measures		Target/ Baseline	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
Domain 2: Enhancing the quality of life for people with long term conditions and Domain 3: Helping people to recoever from edisodes of ill health or following injury	IAPT Coverage - The proportion of people that enter treatment against the level of need	15.0%	3.09%	3.33%			6.42%

Domain	Measure	Target/ Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Domain 2: Enhancing the quality of life for people with long term conditions and Domain 3: Helping people to recoever from edisodes of ill health or following injury	* See Note to the right, Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (All ages)		148	160	142	133	136	155	170	194	223	183			1,644
	* See Note to the right, Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s		15	10	7	7	7	18	11	24	21	12			132
	* See Note to the right, Number of emergency admissions for acute conditions that should not usually require hospital admission (All ages)		293	250	250	276	216	233	269	264	302	261			2,614
	* See Note to the right, Emergency admissions for children with lower respiratory tract infections (Aged 0-18)		11	6	3	6	1	5	12	44	66	23			177
	* See Note to the right, Composite figures for Avoidable emergency Admissions		451	412	394	415	353	393	449	498	584	464			4,413

Local Measures		Target/ Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Indicator 1	Emergency admissions for alcohol related liver disease	44	4	3	3	1	3	2	4	3	3				26

NHS Constitution Pledges and Rights		Target/ Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Referral To Treatment waiting times - Patients on incomplete pathways	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	95.8%	95.5%	95.3%	95.1%	94.7%	95.3%	95.0%	95.4%	94.7%	94.1%	94.4%		95.0%
A&E Waits*	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (Week Ending 29/03/2015)	95%	94.9%	94.7%	97.6%	96.7%	95.8%	95.9%	93.8%	94.6%	90.2%	91.4%	93.8%	94.8%	94.5%
Cancer Waits - 14 Days	Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	93%	98.0%	97.0%	99.5%	95.8%	96.9%	99.4%	99.1%	97.5%	99.1%	97.0%	99.7%		98.1%
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1) - YAS level	75%	69.8%	69.6%	68.0%	69.2%	71.3%	68.7%	73.1%	71.5%	63.4%	70.6%	71.6%		69.6%

Appendix 2

Risks to the achievement of our strategic objectives in 2015/16

Strategic Objective		Risk	Mitigation
1.	Improving Healthcare outcome	CCG not understanding and tackling wider determinants of health and not reducing health inequalities due to a lack of effective partnership working/integrated working, particularly with the Health and Wellbeing Board (HWB); not using intelligence to identify the areas of highest need; services commissioned not evidence based.	▪ Good partnership working with the HWB and through attendance of Dir. Adult Health and Social Care Services and Dir. Public Health at the CCG Governing Body ▪ 5 Year Strategic Plan aligned with Wellbeing Priorities ▪ 5 Year Strategic Plan informed by local and national business intelligence; in line with national indicators; Use of commissioning for value intelligence packs (NHS England); use of member practice intelligence. ▪ Performance monitored through Better Care Fund (BCF) Board, Care Closer to Home and Hospital Services Programme Boards, presentations to Scrutiny Committees. ▪
		Failure to deliver the 5 Year Strategic Plan due to lack of engagement with the public and stakeholders, lack of capacity and capability, quality of relationships resulting in failure to deliver strategic outcomes.	▪ 5 Year Strategic Plan informed by robust and continuous process of public and stakeholder engagement. ▪ Communication of strategic priorities and rationale to the public and stakeholders. ▪ Alignment of capacity and processes to delivery of strategic plan. ▪ Organisational development plan to support capacity and capability

2.	**Improve service user experience**	Risk of not improving patient experience due to not using patient intelligence appropriately with providers to improve that experience; not using patient intelligence to develop commissioning plans or service specifications, resulting in patient dissatisfaction.	▪ Patient and Public Engagement and Experience (PPEE) Strategy (2013-2015) and annual improvement plan. ▪ Use of multiple sources of patient experience information including annual patient survey reports, patient feedback systems, FFE, complaints, information from patient reference groups (PRGs)/Calderdale Health Forum, Patient and Public Engagement and Experience Group (PPEE) ▪ Use of contracting mechanisms for patient feedback, CQUINS reports on patient experience, reported to CCG by providers. ▪ Use of engagement assurance process for development of service specifications such as CC2H.
		Risk of failing to meet statutory duty to engage and involved, with resultant impact on commissioning plans/implementation.	▪ PPEE Strategy and annual implementation plan clear about statutory requirements. ▪ PPEE group terms of reference ▪ Production of Annual Statement of Involvement (2013-14) ▪ Equality and Diversity Strategy and Action Plan and Annual Public Sector Equality Duty Information Report (2014-15) ▪ Governing Body lay member for PPI ▪ Engagement and Equality and Diversity Assurance Process
3.	**Maximise independence and recovery**	Risk that models of care commissioned for Long Term Conditions (LTC) are not fit for purpose, due to not identifying populations and individuals at risk of LTCs, service models not being evidence-based, resulting in not delivering strategic objectives / outcomes for LTC	▪ Yorkshire Public Health Organisation (YPHO) 'Commissioning for Value' packs used to inform strategic priorities - annually updated ▪ Business planning process contains test against clinical evidence base, such as patient and clinical involvement outcomes, NICE/ SIGN

			guidelines, patient and public involvement. ▪ Commissioning Engagement Scheme ensures practice commissioning leads' involvement in commissioning plans' prioritisation; ▪ High Performing Membership Organisation (HPMO) Steering Group Terms of Reference ▪ 5 year Strategic Plan and BCF plan sets out LTC work ▪ Use of risk stratification to target people with 1 or more LTCs
		Risk that models of care commissioned for independence and recovery, with emphasis on supported self-managed care and use of technology, are not fit for purpose, due to service models not being evidence-based, not understanding the wider socio-economic issues, resulting in CCG not delivering strategic objectives / outcomes for re-ablement and recovery	▪ 5 year Strategic Plan identifies priorities and outcomes for recovery and re-ablement, with focus on development of community services. ▪ Partnership working between CCG and local authority including through the HWB, attendance of Dir. Public Health at CCG Governing Body, BCF Board with joint local authority /CCG membership. ▪ Commissioning priorities aligned to Wellbeing Priorities. ▪ BCF Plan: re-ablement and independence key part of plan, 2 national metrics monitoring performance in this area.
4	**Ensure the services that we commission are safe**	Risk of not maintaining and improving the quality and safety of services due to ineffective commissioning arrangements, resulting in harm to patients.	▪ Quality and Safety Dashboard provides information at CCG level and by main providers. ▪ Use of quality standards, quality schedule, patient safety and relevant targets within service specifications. ▪ Use of contract governance and monitoring processes including Contract Quality Boards ▪ Use of CQuINs indicators, contract monitoring

			arrangements in place. ▪ Use of learning from complaints, Serious Incidents/ Serious Case Reviews reported into Quality Committee and private section Governing Body. ▪ Review and triangulation of a range of quality information (e.g. Serious Incidents, CQuINs, CQC).
		Risk that commissioning arrangements for safeguarding do not ensure that providers are effectively safeguarding children and adults due to ineffective safeguarding arrangements, resulting in harm to children and adults	▪ Safeguarding policies and procedures in place. ▪ Mandatory training within CCG, standards in place with providers. ▪ Safeguarding standards included within contracts ▪ Annual Section 11 Audits scrutinise provider safeguarding arrangements, (policies and procedures, training). ▪ Provider s11 assessments scrutinised by Safeguarding Board ▪ Active member of the Local Safeguarding Children's Board and Adults' Board ▪ Active member of West Yorkshire Area Team Safeguarding Forum ensures national policy developments reflected in local commissioning arrangements.
		Risk of patients acquiring avoidable infections while in receipt of commissioned health services due to poor quality service delivery, resulting in harm to patients.	▪ Contract arrangements with providers include requirement for annual programme of infection control. ▪ Provider Infection control policies and procedures in place. ▪ Public Health membership of Quality Committee provide Infection Prevention and Control advice / support ▪ Performance targets on healthcare acquired

			infections (HCAI) included in Quality Dashboard report and discussed at Contract Quality Boards ▪ Risk register monitors targets on HCAIs with review of controls as required.
5	CCG exercises its functions effectively, efficiently and economically in a way that provides good value for money	Risk of pressure on the Medium Term Financial Plan, due to uncertainty of future national planning guidance for 2015/16, (e.g. Continuing Healthcare, Co-commissioning, specialised commissioning, Better Care Fund), resulting in unforeseen financial risk	▪ Medium term financial plan includes detailed QIPP plan, ongoing forecast and contingency to mitigate unforeseen financial risk. ▪ Budgetary control and budgetary reporting systems in place, with processes to ensure recurrent surplus. ▪ Business planning process for non-recurrent monies ensures short term commitment to expenditure. ▪ Regular monitoring arrangements in place, with finance position reported through SMT and the Finance and Performance Committee. ▪ Monthly financial reporting to NHS England
		Long term financial risks that the demand for services increases at a level above annual settlement. Contributing factors include; the CCG does not reduce reliance on unplanned hospital-based care, patient choice, increasing patient expectations – resulting in an affordability gap.	▪ Robust financial planning arrangements, including in-year contingency reserves. ▪ 5 Year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting to planned community services, reducing financial risk. ▪ Development of CC2H model to reduce increasing demand on acute services. ▪ QIPP plans developed and aligned with HWB to help achieve BCF target reduction of emergency admissions by 3.5% in 2015/16 and beyond.
6.	**Empowering Citizens and**	Risk that CCG does not commission information or advice on supported self-managed care and primary	▪ 5 year Strategic Plan sets out strategic direction for supported self-managed care and

	resilient communities	prevention due to commissioning plans not being fit for purpose or evidence-based resulting in an over reliance on health services by local population.	primary prevention, based on identified needs of individual communities and expectations of *Everyone Counts: Planning for Patients.* ▪ BCF contains plans for joint commissioning with Calderdale Council of supported self-managed care and primary prevention. ▪ CC2H model specifies services to deliver supported self-managed care and primary prevention. ▪ Contract with Voluntary Action - Calderdale (VAC) to stimulate third sector to support delivery of supported self-managed care and primary prevention.
7	**An organisation that is fit for purpose**	Risk that CCG is not compliant with statutory and other duties, leading to failure to make legally binding decisions, resulting in the CCG being open to challenge, waste of resources and potential reputational damage.	▪ Robust CCG Constitution reviewed by legal firm and approved by NHS England ▪ Annual review of terms of reference of committees include statutory requirements ▪ Annual committee work plans include statutory requirements. ▪ Rolling programme of policy review to ensure comply with changes in legislation, national guidance. ▪ Robust Procurement Policy compliant with statutory requirements. ▪ Regular reports from internal, external audit and counter fraud to Audit Committee ▪ Internal/external audit reviews/reports ensuring CCG compliant ▪ Horizon scanning
		Risk that CCG has ineffective governance and risk management processes in place due to not having the right structures, capacity and capability	▪ Robust governance structure including annual self -assessment and review, with external review every three years; integrated risk management framework and systems of

			internal control in place (see Governance Statement) ▪ Bi-annual private meetings between Audit Committee members, internal and external audit to discuss any issues of concern. ▪ PDR (Performance Development Review) for staff and governing body to identify and support any development needs. ▪ Organisational Development Framework in place.
		Risk that CCG fails to effectively harness capacity and capability of Governing Body members and CCG staff to commission effectively due to lack of insight and lack of capacity, lack of clear national direction for the commissioning of health and social care, transition period to alternative commissioning support providers - impacting on CCG ability to perform to its full potential, quality of relationships with Calderdale Council - resulting in CCG not maximising its potential / ineffective commissioning of services for its population.	▪ PDR process for staff and Governing Body. ▪ Organisational Development (OD) Framework in place. ▪ Governing Body and committee annual self-assessment identifies development areas. ▪ Use of Associates to provide additional capacity and capability for work on CCG priority areas. ▪ Working with transition board on alternative providers of commissioning support.
		Risk that the CCG does not have a voice / influence commissioning in the wider West Yorkshire healthcare system due to a lack of insight, capacity; relationships across West Yorkshire with NHS England Area Team and CCGs - resulting in strategic solutions which do not take Calderdale concerns taken into account.	▪ Active participation in West Yorkshire CCGs Commissioning Collaborative (10 CCG) structure with clear terms of reference. ▪ Building relationships with NHS England Area Team. ▪ Emerging West Yorkshire Strategy for Stroke, Cancer, urgent Care, Children's Services and Primary Care
		Risk that the wider NHS system fails to commission effectively due to lack of clarity of statutory responsibilities for commissioning, uncertainty created by co-commissioning / blurred boundaries for NHS England responsibilities (e.g. specialised services) -	▪ NHS England statutory responsibilities for commissioning services remain with responsibility for commissioning primary medical services delegated to the CCG. ▪ Primary care co-commissioning overview

		resulting in local people receiving sub optimal healthcare services / falling between gaps in tiers.	September 2014 (Gateway ref: 02299)confirms focus is on general practice co-commissioning in 2015/16 ▪ CCG maintains duty to improve the quality of primary care. ▪ Continue to maintain relationships with NHS England Area Team.
		Risk that CCG does not achieve its strategic objectives due to lack of effective engagement with members, resulting in members not maximising their contribution to the delivery of the objectives	▪ CCG Constitution and Membership Agreement, defines roles and responsibilities of members and Governing Body. ▪ Commissioning Engagement Scheme ensures clinical input to commissioning of services by joint working with clinical leads, CCG managers and practice managers, with a programme of development sessions. ▪ Annual Governing Body member visit to each member practice, 2014/15 focused on securing engagement with wider membership. ▪ High Performing Membership (HPMO) Steering Group with responsibility for membership engagement. ▪ Practice Managers Action Group inputs to clinical commissioning and shares information with member practices on behalf of CCG.

SUSTAINABLE DEVELOPMENT REPORT

'Learn, plan, explore, dare to dream ......the future of our organisations, the future of Calderdale'

Sustainable development is about meeting the needs of today without compromising the needs of tomorrow. The aim is to achieve the right balance between financial, social and environmental priorities. As a CCG we are committed to improving the health and wellbeing of the people who live and work in Calderdale - including staff and members of the CCG - now and in the future.

It is vital therefore, that we work with our partners and key stakeholders to transform our local health and care system in a way that is financially, socially and environmentally sustainable. This will lead to improved health and wellbeing both in the short and long term; it will make best use of the limited resources available, including natural resources, and will improve our planning and response to increasing adverse weather events.

In our Annual Report last year we set out a number of objectives for sustainable development:

- **Produce a Sustainable Development Management Plan**

  The CCG's 5 Year Strategic Plan sets out our priorities for transforming the health and care system in a sustainable way. In February 2014, we introduced our Sustainable Development Management Plan (SDMP) which supports those priorities by identifying the actions that we can take as a membership organisation made up of 26 practices and by formalising the links between our transformation agenda and the need to reduce our environmental impact.

  The SDMP also contains an action plan for 2015/16 and has identified clear governance arrangements to provide the necessary assurances to the Governing Body on progress.

  The SDMP can be found on the CCG's website at:

  http://www.calderdaleccg.nhs.uk/wp-content/uploads/2013/03/Sustainable-Development-Management-Plan-2015.pdf

- **Determine a baseline for our resource impact, backdated to 2013/14 where possible – using this information to develop stretch targets.**

  We continue to work to develop robust baseline information which can prove challenging when in a shared office space. However we now are able to monitor our utility and paper usage.

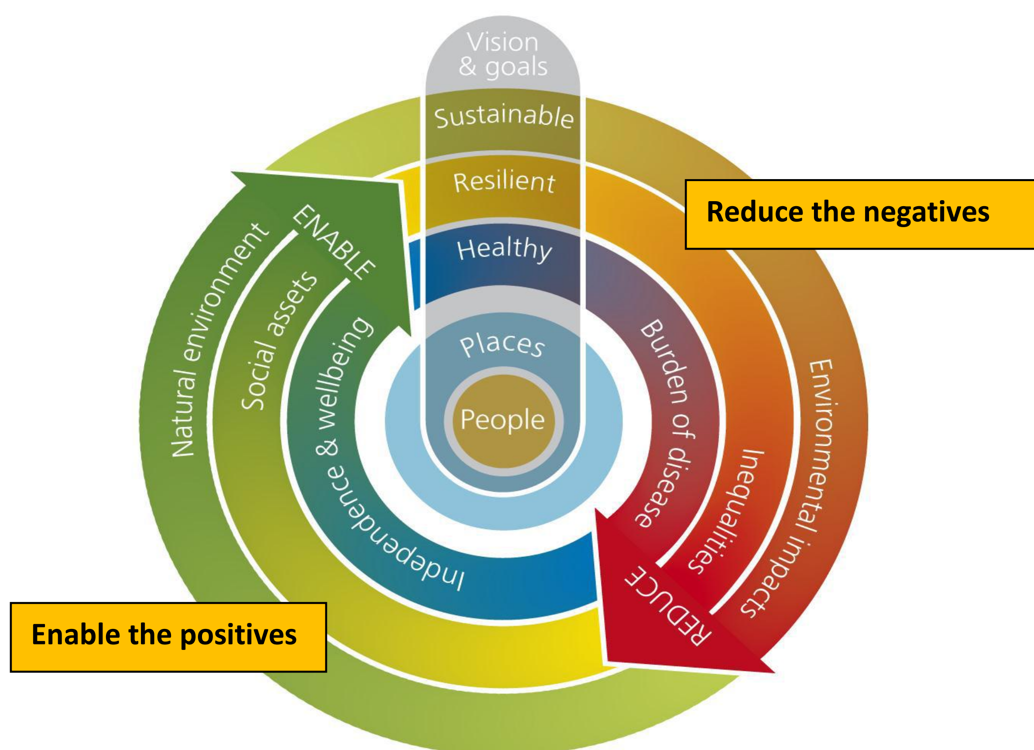
- **Continue to develop the way in which we commission services to achieve high levels of social value and a reduction in our environmental impact.**

  This report highlights some of the actions taken in this area (see also the Strategic Report). Whilst action taken by the CCG to reduce the environmental impact at our headquarters is limited, it is recognised that our main impact will be in how we commission for sustainability. We can also support our 26 member practices in reducing their environmental impact. Activities in these areas will be the main focus for 2015/16 and beyond.

Success in 2014/15

The NHS Sustainable Development Strategy sets out the links between the different aspects of a sustainable system (see figure below):

Sustainable system



In Calderdale, we are clear that there is a strong alignment between the CCG's 5 year Strategic Plan and the approach to achieving a sustainable system as contained within the NHS Sustainable Development Strategy.

The NHS Sustainable Development Strategy also contains three goals for the achievement of sustainable development. Our SDMP sets out the work that was started in 2014/15 in year one of our 5 Year Strategic Plan and aligns these to the three sustainable strategy goals:

GOAL ONE: EVERY OPPORTUNITY CONTRIBUTES TO HEALTHY LIVES, HEALTHY COMMUNITIES AND HEALTHY ENVIRONMENTS (Also see the Strategic Report)

We have continued to deliver our commissioning priorities throughout 2014/15 and in particular as part of developing the;

- Care Closer to Home model
- Integration of health and social care services through the Better Care Fund Programme
- A comprehensive programme of community engagement
- Working with public health colleagues on the development of a Prevention Strategy
- Working with partners on the nationally recognised Food for Life Partnership

Calderdale Food for Life Partnership (FFLP) Pathfinder http://www.foodforlife.org.uk/

Building on commissioning activity to transform food culture within schools, the partnership is now focusing on early years and care homes through the CCG's 'Quest for Quality in Care Homes' initiative.

In February, Calderdale welcomed a Swedish delegation keen to learn from our experience. This included a visit to Ravenscliffe High School which has achieved the FFLP Gold Award and whose Catering Manager was crowned BBC Cook of the Year at the Radio 4, Food and Farming Awards ceremony in May.

The CCG and Calderdale Council (Public Health) commission the FFLP to work in schools and their wider communities to embed lasting changes in positive food culture through school meals, cooking, growing and farm visits as well as engaging parents, staff and the community in food-related training and activities. Independently evaluated impacts of our work are online at www.foodforlife.org.uk/Whygetinvolved/Ourimpact. Over 60% of Calderdale schools are now enrolled in the programme with 15 bronze, 2 silver and 1 gold award.

GOAL TWO: SUSTAINABLE AND RESILIENT SERVICES AND COMMUNITIES –

We have continued to work closely with partners to develop sustainable and resilient communities.

As part of a Department of Health funded national programme, the CCG in partnership with the Voluntary and Community Sector and Adult Health and Social Care commissioners, have been developing a joint approach to implementing social value in health and social care commissioning and contracts. Through a series of events, facilitated by Social Enterprise

Social Value Charter

It supports commissioners to procure services with the potential to improve health and wellbeing of local communities.

It helps providers to demonstrate their ability and willingness to invest in Calderdale improving social, economic and environmental outcomes.

UK, we have shared thoughts and views about social value across a wide range of organisations. Involving procurement, this has culminated in the production of a Social Value Charter for Calderdale that was adopted by partners and the Health and Wellbeing Board in February 2015.

Investment to develop sustainable organisations and communities

We have also made significant investment to support sustainable organisations and communities. Over the past two years we have:

- Developed a supportive approach to working with the third sector in Calderdale with the emphasis being on building future capacity and capability. 'Health Connexions' is one such initiative that is designed to increase the levels of engagement, innovation and partnership across the sector.

- Made a significant investment of non-recurrent monies in 12 schemes to build capacity, capability and resilience in the third sector. The focus for the bids was about making a difference to the health and wellbeing of the population, contributing to 'Care Closer to Home'. Services were commissioned which supported mentoring, supported self-care, the provision of advice and signposting and encouraging healthy living.

- In 2014/15 bids were invited from third sector organisations that could show 'integrated and genuine partnerships' and focused on care and support for older people and people from Black and Minority Ethnic (BME) communities. Examples of partnership working are a diabetes educational programme being run for people from BME communities and Age UK working with the Calderdale Help in Bereavement (CHiBs) group.

- Worked with partners to develop the Winter and Surge and Escalation Plans across Calderdale and Huddersfield. These highlight the important role being played by the third sector in maintaining contact with individuals and families through winter and helping patients to return home following bouts of ill health.

GOAL THREE: HEALTHIER ENVIRONMENT

Air pollution and access to affordable warmth are significant factors contributing to premature death and ill health. As a CCG we will continue to work with Calderdale Council to look at how we can contribute to a reduction in air pollution across Calderdale and to the work being taken forward through the affordable warmth programme. There are clear links between these programmes and the development of the Prevention Strategy and focus on respiratory services.

Reducing our carbon footprint

Whilst we have started to focus on the opportunities to reduce our carbon footprint, actions contributing to the achievement of this goal will be one of the main focusses of the SDMP over the next three years. We will build on the actions below:

Continuing with our internal impact reduction

- **Assessment of resource impact**

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

Calderdale CCG Headquarters are based at Dean Clough Mills in Halifax and as such it is difficult to separate out the actual resource usage and generate target reductions. We continue to work with NHS Property Services, our facilities management provider, to separate out the data that we need to identify all required areas of resource impact and a baseline against which we can set targets for reducing our environmental impact. However, the baseline for 2014/15 is set out in the table below.

Resource usage in 2014/15

Resource	Quantity	CO2 Emissions (tonnes)	Cost (Inc. VAT) (££)
Gas	52,268 (kWh)	11	22,820
Electricity	328513 (kWh)	203	50,933
General waste	--	-	See note1 below
Recycling (including confidential waste)	--	-	2,201
Water	--	-	See note2 below
Business Travel (km)	45,670	21	18,928

Note1: The general waste disposal forms part of the cleaning contract and is not separated out
Note2: The charge for water usage is contained within the general service charge which in 2014/15 was £19,899.

Waste Reduction, Re-use & Recycling

The CCG currently follows a number of processes in-house to:

- Reduce the amount of paper used across the organisation including the use of slates or tablets at senior management and Governing Body meetings where-ever possible.
- Recycle waste paper and printer toner cartridges
- Where-ever possible, our old IT equipment is re-used within the organisation. Where this is not possible, we seek to use pieces of old IT equipment to support our repair function. If unfit for use, we undertake a formal decommissioning process following the Waste, Electrical, Electronic Equipment (WEEE) Regulations 2013.

There is more that we can do to minimize the use of paper across the organisation and we will review this in 2015/16.

Sustainable travel

Our policies, procedures and guidance set out our expectations in terms of sustainable travel. Specifically staff are:

- Expected to share vehicles or use public transport where possible and practical;
- Encouraged to make use of "meetings technology" including teleconferencing and webinars to reduce travel particularly over longer distances;
- Reimbursed for the use of pedal cycles when making journeys in the performance of their duties.

Analysis of staff expenses has been carried out to understand how our employees use public transport in their work-related travel and to establish a baseline for reporting progress in future years.

The information available is currently limited, and is reliant on how staff report their expenses, and the level of detail to which the information can be broken down from the expenses system. A baseline for 2013/14 and 2014/15 is set out below:

Sustainable travel – staff expense claims (1st April - 31st March 2015)

Expenses claimed	2013/14	2014/15
Total Km claimed	44,677	45,670
Average Km claimed	238	227
Number of Km claims	189	202
Number of passenger allowance claims	18	21
Total number of Km with passengers	2,224	1,703
Average number of Km with passengers	130	85
Total number of general travel claims (non-km)see note	24	35

Note: This cannot currently be broken down to separate use of public transport or other non-Km claims such as parking costs.

The nature of work-related travel is influenced by a number of factors, such as any changes in the locations to which employees need to travel, the frequency of this travel, and the feasibility of using public transport to travel to these locations. Any changes in the size or make-up of the workforce and the scope of their roles can also have an impact. A number of our staff are in shared posts with North Kirklees CCG and/or Greater Huddersfield CCG. This requires 'split site working' and regular travel between the sites. Our Continuing Healthcare Team also works in the community visiting clients.

In summary, whilst the data shows an increase in the number of mileage claims, there has also been a slight increase in the number of non-mileage related claims.

Work is currently ongoing with the Staff Forum to develop ideas for improving sustainable travel. This includes an initiative throughout March and April to incentivise car sharing as part of the National Sustainability Day on the 26th March. We will also be monitoring teleconferencing usage throughout 15/16 – again to provide a baseline for future years.

Developments in 2015/16

In 2015/16, by working with our partners and key stakeholders, particularly with the public health team at Calderdale Council and in the third sector, we will take actions in three key areas:

1) *Commissioning for sustainability* – commissioning processes to support financial, social and environmental sustainability.

We will continue to ensure that we use our commissioning, procurement and contracting processes to embed the principles of sustainability into our plans. One of our first tasks will be to develop key performance indicators to monitor our performance against the sustainability agenda.

2) *Being a sustainable organisation* – adopting policies and action plans as a CCG that enhance the environment and social sustainability of the organisation.

We have a responsibility to act in an ethical and sustainable way. We will continue to work with our staff and our Governing Body to:

- Raise awareness about sustainability issues;
- Make sure that the working environment promotes health and wellbeing;
- Optimise our impact by continuing to develop strong and enduring partnerships with key partners and stakeholders;
- Explore opportunities for reducing our carbon footprint, including the encouragement of the use of public transport and the use of technology to reduce the need to travel;
- Ensuring that we are resilient and able to respond appropriately to adverse weather events.

3) *Promoting sustainability amongst our GP member practices* – promoting and supporting action on sustainable development across our 26 practices.

Whilst the opportunities to reduce the carbon footprint of the CCG headquarters are limited, the CCG is made up of 26 member practices all with premises in Calderdale.

Over the next year we will work with our member practices to develop a voluntary initiative aimed at supporting practices to undertake an environmental impact audit which will offer insight into the carbon efficiency of the practice and options for reducing their carbon footprint.

EQUALITY REPORT

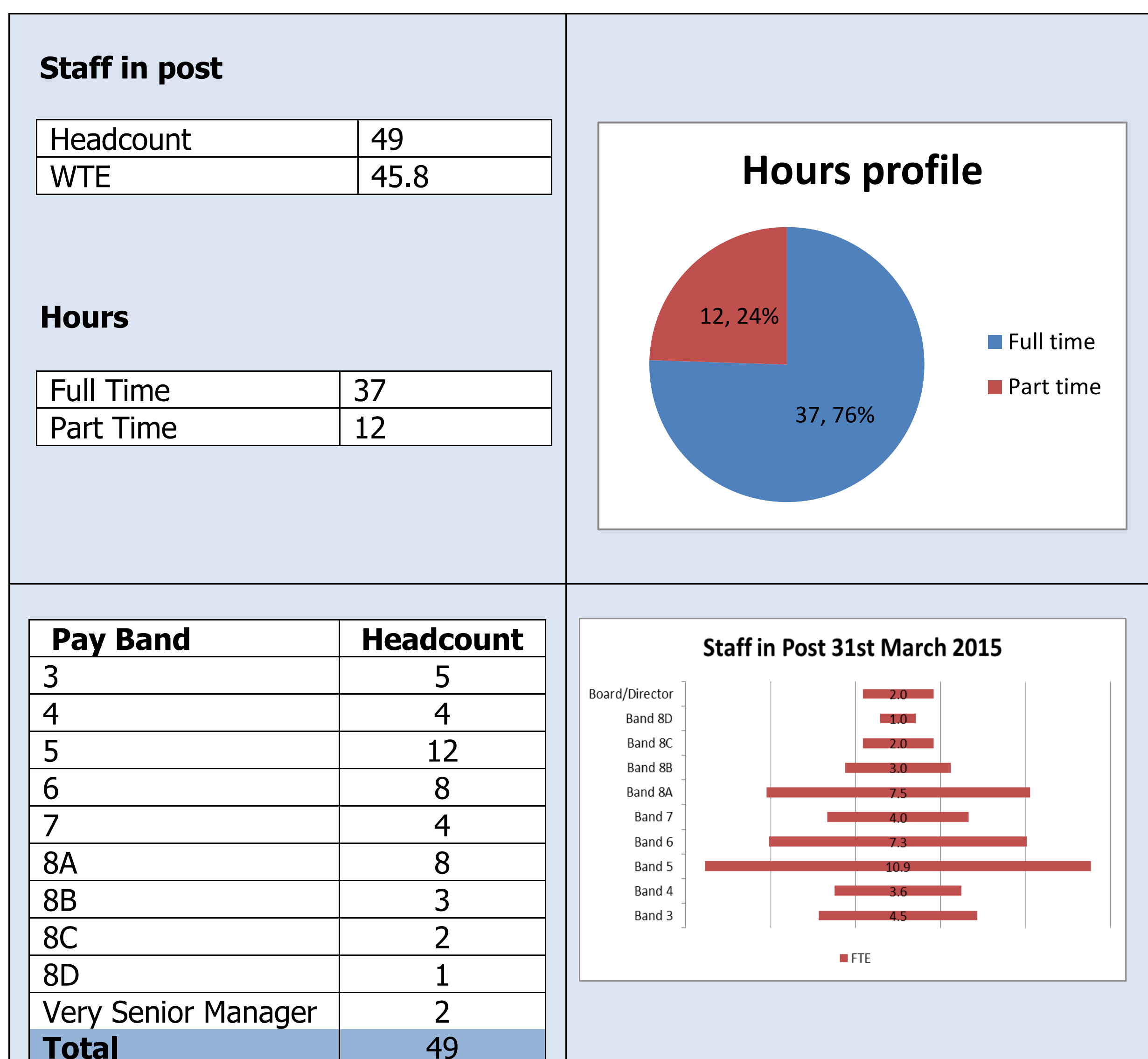
NHS Calderdale CCG is pleased to present its Equality Report for 2014/15.

The CCG continues to work hard to ensure that it meets with best practice in its approach to equality and diversity and complies with its duties under the Equality Act 2010.

Our Annual Public Sector Equality Duty Information Report was received at the Governing Body in February 2015 and can be found at:

http://www.calderdaleccg.nhs.uk/wp-content/uploads/2013/03/NHS-Calderdale-CCG-Public-Sector-Equality-Duty-Information-Report.pdf

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 2015. Information relating to Governing Body members is reported separately. Some data is not shared to avoid identification of individuals.



Staff in post

Headcount	49
WTE	45.8

Hours

Full Time	37
Part Time	12

Pay Band	Headcount
3	5
4	4
5	12
6	8
7	4
8A	8
8B	3
8C	2
8D	1
Very Senior Manager	2
Total	49

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

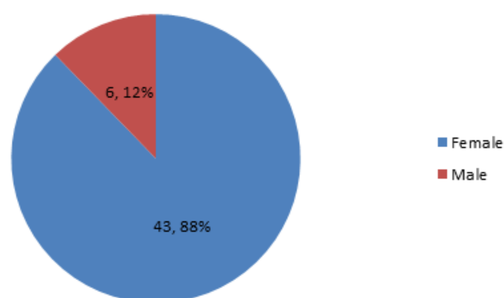
Gender	Headcount
Female	4
Male	7

Gender (Very Senior Managers VSMs)

Gender	Headcount
Female	1
Male	1

Gender (staff excl. Gov. Body and VSMs)

Gender	Headcount
Female	43
Male	6

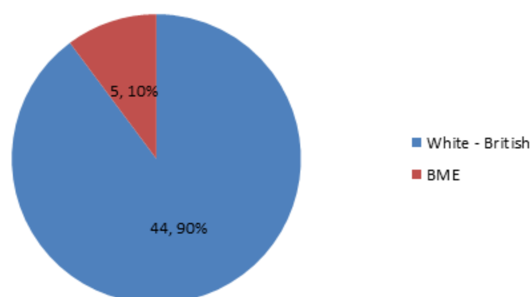


Age (staff excl. Gov. Body)

Age range	Headcount
20 - 29	<5
30 - 39	9
40 - 49	12
50 - 59	23
60 - 69	<5

Ethnicity (staff excl. Gov. Body)

White British	44
White Irish	<5
Asian or Asian British - Pakistani	<5
Filipino	<5



Disabled employees

The CCG's commitment to disabled people is covered in a number of policies and procedures which are available to all staff through the intranet.

Requirement	Policy or procedure
Applications for employment made by disabled people	▪ Diversity and Equal Opportunities in Employment Procedure. ▪ Recruitment and Selection Policy.
Continuing the employment of and for arranging appropriate training for employees who have become disabled during the period.	▪ Diversity and Equal Opportunities in Employment Procedure. ▪ Policy on dealing with ill health.
Training, Career development and promotion of disabled people.	▪ Diversity and Equal Opportunities in Employment Procedure ▪ Personal Development Review and the Knowledge and Skills Framework Procedure and Guidance ▪ Pay Progression Policy

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

The CCG achieved the "Two Ticks" award - positive about disabled people in 2013/14. Job Centre Plus reviewed our practices this year and we are pleased to say that we were successful in retaining this award in February 2015.

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

✓ To interview all disabled applicants who meet the minimum criteria for a job and to consider them on their abilities.

✓ To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.

✓ To make every effort when employed become disabled to make sure that they stay in employment.

✓ To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.

✓ To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and job centre plus know about progress and future plans.

MEMBERS' REPORT

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

NHS CALDERDALE CCG LIST OF MEMBER PRACTICES

Practice Name	Address	Practice Commissioning Lead
Bankfield Surgery	Huddersfield Road, Elland	Dr J L Gray
Beechwood Medical Centre	Keighley Road, Ovenden	Dr L King
Boulevard Medical Practice	Savile Park Road, Halifax	Dr P Rajeswari
Burley Street Surgery	Burley Street, Elland,	Dr F Naz
Brig Royd Surgery	Hirstwood, Ripponden,	Dr B Wyatt
Caritas Group Practice	Woodside Surgery, Boothtown Medical Centre, Boothtown, Mixenden Stones Surgery, Mixenden Shelf Health Centre, Shelf Moor Road, Shelf	Wendy Iles
Care UK, Clinical Services Ltd	Calder Community Practice, Todmorden Health Centre, Todmorden Park Community Practice, Horne Street Health Centre, Hanson Lane, Halifax	Dr Mohammed
Church Lane Surgery	24 Church Lane, Brighouse	Dr S Chambers
Hebden Bridge Group Practice	Valley Medical Centre, Valley Road, Hebden Bridge, Grange Dene Medical Centre, Burnley Road, Mytholmroyd Mini-Clinic, Kershaw Drive, Luddenden Foot	Dr K Moore
Horne Street Surgery	Horne Street Health Centre, Hanson Lane, Halifax	Dr M Niazi

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

Stainland Road Medical Centre	70 Stainland Road, Greetland	Dr K McMichael
Station Road Surgery	Station Road, Sowerby Bridge	Dr S Catlow
The Todmorden Group Practice	Todmorden Health Centre, Lower George Street, Todmorden	Dr J Keighley

The Governing Body and its sub-committees

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

In 2014/15, the Governing Body had four sub-committees: the Finance and Performance, Quality, Remuneration and Audit Committees. The details of the membership and attendance at these committees can be found in appendix 1 of the Governance Statement (Governing Body, Audit, Finance and Performance and Quality) and in the Remuneration Report (Remuneration Committee).

In February 2015, the Governing Body approved the establishment and terms of reference of a new sub-committee for the commissioning of primary medical services. This committee has been established as part of the formal governance arrangements under the delegation of commissioning of certain primary medical services and some associated functions from NHS England. This committee will begin to meet in 2015/16.

Register of Interests

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

Disclosure of Related Information

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

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

Pension Liabilities

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

Sickness absence data

The sickness figures in the Employee Benefits note to the accounts (4.3) will not be completed until mid -May when the data becomes made available nationally, it is not expected to be part of the draft annual report.

Our CCG has a genuine interest in ensuring a healthy working environment for all colleagues. The CCG has policies and procedures in place to support colleagues with sickness absence and has a positive and pro-active approach to supporting colleagues through sickness absence or difficult periods in their lives. The Occupational Health service has been reviewed over the course of 2014-15 and new arrangements will be implemented in 2015/16. The CCG has also introduced an Employee Assistance Programme (EAP) to further support the needs of the workforce.

In 2014/15, the CCG had no significant levels of staff sickness absence.

External Audit

KPMG has been appointed by the Audit Commission to be the external auditor for NHS Calderdale CCG. The cost of the work performed by the auditor in respect of the reporting period is £78,000 (including VAT).

Services from KPMG	£
Audit Services (statutory audit and services carried out in relation to the statutory audit, eg. reports to NHS England	78,000
Further assurance services (i.e. any services unrelated to the statutory audit where the CCG has discretion whether or not to appoint an auditor (e.g. review of achievement of performance indicators)	
Other Services	0
TOTAL	78,000

Disclosure of “serious untoward incidents”

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

Cost allocation and setting of charges for information

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

Complaints handling

Good complaints handling is a high priority for our CCG. We have a robust Complaints Framework which outlines our responsibility for not just receiving and handling complaints about the CCG or about the services that we commission, but

also for adopting the learning to ensure that there is a continuous improvement in the way that the health service delivers care.

This year NHS Calderdale CCG received 20 complaints. 14 of those complaints were in connection with healthcare services that we commission. Six of the complaints related to Continuing Healthcare (including retrospective funding requests). All these complaints were dealt with in line with the NHS Health and Social Care Complaints Policy (2009).

Complaints relating to primary care providers, such as GPs, dentists, optometrists and pharmacists are referred to NHS England as the responsible authority. This year we referred nine complaints to NHS England.

Principles for Remedy

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

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

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

The CCG has fully adopted the principles of remedy in handling the complaints we receive.

If a complainant remains dissatisfied with the outcome of their complaint they can contact the Parliamentary and Health Service Ombudsman (PHSO). The Ombudsman has not contacted the CCG about any complaints dealt with during the year.

Some of the action taken and lessons learned in the complaint cases handled by the CCG during the year are outlined below.

- Improvements to communication and information provided in hospitals;
- Action taken to ensure correct information is provided when using the Choose and Book system;
- Explanations provided regarding maternity and gynaecology care pathways;
- Explanations provided relating to the process followed for the funding of care and treatment.

Employee consultation

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

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

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

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

- A structured staff workshop delivered on a monthly basis. Staff receive an update on the delivery of commissioning performance targets, new policies or initiatives, briefings on areas such as the Better Care Fund, *Right Care, Right Time, Right Place*, the one year operational plan and updates on service improvement developments. It is also an opportunity to receive briefings on areas such as information governance responsibilities, reporting incidents and Human Resources (HR) updates. The interactive session is used to develop thinking in areas such as our clinical commissioning priorities and organisational development.

- Active engagement with the staff side representatives to establish a Social Partnership Forum. The forum meets on a quarterly basis and membership consists of HR professionals, Senior Managers from the CCG, branch trade union representatives and staff side colleagues. Over the past year, the Forum has reviewed 16 HR policies prior to their submission and approval by the Remuneration Committee.

- In 2014/15, an organisational development steering group was established to oversee the development of an Organisational Development Framework. It will now monitor the implementation plan.

Disabled employees

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

Emergency Preparedness, Resilience and Response

"We certify that the Clinical Commissioning Group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. As a category 2 responder we follow NHS England (Yorkshire and Humber) Area Team's major incident plan. The Clinical Commissioning Group regularly reviews and makes improvements to its Business Continuity Plan and has a programme for

regularly testing this plan, the results of which are reported to the Audit Committee (under delegation from the Governing Body)".

Statement of disclosure to Auditors

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

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

- So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group's external auditor is unaware and;
- That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Dr Matt Walsh, Accountable Officer

27th May 2015

Remuneration Report

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

1. Membership of the Remuneration Committee

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

Remuneration Committee		
Member	**Role**	**Attendance**
Kate Smyth	Lay Member and Chair of the committee	5/5
Dr Alan Brook	Chair of CCG	5/5
Dr Hazel Carsley	GP Member	3/5
John Mallalieu	Lay Advisor to the Governing Body	5/5
Dr Nigel Taylor	GP Member (GP substitute)	1/1

Over the past year, the Remuneration Committee has been supported in its determinations, by a senior HR specialist (Yorkshire and Humber Commissioning Support), the Chief Finance Officer and the Corporate and Governance Manager.

The Governance Statement contains more information about the Remuneration Committee.

2. Policy on Remuneration of Senior Managers

For the purpose of this report, Senior Managers includes:

- Very Senior Managers (VSMs)
- GPs on the Governing Body – including the Chair of the CCG
- Registered Nurse and Secondary Care Specialist
- Lay Members

To support the principle of local determination there are no set rates of pay for the different groups of Governing Body members. There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement.
These together with benchmarking and legal guidance from DAC Beachcroft LLP were used to inform the determinations of the Remuneration Committee:

Hutton review fair pay principles (2011):-

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

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

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

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

Very Senior Managers (VSMs)

There are two posts which are subject to VSM terms and conditions at Calderdale CCG. These are the Accountable Officer and the Chief Finance Officer. At the time of establishment, when considering the remuneration for these posts the committee took account of:

- Pay benchmarking information provided by the NHS Commissioning Board (NHS England)
- Complexity factors
- Availability of guidance on recruitment and retention premiums
- Prevailing economic climate and local market conditions
- Any joint management arrangements.

In line with the above principles, VSM remuneration has recently been reviewed and it was agreed in line with national guidance, that no uplift would be paid for VSMs.

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

- RSM Tenon – Technical Employment Status Guidance (2012)

- RSM Tenon FAQs

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

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

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

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

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

- The key and guiding principles set out
- Comparative rates for each of the Governing Body posts
- The requirement to obtain best value for money
- The need for an affordable staffing and remuneration structure within its running cost allowance.

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

- At a rate commensurate with their salary or as needed for replacement costs; or at a rate commensurate with the average rate for their profession and level of seniority.

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

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

3. Benchmarking rates of remuneration

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

4. Senior Managers Performance Related Pay

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

5. Policy on Senior Manager Contracts

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

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

6. Senior Manager Service Contracts

The CCG currently uses the following terms of engagement for Governing Body members; Secondment Agreement (Registered Nurse and Secondary Care Specialist); Contract for Service for GP members, i.e. Clinical Leaders, Lay Members and the Lay Advisor.

A number of factors led to a delay in finalising the contract for service in 2013/14. The Remuneration Committee sought advice from KPMG on the most appropriate remuneration, terms and conditions and has applied that advice over the course of 2014/15.

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

7. Compensation for loss of office

No payment has been made in compensation for loss of office

8. Payments to Past Senior Managers

No payment has been made to past senior managers.

9. Salaries and allowances

9. Salaries and allowances

Salaries & Allowances

Name & Title	2014/15 Staff in Post	2014-15 Salary & Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long term Performance Related Bonuses (bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr.Alan Brook, Chair	All Year	60-65	0	0	0	0	60-65
Dr.Steven Cleasby, Assistant Chair	All Year	60-65	0	0	0	0	60-65
Dr.Hazel Carsley	All Year	30-35	0	0	0	0	30-35
Dr.John Taylor	All Year	30-35	0	0	0	0	30-35
Dr.Peter Davies	01/04/14 - 31/08/14	10-15	0	0	0	0	10-15
Dr.Majid Azeb	All Year	30-35	0	0	0	0	30-35
Dr.Nigel Taylor	All Year	30-35	0	0	0	0	30-35
Dr.Caroline Taylor	03/11/14 - present	10-15	0	0	0	0	10-15
Dr Sanjay Suri, Secondary Care Clinican	01/04/14 - 11/05/14	0	0	0	0	0	0
Dr Rajesh Phatak, Secondary Care Clinican	12/02/15 - present	0	0	0	0	0	0
Jackie Bird, Registered Nurse	All Year	10-15	0	0	0	0	5-10
Kate Smyth, Lay Member	All Year	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member	All Year	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	All Year	5-10	0	0	0	0	5-10
Matt Walsh - Accountable Officer	All Year	130-135	0	0	0	25.0-27.5	155.0-165.0
Julie Lawreniuk - Chief Finance Officer **(Note 1)**	All Year	50-55	0	0	0	10.0-12.5	60-67.5

Note 1 - Same as last year.
Note 2 - GP members have been remunerated through the CCG Payroll this year.
Note 3 - Same as last year.

Note 1: Julie Lawreniuk is employed by NHS Calderdale CCG. This is a shared post with NHS Greater Huddersfield CCG, for whom she is also Chief Financial Officer. Her total salary is in the banding £105k - £110k, however, only 50% has been included in the Salary & Fees column. In the All Pension Related Benefits column, we have included 100% of the increase in pension entitlement, as the overall increase cannot be accurately apportioned between Calderdale & Greater Huddersfield CCGs in relation to Pensions Related Benefits.

Note 2: GP members have been remunerated through the CCG payroll.

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

The increase = ((20 x PE) +LSE) – ((20 x PB) + LSB) where:

- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Salary & Pension Disclosure tables

Name & Title	2014/15 Staff in Post	Real increase in pension at age 60. (Bands of £2,500) £000's	Real increase in lump sum at age 60. (Bands of £2,500) £000's	Total accrued pension at age 60 as at 31/03/15. (Bands of £5,000) £000's	Lump sum at age 60 related to accrued pension as at 31/03/15. (Bands of £5,000) £000's	CETV at 31/03/14 £000's	CETV at 31/03/15 £000's	Real Increase in CETV £000's	Employer's Cont to stakeholders pension £000's
Matt Walsh - Accountable Officer **(Note 1)**	All Year	0-2.5	2.5-5.0	20-25	60-65	361	402	31	22
Julie Lawreniuk - Chief Finance Officer **(Note 2)**	All Year	0-2.5	0-2.5	30-35	95-100	570	610	25	17

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

Note 3: The NHS Pension Agency has informed the CCG that the pensions benefit for Governing Body GPs who are practitioners and where the CCG has a Contract for Service cannot be disaggregated for the element of their role as a Governing Body member. The CCG makes pension contributions to NHS England who acts as the NHS Pension Employing Authority for these GPs.

10. Pay Multiples

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

The banded remuneration of the highest paid member of the Governing Body in Clinical Commissioning Group in the financial year 2014-15 was £150k - 155k (2013-14, £150k-£155k). The pay multiple has increased from 4.9 to 5.07 as the median salary has reduced from £30,764 to £29,759.

In 2014-15, no employees received remuneration in excess of the highest-paid member of the Membership Body/Governing Body.

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

11. Off payroll engagements

Following the review of tax arrangements of public sector appointees published by the chief secretary to the Treasury on 23 May 2012, CCGs must publish information on their highly paid and/or senior off payroll engagements.

Required disclosure

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

The number that have existed:	**Number**
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	14
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2015	14
	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	0
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.	0
Number for whom assurance has been requested	10
Of which, the number:	
For whom assurance has been received	4
For whom assurance has not been received	6
That have been terminated as a result of assurance not being received	0

	Number
Number of off-payroll engagements of membership Body and/or Governing Body members, and/or senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed "Membership Body and/or Governing Body members" and/or senior officials with significant financial responsibility, during the financial year (this figure includes both off-payroll and on-payroll engagements.	11

Dr Matt Walsh, Accountable Officer

27th May 2015

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

Dr Alan Brook, Chair

Longroyde Surgery, Rastrick

Alan Brook has been a GP in Brighouse since 1987. Alan was one of two national GP trainee representatives on the Royal College of General Practitioners. On arrival in Calderdale, he joined the Local Medical Committee (LMC) and later served as its Chair.

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

He strives for excellence in his practice and encourages others to do the same. Alan lives in Calderdale and is married with three grown-up children. His interests include gardening, beekeeping, woodturning, cooking, skiing and walking. He and his wife are season ticket holders at Huddersfield Town Football Club.

Alan was chair of the Finance and Performance Committee until December 2014, and is a member of the Remuneration Committee.

Dr Matt Walsh, Chief Officer

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

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

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

Matt is a member of the Finance and Performance Committee.

David Longstaff,
Deputy Chair,
Audit Committee Chair

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

As a Lay Member and Deputy Chair of the CCG, he chairs the Audit Committee. He's passionate about the CCG being open and transparent and getting the best outcomes for local people.

He has lived in West Yorkshire all his life. Most of his family lives in the Brighouse area and all use the local NHS.

David is married, has one child and three grandchildren. He is a big Rugby League fan. David has been a local magistrate in West Yorkshire for over 25 years, covering adult law and youth law, and also undertakes a range of roles in appeals.

Julie Lawreniuk,
Chief Finance Officer

Julie is a qualified accountant and has worked in the NHS since 1991. During this time she has worked in a number of roles across the Calderdale and Kirklees patch including Executive Director of Finance and Efficiency for Calderdale Primary Care Trust (2010-2011) and Associate Director of Finance for the two former Huddersfield PCTs (2005-2007).

She was also the Chief Operating Officer for NHS Calderdale, sitting on the Calderdale, Kirklees and Wakefield District Cluster Board prior to the establishment of the CCG.

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

Julie is a member of the Finance and Performance Committee.

Dr Steven Cleasby,
Assistant Clinical Chair

Spring Hall Medical Centre

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

As Assistant Clinical Chair at the CCG, he holds a number of lead roles, including being a member of the Audit Committee, lead for Safeguarding and Cardiovascular Disease. Until December 2014 Steven was the Chair of the Quality Committee.

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

Dr Caroline Taylor,
GP member

Beechwood Medical Centre

Caroline graduated from Leeds Medical School in 1992 and underwent GP training in York and Otley and has done a variety of hospital and GP jobs, including working at Overgate Hospice for 2 years. Caroline has been a GP in Calderdale since 1999 when she started working at Beechwood Medical Centre. She has always had a keen interest in mental health and is the clinical lead for mental health for the CCG. Caroline is also a member of the Finance and Performance Committee.

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

Dr Hazel Carsley
GP Member

Boulevard Medical Practice

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

She is the children's clinical lead for the CCG. She finds her work through partnerships stimulating and challenging.

Hazel is Chair of the High Performing Membership Organisation (HPMO) Steering Group and is a member of the Remuneration Committee.

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

Dr Nigel Taylor,
GP Member

Hebden Bridge Group Practice

Nigel qualified in medicine at Kings College, London in 1991 and completed his general practice training in Calderdale in 1995. He joined Hebden Bridge Group Practice as a GP shortly after.

Nigel is the clinical lead for Planned Care, Respiratory Medicine and Medicines Management. He is dedicated to effective prescribing locally and a champion for better equity of care and improving the quality of prescribing across Calderdale.

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

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

Nigel was a member of the Quality Committee until January 2015, and now chairs the Finance & Performance Committee.

Dr John Taylor, GP Member

King Cross Surgery

Dr John Taylor, originally from Sheffield, qualified from Nottingham University Medical School in 1984. After completing house officer jobs in North Yorkshire he moved to Calderdale in 1985 to join the GP Training Scheme. He has been a full time GP partner at King Cross Surgery, Halifax since August 1988.

He has always had an interest in improving healthcare delivery and was first involved in commissioning as a GP Fundholding Practice in the 1990s.

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

John has been a member of the Finance and Performance Committee throughout 2014/15 and will be joining the quality committee from April 2015.

Dr Majid Azeb, GP Member

Southowram Surgery

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

As well as his practice role, Majid holds a number of lead roles within the CCG including urgent care and non- elective care which put him at the heart of developing services in these areas. From January 2015 he has chaired the Quality Committee.

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

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

Kate Smyth,
Lay Member
(Public and Patient Involvement)

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Kate has lived in Todmorden for over 30 years and has a special interest in how health and care services are delivered. Her appointment to the Governing Body provides a perfect opportunity to be a champion for commissioning the best health services for the people of Calderdale and she believes passionately that the patient and public voice should be heard.

As a full time wheelchair user, Kate (and her trusted assistance dog Hal), has direct experience of how the delivery of health and care services impact on patients and service users. Kate holds a variety of non-executive posts in the voluntary sector in the local area and has a good understanding of the needs of vulnerable people. Kate has a degree in Town Planning and finds time to keep chickens and geese in her garden as well as being a self-appointed head gardener.

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

Jackie Bird,
Registered Nurse

Jackie has the statutory role of 'Registered Nurse' on the CCG's Governing Body. She is seconded to this role for the equivalent of 2.5 days per month, from her substantive position as Executive Director of Nursing & Quality at The Christie NHS Foundation Trust. The '*Registered Nurse'* role allows Jackie to develop her long standing interest in patient safety, patient experience and clinical outcomes from a commissioning perspective.

Jackie is a member of the Audit Committee at the CCG and will be joining the Remuneration Committee from May 2015.

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

Dr Rajesh Phatak,
Secondary Care Specialist

Rajesh joined the CCG's Governing Body in February 2015.

Rajesh graduated from Mumbai University in 1997 and moved to the UK in Dec 2002 after completing his initial Paediatric Training. After further training posts in London, Leeds, Hull, Bradford (Anaesthesia) and Southampton (PICU), he was appointed as a Consultant Paediatric Intensivist in July 2011.

He is part of a small team (NWTS) delivering PICU retrieval services to North West England and North Wales. He is an exams board member for the RCPCH and has a keen interest in education and regularly teaches on APLS and Paediatrics BASIC courses. He has worked with a cardiac surgical charity and has a keen interest in ensuring key learning from untoward clinical events is shared with new and inexperienced staff.

When not at work, he maintains a healthy interest in sports and music. He is currently gaining photography skills and hopes to get to professional quality prints in the next couple of years."

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

John joined the CCG having been a Non-Executive Director of Calderdale Primary Care Trust since 2009 and is a lay advisor to the Governing Body.

John is the Managing Director of Turning Point, one of the Country's leading social enterprises, with extensive experience in public, private and social enterprise organisations, John has held senior roles in both NHS Professionals and NHS Direct and moved to healthcare following a successful period as Business Operations Manager for Dixons Stores Group International.

John is a Lay Advisor on both the Audit and Remuneration Committees, and a member of the Finance and Performance Committee.

Penny Woodhead,
Head of Quality Advisor to Governing Body

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

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

Penny's role within the CCG is as Head of Quality and is responsible for making sure that the services that are commissioned are of a high standard. This includes safety, safeguarding, effectiveness and patient experience.

Penny’s hobbies are exercising at the gym, walking and spending time with her family.

Penny is an advisor to the Governing Body and a member of the Quality Committee.

NHS Calderdale Clinical Commissioning Group

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

REGISTER OF INTERESTS

Name	Own interests	Interests of family members and close associates
Dr Alan Brook	GP Principal at Longroyde Surgery, Rastrick, Brighouse	Spouse is an employee of Mid Yorkshire Hospitals Trust (Dewsbury)
Dr Majid Azeb	Director of M & N Medicals Ltd (a company not believed to have any direct dealings with the NHS) GP Principal at Southowram Surgery, Halifax A member of the LMC	Brother is an employee of Calderdale and Huddersfield NHS Foundation Trust
Jackie Bird	Executive Director of Nursing and Quality at the Christie NHS Foundation Trust Elected nurse representative for Health Education England North West	No interest declared
Dr Hazel Carsley	GP Principal at Boulevard Medical Practice, Halifax	Spouse is an employee of Calderdale Metropolitan Borough Council
Dr Steven Cleasby	Director of Ryecroft Medicines Management Solutions GP Principal at Spring Hall Group Practice, Halifax Medical Advisor and Board member, The Medicines Management Trust	Spouse is an employee of Insight (IAPT), and sub-contracted to Calderdale Parents & Carers
Dr Caroline Taylor	GP partner PMS practice (Beechwood Medical Centre) – responsible for mental health, prescribing and intermediate care	Spouse is a GP partner at GMS practice (Rosegarth Surgery) Sister is a Director at Tesco supermarkets
Julie Lawreniuk	Employed jointly as Chief Finance Officer of both NHS Calderdale Clinical Commissioning Group and NHS Greater Huddersfield Clinical Commissioning Group	No interests declared
David Longstaff	Magistrate, West Yorkshire Chairing of Mental Health Tribunals in West Yorkshire Chairing of School Appeals	Spouse is a Kirklees Council Manager, Gateway to Care

John Mallalieu	Director of Social Enterprise – Turning Point (a provider of Health and Social Care services across England and Wales but not presently providing services to NHS Calderdale) Independent Steering Group Member of Orangebox Young People's Centre, Halifax Independent Chair – Department of Work & Pensions – Work Programme Mental Health Expert Panel	No interests declared
Dr Rajesh Phatak	Consultant Paediatric Intensivist with NWTS and PICU (Employed by Central Manchester Foundation Trust) Director of Timely and Efficient Solutions Ltd Has worked as a volunteer for healinglittlehearts – a UK charity catering to congenital heart surgery in India	Spouse is a secretary in Timely and Efficient Solutions Ltd
Kate Smyth	Secretary of Disability Partnership Calderdale (a user-led organisation of people with physical and/or sensory impairment) Member of Calderdale and Huddersfield Foundation Trust (member only in the capacity of a Calderdale resident and not serving on the Membership Council) Volunteer at Calderdale Royal Hospital and Huddersfield Royal Infirmary specialising in disability issues Independent Board Member of Kirklees Neighbourhood Housing Working with Age UK to prepare a report on the development of an enhanced PA service	Spouse is a consultant at DLA Piper Solicitors (although the organisation deals with NHS related matters, the spouse does not practice in the NHS field) Sister in law is an employee of Pennine Acute Hospitals NHS Trust
Dr John Taylor	GP Principal at King Cross Practice, Halifax Provider of primary care to 17 intermediate care beds at Brackenbed View Care Home Occupational Health Physician to Aquaspersions Limited (the company does not have any NHS contracts)	Spouse is an employee of King Cross Practice, Halifax Sister in law is an employee of Northolme Practice, Halifax Stepson is an employee of Hear Care, Specsavers, Barnsley
Dr Nigel Taylor	GP Principal at Hebden Bridge Group Practice	Spouse is an employee of Bradford Teaching Hospital NHS Foundation Trust
Dr Matt Walsh	Ownership of a $^{2}/_{9}$ share of premises at Thornton Medical Centre, Bradford (a GMS practice with a Bradford contract)	Spouse is an employee of Calderdale and Huddersfield NHS Foundation Trust

PART TWO

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Dr Matt Walsh, Accountable Officer

27th May 2015

GOVERNANCE STATEMENT

NHS Calderdale Clinical Commissioning Group

Governance Statement

By Dr Matt Walsh as Accountable Officer

Introduction and context

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

As at 1 April 2014, the Clinical Commissioning Group was licensed without conditions.

Over the past year, the CCG has built on the strong foundations put in place in 2013/14 and carried out an ambitious programme of service transformation development and deliver culminating in the achievement of Vanguard status. The work has included the development of:

- the 5 Year Strategic Plan
- the Care Closer to Home Model
- the Better Care Fund Plan
- the future hospital services programme
- the strategic resilience partnership to manage our response to demands on the urgent care system
- A comprehensive public engagement programme

We are clear that we will not achieve the level of sustainable change required without strong relationships and good partnership working and have continued to focus on these throughout the year.

We have also maintained a high level of grip on the finance, performance and quality of commissioned services through our governance arrangements, risk management and systems of internal control.

We are now preparing for 2015/16 and the move towards greater partnership working across the 10 CCGs and as part of co-commissioning of primary medical services.

Scope of Responsibility

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

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

Over the past year this has included:

- **(Code ref: B4.1)** New members to receive a full, formal and tailored induction on joining the Governing Body.

  Action: The induction process in 2014/15 incorporated the requirement that new Governing Body members met with practice commissioning leads and practice managers at one of their regular events. The induction process for new Governing Body members and sub-committee members will be developed further in 2015/16 (see below – Governing Body and sub-committee self-assessment).

- **(Code ref: 4.2)** The Chair to regularly review and agree individual training and development needs with Governing Body members –

  Action: Each Governing Body member received a performance and development review in 2014/15. The terms of reference of the Remuneration Committee have also been amended to incorporate a responsibility for the oversight of the PDR process for Governing Body members and Very Senior Managers (VSMs). This will take effect in 2015/16.

- **(Code ref: B6.1)** The Annual Report should state how the performance of the Governing Body, its committees and its individuals has been conducted.

Action: This Annual Governance Statement refers to the process of Governing Body and sub-committee assessment.

- **(Code ref: B6.2)** Externally facilitated evaluation of the Governing Body every three years –

  Action: This is planned to take place in 2015/16. In addition KPMG has been commissioned to carry out a governance review of the CCG, two years into its existence, to identify any ways in which it can improve its effectiveness and make best use of capacity and capability.

- **(Code Ref: C3.5)** The Audit Committee should review whistle-blowing arrangements.

  Action: The revised whistle-blowing policy was approved by the Remuneration Committee in 2014/15. The Corporate Governance Plan includes a review of awareness and implementation of the arrangements in 2015/16.

  A survey of staff awareness of counter-fraud measures and the policy was conducted in 2014/15 and the results reported to the Audit Committee in March 2015.

The Clinical Commissioning Group Governance Framework

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

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

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

Key Features of the CCG Constitution in relation to Governance

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

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

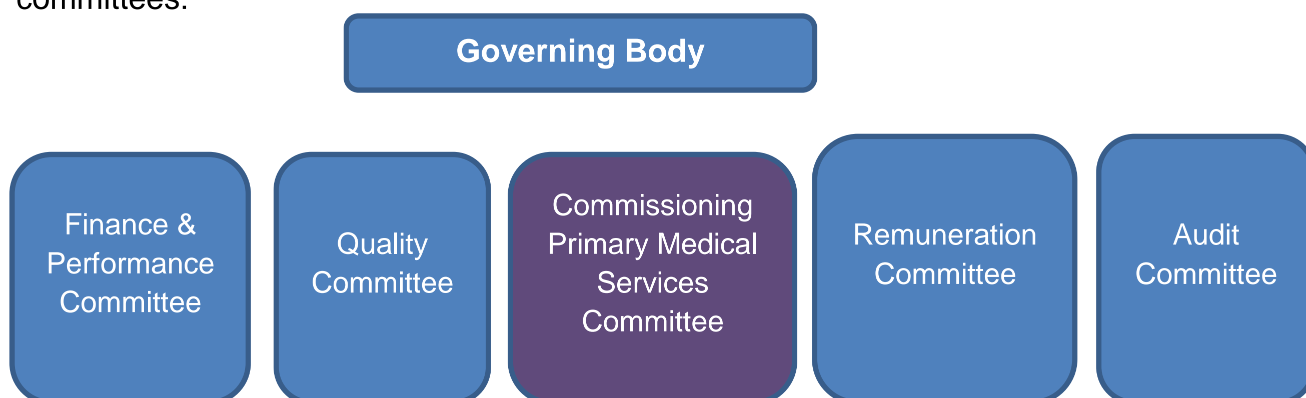
- Compliance with the seven key principles of the NHS Constitution and with the Equality Act 2010
- Compliance with the statutory requirements and NHS England statutory guidance[6] on arrangements to manage conflicts and potential conflicts of interest.

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

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

Over the past few months, the CCG has worked with NHS England to take on delegated responsibility for certain functions relating to the commissioning of primary medical services. In preparation for this extension in the CCG's role, our arrangements for the management of actual or potential conflicts of interest have been strengthened by the introduction of a Conflicts of Interest Policy and the establishment of a separate Commissioning Primary Medical Services Committee. Responsibilities for the commissioning of primary medical services were delegated to the CCG on the 1st April 2015 and the newly formed committee will begin meeting in June.

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



The membership of the Governing Body and its sub-committees (with the exception of the Commissioning Medical Services Committee), together with the attendance record is set out Appendix 1 at the end of this Governance Statement. Details of the membership and attendance of the Remuneration Committee is set out in the Remuneration Report. Attendance at the Governing Body and sub-committees

[6] section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act;

throughout the year has been strong and all meetings have been quorate throughout the year.

Work of the Governing Body and Sub-Committees

Governing Body

The main function of the Governing Body as set out in the Health and Social Care Act 2012 is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance as outlined above.

The membership currently comprises the Chair; seven GPs (including the chair) as elected by the membership, two lay members (one of whom is the deputy chair and leads on audit matters and one who leads on public and patient involvement matters); one registered nurse; one secondary care specialist; the Accountable Officer and the Chief Finance Officer.

The Governing Body is supported in carrying out its role by a Lay Advisor (finance, performance and external relations) and by the Head of Quality. These roles confirm the importance placed by the CCG on quality, safety and patient engagement as well as strengthening the degree of lay scrutiny on the Governing Body - improving its overall effectiveness.

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

Coverage of Work by the Governing Body

In 2014/5, the Governing Body met in public on nine occasions, including the Annual General Meeting (AGM).

During the year, the Governing Body has continued to consider a suite of performance reports at each planned meeting. These include finance, QIPP (Quality Innovation, Prevention and Productivity) and contracting, quality and safety, and performance. The workforce report is received on a quarterly basis.

These reports are submitted to the Governing Body following a detailed review in the Finance and Performance or Quality Committees. This enables the Governing Body and the CCG to maintain a high degree of rigour in its management of quality, safety,

finance and performance – including performance against contract for clinical and non-clinical services.

Other areas of work covered by the Governing Body include:

Governance

- Presentation of the Annual Report and Accounts at the AGM
- Review of the legal and governance arrangements in support of the Better Care Fund Programme
- Governance arrangements for the Hospital Services Programme Board and co-commissioning primary medical services
- Assurance Framework, High Level Risk Log and Report
- Committee Terms of Reference and Policies
- Variation to the CCG Constitution
- Minutes from sub-committees and other groups reporting into the CCG

Staff and the CCG membership

- Workforce reports
- Organisational Development Framework

Quality and safety

- Safeguarding reports including the annual safeguarding reports for adults and children
- Public and patient experience and engagement reports including the presentation of the Annual Statement of Involvement (Patient and Public Engagement) at the CCG's AGM
- Public Sector Equality and Diversity Report

Strategic and financial planning

We have had a full and productive year, making a number of important decisions on the transformation of services for the people of Calderdale. These areas, which are covered in more detail in the Strategic Report, include:

- 5 year Strategic Plan, one year operational plan and investment of resources
- Right Care, Right Time, Right Place (previously known as Strategic Review) plans and engagement plan
- Commissioning Care Closer to Home
- Care for people over 75 years
- Commissioning local enhanced services
- Co-commissioning primary medical services
- Mental health Crisis Concordat
- Procurements including wheelchair services
- Sustainable Development Management Plan
- Financial plans and budgets

Governing Body Performance

At the time of writing, the CCG is on track to deliver against the majority of its key NHS Constitution duties and all of its key statutory financial duties. We have maintained an unremitting focus upon the delivery of key performance targets and key financial and contractual requirements through the year. The commissioner approach to the delivery of QIPP has sharpened further this year. The strength of the CCG's financial position moving into 2015-16 reflects well upon the financial grip exerted by the CCG and underpinned by the governance provided by the Finance and Performance Committee.

Governing Body and Sub-Committee Effectiveness

Ensuring that the Governing Body and its sub-committees are working effectively is key to our ability to achieving our statutory duties, strategic priorities and strong financial position.

The development of Governing Body and sub-committee effectiveness is taken forward in a number of ways:

- **Bi-monthly Governing Body development sessions which aims to:**

  - Provide members with sufficient knowledge to understand the key financial, strategic and performance issues facing the CCG and to

  - Develop the skills needed, ensuring the right degree of scrutiny and challenge on critical and sensitive matters.

  In 2014/15 we have covered topics such as managing conflicts of interest, improving our effectiveness as a CCG, preparing for co-commissioning of primary medical services as well as looking at the organisational development framework. We also implemented the recommendations made by the internal auditors in 2013/14 on the development of the Assurance Framework. This formed the basis of two of our Governing Body sessions.

- **Development sessions with sub-committees.**

  In September we held an externally facilitated session with our Audit Committee which focused on roles and responsibilities and looking at the implications for the committee of the changing context in which the CCG would be working in the forthcoming year.

- **Development of individual Governing Body members**

  Governing Body members are able to access individual coaching sessions, national and regional briefings relating to their role in the CCG. This ensures that individuals are supported in developing their knowledge and skills on a continuous basis.

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

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

- A strong focus on patient safety and high quality services.
- A strong culture of openness and transparency in our decision making, with the tough decisions continuing to be taken in public.
- A high level of scrutiny and rigour across our work.
- Appropriate management of conflicts of interest
- A robust risk management system and increased use of the Assurance Framework
- Good use is made of clinical engagement
- A real commitment to continually improve our effectiveness and performance

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

- Patients and the needs of the local population are at the heart of everything we do, however it is recognised that we need to develop the way that we demonstrate this through our Governing Body agenda.
- Formalise the induction and training process for new Governing Body and committee members.
- Providing training and support to ensure that all Governing Body and committee members are able to provide high quality scrutiny and challenge across the breadth of the CCG's agenda.
- Continuing to embed the understanding of what it means to be a membership organisation for both the members and the Governing Body.
- Increase the focus on developing future leaders (clinical and non-clinical) and talent management.
- Review the governance processes to minimise the degree to which work is duplicated across the commissioning development forum, the Governing Body and its sub-committees.

We will continue our focus on developing these areas next year and have commissioned an external review of our governance arrangements from KPMG.

The CCG as a membership organisation

One of the key differences between our predecessor, the Primary Care Trust, and the CCG is that the CCG is a membership organisation made up of all the 26 General Practices in Calderdale. Over the year we have continued to develop our understanding of what this means in practice.

Work with the member practices is steered by the HPMO (High Performing Membership Organisation) group. The CCG holds regular events for all member practices (Practice Leads' meetings). These are attended by the clinical commissioning lead and practice manager from each of the member practices. In addition, each of the practices is a member of a locality-based commissioning team. The aim of the commissioning teams, which are key to our membership model, is to:

- Focus on delivery of the identified quality indicators (peer review, sharing best practice etc.)
- Focus on at least one area from the list of seven clinical priorities as identified by the CCG and to develop a project, based on the principles of clinical audit, linked to the priority area and delivery of the objectives of the scheme.
- Undertake one additional audit linked to a service development area in the year
- Report back and share the learning at the Practice Leads' meetings

The focus and resourcing of the work of the commissioning teams is set out in the annual Commissioning Engagement Scheme. The scheme involves the whole CCG membership working together to:-

- Improve the quality of patient care
- Support each other in the sharing of best practice
- Promote the development of new services
- Enable the review of existing services and service redesign

The HPMO informs the content of the commissioning engagement scheme and drives forward the member engagement element.

The Finance and Performance Committee monitor the effectiveness and value for money aspect of the commissioning engagement scheme.

The locality-based commissioning teams are a great example of partnership working, with all our practices actively working together to support each other in achieving better health for their patients. Further information can be found in the Strategic Report.

Finance and Performance Committee

The Finance and Performance Committee advises and supports the Governing Body in scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's strategic and operational plans. The duties and responsibilities of the committee are set out in their terms of reference.

The membership of the committee is set out in appendix 1. In addition, the committee is supported by the attendance of the Heads of Service and the performance manager. The committee meets monthly and has been quorate on all occasions.

Coverage of work by the Finance & Performance Committee

The work carried out by the Finance and Performance Committee is contained within its annual work plan and has been delivered in full. Each month, the Committee receives and scrutinises reports on finance, contracting, QIPP (Quality, Innovation, Productivity and Prevention) and performance. It also reviews the finance, performance and corporate risks every second month. The agenda for the committee has flexed and developed throughout the year to take account of new responsibilities as they have emerged.

The Committee's terms of reference have been reviewed during the year and amended to formalise the governance role of the committee in relation to the commissioning support unit, co-commissioning of primary medical services and the Better Care Fund Programme. Reporting lines into the committee from the Systems Resilience Group, the Urgent and Planned Care Boards have also been formalised.

Finance and Performance Committee Highlights

Maintained strong focus upon the delivery of key performance targets

Continued to use themed reports to support our management of issues such as 111 and ambulance service contract; the relationship between 18 weeks (referral to treatment (RTT) performance and acute services contracts' management.

Strong financial position moving into 15/16 due to financial grip by the committee and Governing Body

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

Quality Committee

The Quality Committee advises the Governing Body and ensures that effective quality arrangements underpin all services commissioned on behalf of the CCG; that regulatory requirements are met and patient safety is continually improved to deliver a better patient experience. The responsibilities of the quality committee are set out in the terms of reference.

The Quality Committee reports into the Governing Body by submitting a comprehensive Quality and Safety report to every meeting of the Governing Body, updating members on key quality activities related to patient safety, clinical effectiveness and patient experience. The Governing Body also receives copies of the minutes of all Quality Committee meetings.

The members of the committee are set out in appendix 1 attached to this report. They are supported by the attendance of the Head of Primary Care Quality and Improvement, Head of Service Improvement, a public health representative from Calderdale Council. The Committee meets on a monthly basis and has been quorate on all occasions.

Coverage of Work by the Quality Committee

The work carried out by the Quality Committee is contained within the annual work plan and has been completed in full.

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

The Committee's terms of reference have been reviewed during the year as part of the annual review cycle. The committee made a small number of amendments to reflect a change in the membership and to confirm its role in reviewing those strategic objectives (Assurance Framework) which relate to the remit of the quality committee. Amendments were also made in relation to the committee's responsibility under co- commissioning of primary medical services.

Quality Committee Highlights

Robust contribution to governance arrangements across all aspects of quality.

Introduced process to embed engagement in day to day work of the CCG.

Further developed quality dashboard to include friends and family information, Care Quality Commission reports.

Scrutiny and monitoring of quality work streams with regard to patient safety including safeguarding, serious incident management, continuing care, learning disability services and Care Quality Commission activity

Remuneration Committee

The Remuneration Committee has two key functions:

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

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

The responsibilities of the remuneration committee are set out in their terms of reference.

The members of the committee are set out in the Remuneration Report. They are supported by the attendance of the Chief Finance Officer, the Human Resources Specialist from the Commissioning Support Unit and the Corporate and Governance Manager. The committee meets on a quarterly basis with any additional meetings being held as business requires. Five meetings were held in 2014/15 all of which were quorate.

Coverage of work by the Remuneration Committee

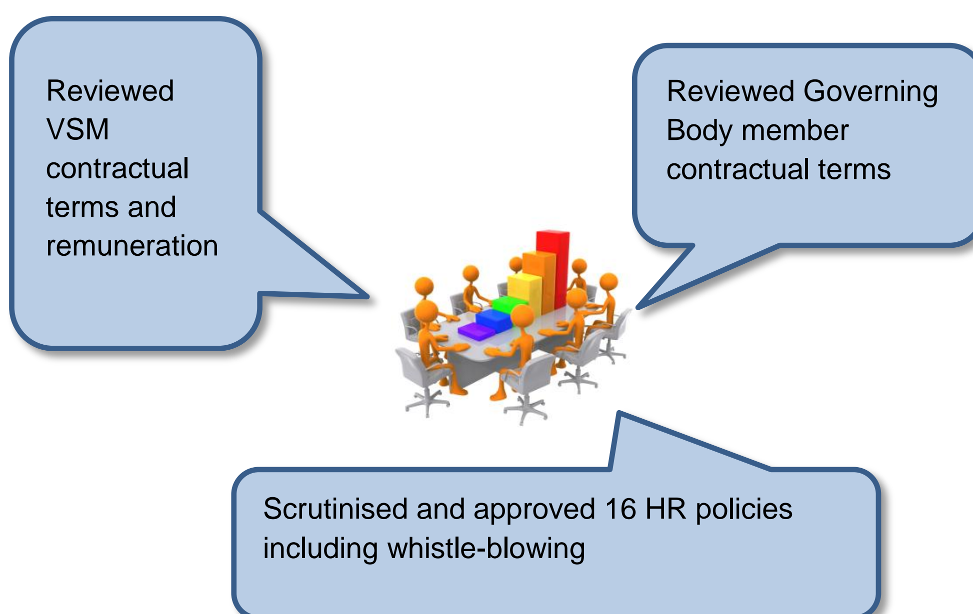
The committee has had a very full agenda this year considering Governing Body member contractual terms, Very Senior Manager (VSM) contracts and remuneration

and GP seniority payments. In considering the VSM contracts, the committee recommended the production of a Memorandum of Understanding for staff in shared posts across CCGs. This is currently under development and should provide clarity and protection to the CCGs.

The committee has also reviewed and approved 16 Human Resources Policies which had been transferred across from the predecessor organisation – the Primary Care Trust.

The Remuneration Committee reviewed their terms of reference in 2014/15 as part of the annual review cycle. The amendments were designed to ensure that the membership was in line with statutory requirements and to strengthen the non-GP membership of the committee. The terms of reference also confirm the role of the committee in having oversight of the process for the review of Very Senior Manager (VSM) performance and that of Governing Body members.

Remuneration Committee Highlights



Audit Committee

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

The committee meets every second month with additional meetings being held as business requires. The committee met 7 times in 2014/15 with an additional meeting being held to approve the annual report and accounts on behalf of the Governing Body. The members of the committee are included at appendix 1 to this

Governance Statement. The committee is supported by the attendance of the Chief Finance Officer, the Corporate and Governance Manager and the external and internal auditors. Attendance at the committee has been good throughout the year and meetings have been quorate on all occasions.

The terms of reference were reviewed in 2014/15 as part of the annual review cycle and were amended to incorporate the responsibility of the committee in respect of reviewing the effectiveness of the whistle-blowing arrangements in place.

Audit Committee Highlights

The Committee has worked well in providing assurance and keeping the organisation safe, including a review of committee effectiveness

Head of Internal Audit Opinion provided significant assurance that a generally sound system of internal control, designed to meet the organisation's objectives is in place.

Reviewed governance arrangements for the Better Care Fund Programme.

Held a 'page-turn of the 2013/14 Annual Report and Accounts for all Governing Bodv members

Achieved compliance (level 3 in 18 areas; level 2 in 6 areas) against the Information Governance Toolkit.

The Clinical Commissioning Group Risk Management Framework

The CCG has had a comprehensive Integrated Risk Management Framework (IRMF) in place since it was first established in April 2013. The IRMF was reviewed and updated during 2014/15 and was formally approved by the Governing Body in March 2015 following recommendation from the Audit Committee.

The IRMF describes our approach to managing risk, our risk appetite, our risk management objectives and the processes in place to ensure these objectives are achieved.

RISK APPETITE

NHS Calderdale 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 score (i.e. the level at which the risk can be tolerated). The acceptability of the target risk score is subject to review by senior management and relevant Committee as part of the normal review and reporting process for the Risk Register.

Further development of the CCG's definition of risk appetite is scheduled to be undertaken by the Governing Body in early 2015-16.

RISK MANAGEMENT OBJECTIVES

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

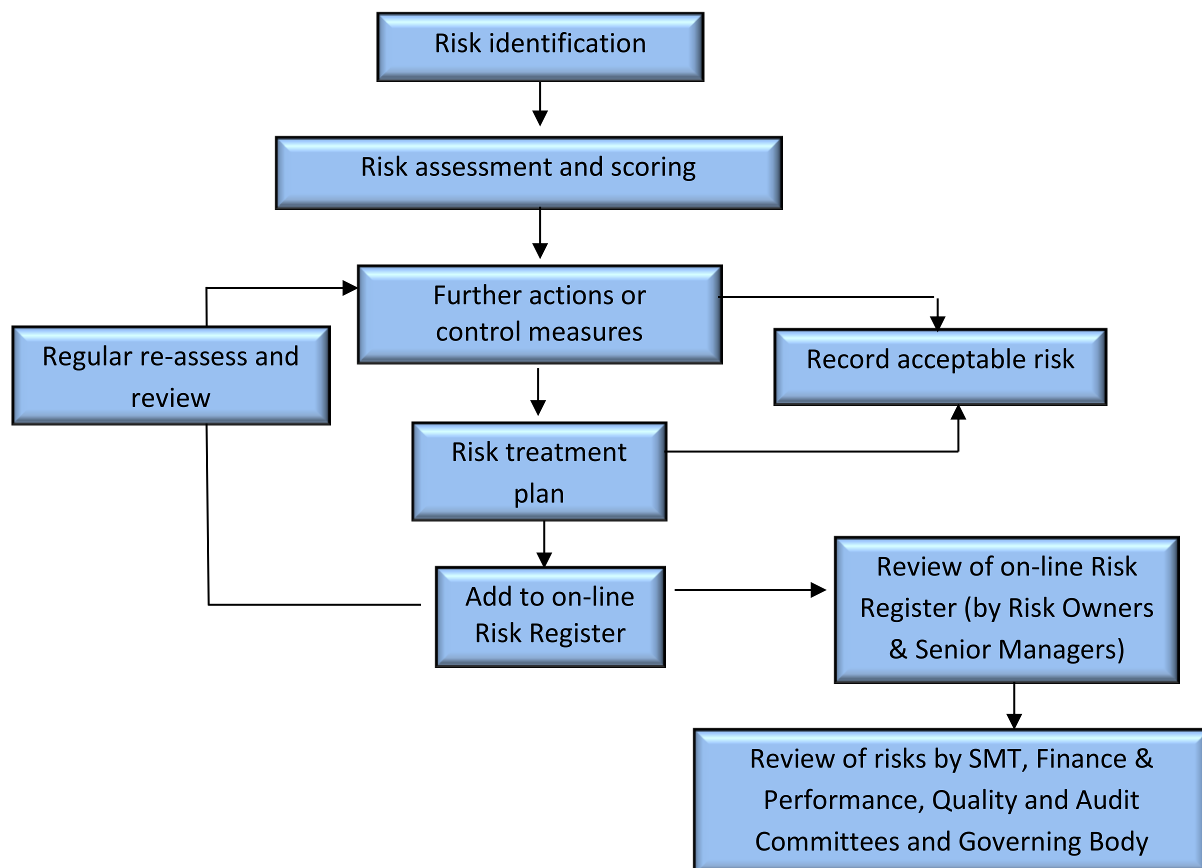
The CCG monitors and reports on risk in two key ways:

- The Governing Body Assurance Framework, which focusses on strategic / long-term risks to the delivery of the CCG's strategic objectives. The Assurance Framework is formally reviewed and updated twice per annum.
- The Corporate Risk Register, which focusses on more operational risks that may rise and fall within relatively short time periods. The Corporate Risk Register is reviewed and updated six times per annum.

More detail regarding the Governing Body Assurance Framework is given in the Internal Control Framework section of this report.

Risk Management Objectives

1. Effectively identify, report and manage risk



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

- Performance and quality dashboard data.
- Compliance with regulatory requirements such as Ofsted reviews, Care Quality Commission, Parliamentary Ombudsman, information governance systems.
- Routine review of serious incidents, incident reports and complaints.
- Intelligence through partner networks and from stakeholders.
- Early warning on serious or major adverse events.
- Risk review and discussion through operational groups and formal meetings, e.g. Senior Management Team, Governing Body and sub-committees which highlight problems and issues that should be reflected in the Risk Register.

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

- Understand its potential impact and likelihood;
- Examine what control measures are already in place to manage the risk and evaluate their effectiveness;

- Score the outstanding risk taking into account existing controls (net risk), using a 5 x 5 matrix;
- Identify the target risk score (i.e. the level at which the risk can be accepted, taking into account the CCG's risk appetite)
- Identify any further actions are necessary to reduce the risk score to the target level.

Staff record their risks, including current and target risk scores, details relating to controls, assurance and any actions required to close gaps in control and / or assurance, on the on-line Corporate Risk Register system.

Whilst the Corporate Risk Register is a live system, a formal review of risks is carried out every eight weeks (i.e. six risk review cycles per annum). During each cycle, all risks are reviewed individually by the Risk Owner and then by the allocated Senior Reviewer. Following this, the Senior Management Team reviews the Corporate Risk Register in full to:

- Assess the appropriateness of the risk score, controls and assurance.
- Identify any new risks. Triangulation of soft and hard information from different sources is used to provide assurance that all significant risks have been captured.

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

The Audit Committee maintains an overview of the adequacy and effectiveness of the integrated risk management system. The Committee also reviews risks scoring 12 or above as part of the risk review cycle. The High Level Risk Register (risks scoring 15 or above) and report is presented to the Governing Body at the end of each risk cycle.

A process is in place whereby any risks deemed "critical" (risks scoring 20 or more) are immediately reported via email to the Senior Management Team and members of the Governing Body, as soon as the risk is added to the register or its score increases to 20, instead of waiting until the normal reporting cycle.

2. Ensure clear accountability for the management and reporting of risk

Accountability arrangements for risk management are split into two elements:

i. Accountability for the scrutiny of risk processes and management.
ii. Accountability for the management and reporting of risk.

The detailed responsibilities of the Governing Body, the Audit Committee, the Finance & Performance Committee, the Quality Committee, the Senior Management Team, CCG staff and of named individuals are set out in full in the CCG's Integrated Risk Management Framework.

3. Effectively capture and learn from mistakes to reduce future risks

NHS Calderdale CCG is committed to the following principles:

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

Valuable learning information is identified through a variety of internal systems and activities and from external data sources:

- Incident and near miss reporting (using the on-line Datix system);
- Complaints received;
- Issues raised via Patient And Liaison Services (PALS);
- The investigation of incidents, complaints and claims using root cause analysis techniques to identify underlying issues which require improvements or interventions to reduce the chance of re occurrence;
- Feedback from operational managers who are able to triangulate intelligence on complaints, incidents and claims with soft intelligence and feed-back from stakeholders;
- Feedback from Independent Contractors and their associated bodies;
- National Patient Safety Agency, National Reporting & Learning Service and NHS England guidance and reports;
- Feedback from external reviews of organisational systems e.g. internal audit, external audit, Care Quality Commission reviews, Ofsted and Ombudsman.
- Using local and national professional networks to identify best practice and benefit from the experience of others.
- Research and guidance published by professional bodies.
- Recommendations from external investigations and formal enquiries.

All staff are encouraged to report incidents and near misses through briefings at staff workshops and through the use of the on-line system Datix.

There is regular reporting of incidents and near misses to the Quality Committee (CCG clinical incidents and provider serious incidents) and the Audit Committee (CCG corporate incidents) as part of the quarterly Governance Assurance Report. Learning identified via other sources is reported to the relevant group or Committee as appropriate.

4. Ensure and evidence statutory and regulatory compliance

The Integrated Risk Management Framework is designed to both support and evidence compliance with statute and regulation, for example by:

- Scrutiny of the effectiveness of risk management arrangements by the Audit Committee.
- Providing a robust audit trail of the identification, management and reporting of risk.

5. Effectively manage partnership and project risks

The key partnerships for NHS Calderdale CCG include a number of NHS providers, the local authority, independent contractors including a social enterprise, the commissioning support unit, the third sector and patient and public involvement representatives. Partner organisations are required to contribute where appropriate to joint risk registers and risk management frameworks.

Recognising the need to manage risk across organisations to deliver whole system change and improvement, the CCG endeavours to manage risk across organisational boundaries. This is achieved via:

- Maintaining a corporate record of the key partnerships for the organisation.
- Implementation and maintenance of a scoring system to identify partnerships with high risk scores.
- Prioritised implementation of programme / project risk registers for those areas categorised as high risk.

Major programmes such as the Right Care, Right Time, Right Place Programme and the Better Care Fund have their own programme management and governance arrangements, which include a risk register and reporting systems. These risk registers contain risks for all the stakeholders associated with the programme. Risks with a score of 12 or more, or a score of 5 for Consequence / Impact, are considered for escalation from the programme / project risk register to the CCG Corporate Risk Register or Governing Body Assurance Framework as appropriate.

Other Controls to Manage Risk

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

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

- The CCG has a Business Continuity Plan in place, which sets out the CCG's contingency plans to maintain an effective service in the event of a critical incident. This was subject to a full desk top exercise in December 2014 and updated accordingly.

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

- The CCG commissions Yorkshire & Humber Commissioning Support to provide equality and diversity expertise, guidance and support to ensure that we are compliant with the Equality Act 2010 Public Sector Equality Duty. All CCG staff and Governing Body members participate in equality and diversity training appropriate to their role. This means that we are in a strong position to identify those CCG policies, Governing Body papers and improvement programmes

that will need a detailed equality impact assessment (EIA) to identify and mitigate any potential adverse impact on any group of local people with an Equality Act protected characteristic

The Clinical Commissioning Group Internal Control Framework

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

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

The Governing Body Assurance Framework provides the CCG with a simple but comprehensive method for the management of the principal risks to the delivery of strategic objectives and in doing so provides key evidence to support this Annual Governance Statement.

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

- The key controls in place to manage the risk.
- Mechanisms to provide assurance on controls.
- Key positive assurances (i.e. specific evidence that controls are effective and the risk is being managed)
- Any gaps in control and / or assurance and the actions being taken to address these.

The Governing Body Assurance Framework is updated twice per annum and is reviewed by the Audit Committee prior to submission to the Governing Body for approval. Furthermore, the Assurance Framework is considered by all Governing Body sub-Committees when reviewing their Terms of Reference and Annual Work Plans to ensure appropriate alignment.

During 2014-15, following a detailed review of the Assurance Framework by the Senior Management Team and the Governing Body, the document was fully revised to take account of the CCG’s strategic objectives as set out in the 5 Year Strategic Plan. A standard approach to the articulation of risk was adopted to ensure consistency and the clear differentiation of risks, their causes and their impacts. In addition, the revision of the Assurance Framework also took account of previous recommendations from Internal Audit relating to:

- More detail as to the specific assurances received.
- Greater clarity (including timeframes and lead officer) of the actions being taken to address gaps in assurance.

The revised document was reviewed during a development session with the Governing Body, prior to its submission for approval. Following the recommendations of internal audit, the Governing Body in development mode, also considered how the Assurance Framework could be used more effectively by the sub-committees and the senior management team (SMT) as part of their assessment and monitoring of strategic risks and any mitigating actions. This has led to a rolling programme of review of the strategic objectives by the SMT and periodic review by the sub-committees of strategic objectives pertinent to their field of responsibility.

Information Governance

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

This year the CCG set itself the exacting target of achieving level 3 compliance across 20 target areas within the IG toolkit. This is a measure of the importance that we place on ensuring that:

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

I am pleased to be able to report that the CCG has attained a level 3 in 18 and a level 2 in 6 of the Information Governance (IG) Toolkit (version 12) requirements with an overall grade of satisfactory.

The roles of Senior Information Risk Owner, Caldicott Guardian and Information Governance lead have been assigned. The CCG is supported by the Yorkshire and Humber Commissioning Support Information Governance Team, which is an experienced team who are able to provide advice and assistance on all areas of information governance. Assurance is provided through the quarterly Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving data security) and any actions to mitigate.

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

We have ensured that all staff undertake annual information governance training and have distributed a staff Information Governance Handbook to ensure that staff are aware of their information governance roles and responsibilities, including the management of risks in relation to security of person identifiable data. I am pleased to be able to report 100% compliance with the information governance training.

There is an effective system in place to for incident capture, reporting and investigation of serious incidents including those relating to Information Governance security incidents and near misses. There have been no serious untoward Information Governance security incidents during 2014-15.

Pension Obligations

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

Equality, Diversity & Human Rights Obligations

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

All CCG staff participate in equality and diversity training. Staff directly involved in commissioning work attending a two hour session which describes the implications of the Public Sector Equality Duty for people commissioning health services; all other staff complete an e-learning course.

This training ensures that staff can identify CCG policies, Governing Body papers and improvement programmes that will need a detailed equality impact assessment (EIA) to identify and mitigate any potential adverse impact on any group of local people with an Equality Act protected characteristic – age, disability, gender reassignment, marriage or civil partnership, pregnancy & maternity, race, religion or belief, sex and sexual orientation.

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

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

- Through **internal governance arrangements** taking account of self-assessment activity, the annual review of the CCG constitution, new national guidance or regulations and external inquiries such as the Francis, Winterbourne Reviews and the more recent Kirkup report.

- Through the annual **internal audit** plan by the West Yorkshire Audit Consortium which is developed from a risk assessment of all areas of the CCG's activities. Internal Audit also attend the Audit Committee, meeting with Audit Committee members twice a year to discuss any concerns without the executive being present.

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

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

Major Risks to Governance, Risk Management and Internal Control

The open risks classed as 'serious' on the Corporate Risk Register, i.e. with a score of 15 or above, are detailed below:

Risk summary	Action to manage	Means to assess outcome
Needs of service users not met due to slippage against the agreed recovery plan for Children & Adolescent Mental Health Services in Calderdale & Kirklees. (New risk - 2014-15)	Executive Steering Group established to assure the delivery and quality of services. Additional clinical support recruited. Management of individual staff in line with HR processes where appropriate.	Monthly monitoring of the delivery of the recovery plan. Patient feedback.
Non-delivery of co-ordinated change across hospital and community services at sufficient pace and scale by the Right Care, Right Time, Right Place Programme. (New risk - 2014-15)	Programme management and governance arrangements.	Monitoring of delivery by Programme Board, reporting to Finance & Performance and Quality Committees and Governing Body
Resource to support any planned consultation for the Right Care, Right Time, Right	Programme management and governance arrangements.	Monitoring of delivery by Programme Board, reporting to Finance &

Place Programme during transition to in-house Communications services. (New risk - 2014-15)	Additional communications support commissioned if required.	Performance and Quality Committees and Governing Body
Non-delivery of Right Care, Right Time, Right Place Programme financial savings. (New risk - 2014-15)	Programme management and governance arrangements. Programme Finance Assurance Group in place and meets monthly.	Monitoring of delivery by Programme Board, reporting to Finance & Performance and Quality Committees and Governing Body
Continuing Healthcare team unable to deliver the level of performance required due to workload demands. (New risk - 2014-15)	Performance management through the Finance & Performance Committee. Gap analysis of workload versus capacity undertaken and reported. Plan in place to address findings from this analysis.	Plan in place to address workload issues, with monitoring of delivery by the Finance and Performance Committee.
Risk that outstanding IT issues / CSU capacity issues in the Quest for Quality in Care Homes project are not resolved resulting in staff not being able to access clinical records. (New risk - 2014-15)	Fortnightly meetings between CCG and CSU IT, IG and Relationship Manager. Recovery plan drafted and being reviewed by the CCG.	Monitoring of the delivery of the project recovery plan, with reporting to Finance & Performance Committee.
The CCG is not fully sighted on the work being undertaken by NHS England on Specialised Commissioned Services.	West Yorkshire CCG Collaborative presents opportunity for informal view from the Local Area Team. Ongoing dialogue with NHS England and other CCGs. Update on specialised commissioning to the Finance & Performance Committee as part of the Contract Report.	The risk is being managed as effectively as possible given current national arrangements for specialised commissioning.
Risk that the local system does not deliver Accident & Emergency performance targets.	Local health economy Urgent Care Board (USB) in place and meeting monthly. New work programme agreed by all UCB partners. Resilience arrangements were in place to strengthen delivery through the winter months.	Performance targets were delivered in Q1 and Q2 but not in Q3 or Q4. Penalties for non-delivery of monthly performance targets set within the 2015-16 CHFT contract.

No new major risks have been identified since 31 March 2015.

The CCG's Governing Body Assurance Framework describes the CCG's principal risks to its licence and being able to fulfil its strategic objectives. These are set out in Appendix 2 of the Strategic Report.

Key controls, processes and actions to mitigate the risks set out above are detailed below:

- Effectiveness of Governance Structures

  The CCG keeps under review the principal risks as set out in the Assurance Framework and in compliance with our licence. The Assurance Framework is kept under review by the Senior Management Team as part of the risk cycle. New risks identified on the Corporate Risk Register are assessed to identify any impact of achieving our strategic objectives set out in the Assurance Framework.

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

- Responsibilities of the Senior Management Team and Committees

  The CCG's principal risks to achieving our strategic objectives are set out in the Governing Body's Assurance Framework. Each of the principle risks has an identified Senior Manager, Governing Body Clinical Lead and a named committee with responsibility.

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

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

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

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

Following review by the Senior Management Team, the risk register is submitted to the appropriate committee for review. Each committee has clear responsibility for the monitoring of existing risks and identification of further risks as set out in their terms of reference.

The Audit Committee requires assurance of the effectiveness of the risk management system and reviews the High Level Risk Log and Report, before recommending it as an accurate position statement to the Governing Body. These reports are received at each Audit Committee meeting.

- <u>Timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's licence</u>

  The assessment of risks is a continuous process informed by

  - Senior Management Team identifying new risks or changes to risk profile.
  - Financial, contracting, QIPP and performance reports, which are submitted on a monthly basis to the Finance & Performance Committee.
  - Quality risk reports submitted monthly to the Quality Committee.
  - Discussions taking place at the sub-committees and Governing Body on the Risk Register and Assurance Framework.

  <u>Degree and rigour of oversight of CCG performance by the Governing Body</u>

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

  - The Finance, QIPP (Quality, Innovation, Productivity and Prevention) and Contracting Report
  - Quality and Safety Report and Dashboard
  - Performance Report
  - High Level Risk Log and Report.

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

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

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

The Governing Body receives regular reports from the Finance and Performance, and Quality Committees regarding performance, financial and contractual matters as set out above. A separate QIPP report together including the dashboard and RAG rating is presented on a monthly basis to the Finance and Performance Committee ensuring robust performance management of the projects to deliver the QIPP targets.

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

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

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

Capacity to Handle Risk

The CCG takes the identification and management of risks extremely seriously. As Chief Officer I am supported by the Senior Management Team in ensuring that we have a positive and open approach to the identification and management of risk.

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. Guidance for Users of the Risk Register System was updated and issued during 2014-15.

We are supported in the management of risks by the Yorkshire & Humber Commissioning Support (YHCS) Governance & Risk team. YHCS provides expert advice on the use of the risk management system; identifies good practice from elsewhere and provides support and guidance to staff on the identification of risks and associated controls and assurances

Throughout the year we have reviewed the way that we record and report on risk. As part of this:

- A standard approach to risk articulation has been introduced ("there is a risk of….due to… resulting in"), which allows clear identification of the risk, its causes and its impacts and applies to both the Corporate Risk Register and the Assurance Framework.
- A Corporate Risk Register Dashboard has been introduced at CCG and Finance & Performance / Quality Committee levels. This includes: comparative data on the number of risks and average risk score, details of risks with static scores or descriptions and a pictorial overview of current risk exposure.
- Risk categories have been identified and allocated to risks on the Corporate Risk Register to allow improved thematic analysis and reporting of risk.

Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance

information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

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

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

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

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

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

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

- **Auditors**, external and internal auditors provide 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.

- **Third Party Assurance.** Alongside the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as NHS Shared Business Services, Yorkshire & Humber Commissioning Support and Calderdale & Huddersfield NHS Foundation Trust (provider of payroll services). At the time of writing no significant issues have been reported although the formal assurance reports have not been received as yet.

During the year no significant internal control issues were raised.

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

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

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

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

Data Quality

The quality of data being presented to the Committees and the Governing Body has developed well over the year. Both the Committees and the Governing Body receive reports which provide substantial, informative and detailed analysis across a range of areas within finance, contracting, performance, quality and patient experience. Themed reports enable the Governing Body and Committees to understand at a much more detailed level some of the areas of challenge on performance related to the resilience of the urgent care system overall and in Delayed Transfer of Care. The Contracting report has continued to develop enabling a better understanding of the areas requiring a greater focus.

Throughout the year the Quality Committee has reviewed its activities in relation to information it needs to consider and has improved the way in which it reports that information enabling a greater level of understanding and scrutiny. The Quality Dashboard has evolved and as more information is added, additional tabs have been developed. Examples include:

- Separate reporting of the Friends and Family Test information as more providers are now reporting this information.
- Care Quality Commission reports presented as a separate tab on the dashboard.
- Presentation of the Combined Patient Experience report in the form of a separate dashboard with information and recommendations for improvement included for each provider on an individual page.

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

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

Business Critical Models

In the Macpherson report 'Review of Quality Assurance of Government Analytical Models', published in March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance framework is in place and is used for all business critical models. Business critical models were deemed to be analytical models that informed government policy. The CCG can confirm that in 2014/15 it has not developed any analytical models which have informed government policy.

Data Security

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

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

Discharge of Statutory Functions

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

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

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

Conclusion

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

Dr Matt Walsh, Accountable Officer,

27th May 2015

Appendix 1

Governing Body and Sub-Committees

Membership and Attendance (1 April 2014 – 22nd May 2015)

Governing Body		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair and GP member [7]	9/10
Dr Matt Walsh	Chief Officer (Accountable Officer)	8/10
Julie Lawreniuk	Chief Finance Officer	10/10
David Longstaff	Lay Member and Deputy Chair	10/10
Dr Steven Cleasby	Assistant Clinical Chair and GP member	9/10
Dr Majid Azeb	GP Member	9/10
Dr Hazel Carsley	GP Member	9/10
Dr Peter Davies	GP Member (left the Governing Body 31.8.14)	4/4
Dr John Taylor	GP Member	9/10
Dr Nigel Taylor	GP Member	7/10
Dr Caroline Taylor	GP Member (joined the Governing Body 1.11.14)	3/4
Kate Smyth	Lay Member (patient and public involvement)	10/10
Jackie Bird	Registered Nurse	8/10
Dr Sanjay Suri	Secondary Care Specialist (left the Governing Body 9.5.14)	0/1
Dr Rajesh Phatak	Secondary Care Specialist (joined the Governing Body 12.2.15)	3/3
Advisors to the Governing Body		
John Mallalieu	Lay Advisor (finance, performance and external relations)	10/10

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

Penny Woodhead	Head of Quality	9/10
Paul Butcher	Director of Public Health (Calderdale MBC)	8/10
Bev Maybury	Director of Adult Health and Social Care Services (Calderdale MBC)	6/10
Finance and Performance Committee		
Member	**Role**	**Attendance**
Dr Alan Brook	Committee Chair (stood down from the committee 31.12.14)	8/9
Dr Matt Walsh	Chief Officer	11/13
Julie Lawreniuk	Chief Finance Officer	8/13
Dr John Taylor	GP Member (left the committee 31.3.15)	10/12
John Mallalieu	Lay Advisor (finance, performance and external relations)	11/13
Dr Nigel Taylor	Committee Chair (joined the committee 1.1.15)	4/4
Dr Caroline Taylor	GP Member (in an observational capacity from 1.1.15 to 31.3.15)	4/4
Kate Smyth	Lay member (PPI) deputy for lay advisor	2/2
Quality Committee		
Member	**Role**	**Attendance**
Dr Steven Cleasby	Committee Chair (stood down from the committee 31.12.14)	6/9
Dr Majid Azeb	Chair and Governing Body member (joined the committee 1.1.15)	4/4
Dr Nigel Taylor	Governing Body member (stood down from the committee 31.1.15)	9/10
Kate Smyth	Lay member	13/13
Penny Woodhead	Head of Quality	12/13
Dr John Taylor	Governing Body Member (joined the committee 1.4.15)	1/1
Audit Committee		
Member	**Role**	**Attendance**
David Longstaff	Lay member and Chair	9/9
John Mallalieu	Lay advisor	9/9

Kate Smyth	Lay member	9/9
Dr Peter Davies	GP member (left the Governing Body 31.8.14)	1/3
Dr Majid Azeb	GP member (stood down from the committee 31.12.14)	4/5
Dr Hazel Carsley	Deputy GP member	2/2
Jackie Bird	Registered Nurse	6/9
Dr Steven Cleasby	GP member (1.1.15 – present)	4/4

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Appendix 2

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS CALDERDALE CCG FOR THE YEAR ENDED 31 MARCH 2015

Roles and responsibilities

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

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

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

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

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

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My overall opinion is that;

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

The basis for forming my opinion is as follows:

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

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

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

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

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

Internal Audit work is planned using a Risk Based Approach. The Audit Committee approved the annual plan at the start of 2014/15. This plan took into consideration the changing risk profile of the CCG. Further, the plan is derived from a combination of the risks highlighted in the Assurance Framework and from a separate Internal Audit and management assessment. This ensures that an audit plan is developed that is targeted towards the areas of greatest risk and allows Internal Audit to discharge its duties effectively.

In summary the Internal Audit reports issued in the year have generated the "significant assurance" opinion highlighted on the previous page. There have been no reports issued during the year with a "limited" or "no" assurance opinion.

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

NIGEL BELL, HEAD OF AUDIT
March 2015

Calderdale
Clinical Commissioning Group

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2014-2015

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2015 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 2014-15

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Calderdale Clinical Commissioning Group - Annual Accounts 2014-15

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	2,834	2,696
Operating Expenses	5	269,032	262,807
Other operating revenue	2	(2,949)	(3,542)
Net operating expenditure before interest		**268,917**	**261,961**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**268,917**	**261,961**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**268,917**	**261,961**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,047	2,101
Operating Expenses	5	3,287	3,661
Other operating revenue	2	(293)	(588)
Net administration costs before interest		**5,041**	**5,174**
Programme Income and Expenditure			
Employee benefits	4.1.1	787	595
Operating Expenses	5	265,745	259,146
Other operating revenue	2	(2,656)	(2,954)
Net programme expenditure before interest		**263,876**	**256,787**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**268,917**	**261,961**

Calderdale Clinical Commissioning Group - Annual Accounts 2014-15

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	597	631
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**597**	631
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	827	444
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	14	11
Total current assets		**841**	455
Non-current assets held for sale	21	0	0
Total current assets		**841**	455
Total assets		**1,438**	1,086
Current liabilities			
Trade and other payables	23	(14,916)	(15,871)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Bank Overdraft	26	(305)	0
Provisions	30	0	0
Total current liabilities		**(15,221)**	(15,871)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(13,783)**	(14,785)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(13,783)**	(14,785)
Financed by Taxpayers' Equity			
General fund		(13,783)	(14,785)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(13,783)**	(14,785)

The notes on pages 5 to 31 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit Committee on 21st May 2015 and signed on its behalf by:

Chief Accountable Officer
Dr.Matt Walsh

Calderdale Clinical Commissioning Group - Annual Accounts 2014-15

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(14,785)	0	0	**(14,785)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(14,785)**	**0**	**0**	**(14,785)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(268,917)	0	0	(268,917)
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 Yea	**(268,917)**	**0**	**0**	**(268,917)**
Net funding	269,919	0	0	269,919
Balance at 31 March 2015	**(13,783)**	**0**	**0**	**(13,783)**

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

Calderdale Clinical Commissioning Group - Annual Accounts 2014-15

Statement of Cash Flows for the year ended 31 March 2015

	Note	**2014-15 £000**	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(268,917)	(261,961)
Depreciation and amortisation	5	97	84
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in borrowings		(305)	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(383)	(444)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(713)	15,871
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		**(270,221)**	(246,450)
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
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		**(270,221)**	(246,450)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		269,919	246,461
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**269,919**	246,461
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(302)**	11
Cash & Cash Equivalents at the Beginning of the Financial Year		**11**	0
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		**(291)**	11

Cash and cash Equivalents total comprises the Bank balance as at 31st March 2015 of £14K less £305K of payments made which did not clear The bank until after 1st April 2015. this is acceptable and merely reflects a timing difference in the drawdown process and the cash being available in the bank.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies’ own returns is removed. Under the provisions of IFRS 10: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ accounts.

1.6 Pooled Budgets

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 *Critical Judgements in Applying Accounting Policies*

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

1.7.2 Key Sources of Estimation Uncertainty

The CCG has made no key estimations during the period.

Notes to the financial statements

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.11.2 **Valuation**

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

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

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

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

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

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

1.11.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.14 **Donated Assets**

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 **Government Grants**

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

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

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

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

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

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

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

1.17 **Leases**

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

Notes to the financial statements

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

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

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

1.18 **Private Finance Initiative Transactions**

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

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

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 **Services Received**

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

1.18.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **PFI Liability**

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

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

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

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

1.18.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

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

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

1.19 **Inventories**

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Notes to the financial statements

1.20 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.21 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning

1.26 **Contingencies**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group’s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

1.27.4 **Loans & Receivables**

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

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

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

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

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

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

1.28 **Financial Liabilities**

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

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

1.28.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

1.3 **Foreign Currencies**

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

Notes to the financial statements

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

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

1.33 **Subsidiaries**
Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

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

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

1.37 **Research & Development**

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

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

2 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Recoveries in respect of employee benefits	172	172	0	218
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,670	90	2,580	3,133
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	107	31	76	191
Total other operating revenue	**2,949**	**293**	**2,656**	**3,542**

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

3 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	2,949	293	2,656	3,542
From sale of goods	0	0	0	0
Total	**2,949**	**293**	**2,656**	**3,542**

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

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,472	1,691	781	1,782	1,215	567	690	476	214
Social security costs	148	146	2	112	111	1	36	35	1
Employer Contributions to NHS Pension scheme	214	211	3	153	151	2	61	60	1
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,834**	**2,048**	**786**	**2,047**	**1,477**	**570**	**787**	**571**	**216**
Less recoveries in respect of employee benefits (note 4.1.2)	(172)	(172)	0	(172)	(172)	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,662**	**1,876**	**786**	**1,875**	**1,305**	**570**	**787**	**571**	**216**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,662**	**1,876**	**786**	**1,875**	**1,305**	**570**	**787**	**571**	**216**

2013-14	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,361	1,593	768	1,828	1,289	539	533	304	229
Social security costs	137	137	0	115	114	0	23	23	0
Employer Contributions to NHS Pension scheme	198	198	0	159	159	0	39	39	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,696**	**1,928**	**768**	**2,101**	**1,563**	**539**	**595**	**366**	**229**
Less recoveries in respect of employee benefits (note 4.1.2)	(218)	(218)	0	(217)	(217)	0	(1)	(1)	0
Total - Net admin employee benefits including capitalised costs	**2,478**	**1,710**	**768**	**1,884**	**1,345**	**539**	**594**	**365**	**229**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,478**	**1,710**	**768**	**1,884**	**1,345**	**539**	**594**	**365**	**229**

4.1.2 Recoveries in respect of employee benefits

	2014-15			2013-14		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits - Revenue						
Salaries and wages	(138)	(138)	0	(183)	(183)	0
Social security costs	(15)	(15)	0	(15)	(15)	0
Employer contributions to the NHS Pension Scheme	(19)	(19)	0	(20)	(20)	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Total recoveries in respect of employee benefits	**(172)**	**(172)**	**0**	**(218)**	**(218)**	**0**

4.2 Average number of people employed

	2014-15 Total Number	2014-15 Permanently employed Number	2014-15 Other Number	2013-14 Total Number
Total	52	52	0	51
Of the above: **Number of whole time equivalent people engaged on capital projects**	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	76	80
Total Staff Years	41	40
Average working Days Lost	**1.8**	**2**

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

The staff sickness absence statistics relate to the calendar year (January to December 2014).

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

4.4 Exit packages agreed in the financial year

There were no exit packages agreed by Calderdale CCG in 2013/14 & 2014/15.

4.6 Severance Payments agreed in the financial year

There were no severance payments agreed by Calderdale CCG in 2013/14 & 2014/15.

4.5 Pension costs

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

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

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting data by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.3 Scheme Provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

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5. Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	2,516	1,729	787	2,399
Executive governing body members	318	318	0	297
Total gross employee benefits	**2,834**	**2,047**	**787**	**2,696**
Other costs				
Services from other CCGs and NHS England	3,899	1,612	2,287	3,838
Services from foundation trusts ***1**	164,075	39	164,036	161,200
Services from other NHS trusts	18,367	2	18,365	16,708
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	43,399	0	43,399	43,307
Chair and Non Executive Members	371	371	0	335
Supplies and services – clinical	0	0	0	0
Supplies and services – general	74	74	0	11
Consultancy services	0	0	0	109
Establishment	255	144	111	162
Transport	0	0	0	0
Premises	1,767	500	1,267	1,460
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	97	97	0	84
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	78	78	0	86
Other non statutory audit expenditure				
· Internal audit services ***1**	0	0	0	43
· Other services	0	0	0	10
General dental services and personal dental services	0	0	0	0
Prescribing costs	34,346	0	34,346	34,015
Pharmaceutical services	0	0	0	0
General ophthalmic services	84	0	84	105
GPMS/APMS and PCTMS	1,742	320	1,422	1,239
Other professional fees excl. audit	32	32	0	36
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	59	18	41	59
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
CHC Risk Pool contributions	387	0	387	0
Total other costs	**269,032**	**3,287**	**265,745**	**262,807**
Total operating expenses	**271,866**	**5,334**	**266,532**	**265,503**

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 are included in Services from Foundation Trusts for 2014/15.

6.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,001	49,752	8,088	40,623
Total Non-NHS Trade Invoices paid within target	9,988	49,511	8,038	39,001
Percentage of Non-NHS Trade invoices paid within target	**99.87%**	**99.52%**	**99.38%**	**96.01%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,505	187,273	1,854	181,000
Total NHS Trade Invoices Paid within target	2,352	186,576	1,700	176,871
Percentage of NHS Trade Invoices paid within target	**93.89%**	**99.63%**	**91.69%**	**97.72%**

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2014-15 £000**	2013-14 £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 has no investment revenue during the period.

9. Other gains and losses

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

10. Finance costs

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

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

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

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land	Buildings	Other	2014-15 Total	2013-14 Total
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments	0	1,358	0	**1,358**	1,131
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**1,358**	**0**	**1,358**	**1,131**

The lease payments above include £654K for NHS Property Services, in 20013/14 the equivalent amount was £602k.

12.1.2 Future minimum lease payments

	Land	Buildings	Other	2014-15 Total	2013-14 Total
	£000	£000	£000	£000	£000
Payable:					
No later than one year	0	876	0	**876**	704
Between one and five years	0	3,072	0	**3,072**	2,814
After five years	0	6,803	0	**6,803**	7,506
Total	**0**	**10,751**	**0**	**10,751**	**11,024**

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

2014-15	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 1 April 2014	0	0	0	0	0	0	64	651	715
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	14	49	63
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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**78**	**700**	**778**
Depreciation 1 April 2014	0	0	0	0	0	0	28	56	84
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	20	76	96
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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**48**	**132**	**180**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**30**	**567**	**597**
Purchased	0	0	0	0	0	0	30	567	597
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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**30**	**567**	**597**
Asset financing:									
Owned	0	0	0	0	0	0	30	567	597
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 2015	**0**	**0**	**0**	**0**	**0**	**0**	**30**	**567**	**597**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment - 2013/14

2013 14	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 1 April 2013	0	0	0	0	0	0	64	651	715
Addition of assets under construction and payments on account									0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**64**	**651**	**715**
Depreciation at 1 April 2013	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	28	56	84
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**56**	**84**
Net Book Value at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**
Purchased	0	0	0	0	0	0	36	595	631
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**
Asset financing:									
Owned	0	0	0	0	0	0	36	595	631
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**36**	**595**	**631**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2013	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group do not have assets under construction.

13.2 Donated assets

The Clinical Commissioning Group do not have Donated Assets.

13.3 Government granted assets

The Clinical Commissioning Group do not have Government granted assets.

13.4 Property revaluation

The Clinical Commissioning Group do not have any properties.

13.5 Compensation from third parties

Not applicable to Calderdale 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:

	2014-15	2013-14
	£000	£000
Information technology	11	7
Furniture & fittings	24	0
Total	**35**	**7**

13.9 Economic lives

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

14 Intangible non-current assets

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

14.1 Donated assets

The Clinical Commissioning Group do not have Donated Assets.

14.2 Government granted assets

The Clinical Commissioning Group do not have Government granted assets.

14.3 Revaluation

The Clinical Commissioning Group 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 depreciated 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 had no investment property at 31 March 2015.

16 Inventories

The Clinical Commissioning Group had no inventories at 31 March 2015.

17 Trade and other receivables

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	266	0	186	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	164	0	0	0
Non-NHS receivables: Revenue	38	0	24	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	320	0	208	0
Provision for the impairment of receivables	0	0	0	0
VAT	39	0	26	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**827**	**0**	**444**	**0**
Total current and non current	**827**		**444**	
Included above:				
Prepaid pensions contributions	**0**		**0**	

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

17.1 Receivables past their due date but not impaired

	2014-15 £000	2013-14 £000
By up to three months	303	33
By three to six months	0	6
By more than six months	1	0
Total	**304**	**39**

£206K of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2015.

17.2 Provision for impairment of receivables

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2015	**0**	**0**

18 Other financial assets

18.1 Current

The Clinical Commissioning Group have no current assets as at 31 March 2015.

18.2 Non-current

The Clinical Commissioning Group have no non-current assets as at 31 March 2015.

18.3 Non-current : capital analysis

The Clinical Commissioning Group have no non-current capital analysis as at 31 March 2015.

19 Other Current assets

The Clinical Commissioning Group have no other current assets as at 31 March 2015.

20 Cash and cash equivalents

	2014-15	2013-14
	£000	£000
Balance at 1 April 2014	11	0
Net change in year	(302)	11
Balance at 31 March 2015	**(291)**	**11**
Made up of:		
Cash with the Government Banking Service	14	11
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**14**	**11**
Bank overdraft: Government Banking Service	(305)	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**(305)**	**0**
Balance at 31 March 2015	**(291)**	**11**

The Clinical Commissioning Group has a bank overdraft as at 31 March 2015 (£291K) which are the payments made after 27 March 2015. This is derived from £14k cash in the bank and £305k overdrawn balance in another account. The payments were made to meet contractual commitments which are included in the cash book and ledger but will not clear until 1 April 2015.
This has resulted in the CCG having a credit ledger cash position which is acceptable and only reflects a timing difference in the drawdown process and cash being made available in the bank.
This is acceptable within NHSE guidance.

21 Non-current assets held for sale

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

22 Analysis of impairments and reversals

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

23 Trade and other payables	Current 2014-15 £000	Non-current 2014-15 £000	Restated Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,280	0	3,117	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	2,779	0	2,368	0
Non-NHS payables: revenue	5,021	0	4,715 *	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	5,599	0	5,521 *	0
Social security costs	0	0	0	0
VAT	0	0	0	0
Tax	0	0	0	0
Payments received on account	0	0	0	0
Other payables	237	0	150	0
Total Trade & Other Payables	**14,916**	**0**	**15,871**	**0**
Total payables (current and non-current)	**14,916**		**15,871**	

The CCG has no liabilities for early retirement.

Other payables include £5K outstanding pension contributions at 31 March 2015.

* The 2013/14 figures have been reclassified between categories in line with changes to NHS England guidance but the overall value for 2013/14 has remained unchanged.

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31 March 2015.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31 March 2015.

26 Bank Overdraft

The Clinical Commissioning Group has a bank overdraft as at 31 March 2015 (£291K) which are the payments made after 27 March 2015. This is derived from £14k cash in the bank and £305k overdrawn balance in another account. The payments were made to meet contractual commitments which are included in the cash book and ledger but will not clear until 1 April 2015.
This has resulted in the CCG having a credit ledger cash position which is acceptable and only reflects a timing difference in the drawdown process and cash being made available in the bank.
This is acceptable within NHSE guidance.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group has no private finance initiative, LIFT or other service concession arrangements as at 31 March 2015.

28 Finance lease obligations

The Clinical Commissioning Group has no finance lease obligations as at 31 March 2015.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31 March 2015.

30 Provisions

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	0	0	0	0
Other	0	0	0	0
Total current and non-current	0	0	0	0

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However , the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £2,425,000. (2013/14 £2,480,000).

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

31 Contingencies

The Clinical Commissioning Group do not have any Contingencies.

	2014-15 £000	2013-14 £000
Contingent liabilities		
Equal Pay	0	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	0	0
Contingent assets		
Amounts recoverable against contingent assets	0	0
Net value of contingent assets	0	0

32 Commitments

32.1 Capital commitments

	2014-15 £000	2013-14 £000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

32.2 Other financial commitments

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

	2014-15 £000	2013-14 £000
In not more than one year	0	0
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**0**	**0**

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0	0	0	0	0
Receivables:								
· NHS	0	266	0	266	0	186	0	186
· Non-NHS	0	38	0	38	0	24	0	24
Cash at bank and in hand	0	14	0	14	0	11	0	11
Other financial assets	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**318**	**0**	**318**	**0**	**221**	**0**	**221**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0	0	0
Payables:						
· NHS	0	4,059	4,059	0	5,485	5,485
· Non-NHS	0	10,858	10,858	0	10,236	10,236
Private finance initiative, LIFT and finance lease obligations	0	0	0	0	0	0
Other bank overdraft	0	305	305	0	0	0
Other financial liabilities	0	0	0	0	0	0
Total at 31 March 2015	**0**	**15,222**	**15,222**	**0**	**15,721**	**15,721**

33.4 Maturity of financial liabilities

	Payable to DH 2014-15 £000	Payables to Other Bodies 2014-15 £000	Total 2014-15 £000	Payable to DH 2013-14 £000	Payables to Other Bodies 2013-14 £000	Total 2013-14 £000
In one year or less	0	15,222	15,222	0	15,721	15,721
In more than one year but not more than two years	0	0	0	0	0	0
In more than two years but not more than five years	0	0	0	0	0	0
In more than five years	0	0	0	0	0	0
Total CCG at 31 March 2015	0	15,222	15,222	**0**	**15,721**	**15,721**

33.5 CCG's exposure to risk

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

34 Operating segments

The Clinical Commissioning Group and consolidated group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2014-15 £'000	2013-14 £'000
Total net expenditure reported for operating segments	268,917	261,961
Reconciling items:		
Total net expenditure per the Statement of Comprehensive Net Expenditure	268,917	261,961

34.2 Reconciliation between Operating Assets and SoFP

	2014-15 £'000	2013-14 £'000
Total assets reported for operating segments	1,438	1,086
Reconciling items:		
Total assets per the Statement of Financial Position	1,438	1,086

34.3 Reconciliation between Operating Liabilities and SoFP

	2014-15 £'000	2013-14 £'000
Total liabilities reported for operating segments	(15,222)	(15,871)
Reconciling items:		
Total liabilities per Statement of Financial Position	(15,222)	(15,871)

35 Pooled budgets

The Clinical Commissioning Group and consolidated group were not party to any pooled budget arrangements during 2014-15.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Intra-government and other balances

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	0	0	51	0
· Local Authorities	0	0	176	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	316	0	151	0
· NHS Trusts and Foundation Trusts	114	0	3,905	0
Total of balances with NHS bodies:	**430**	**0**	**4,283**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	397	0	10,633	0
Total balances at 31 March 2015	**827**	**0**	**14,916**	**0**

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

38 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health. During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practise for which Governing Body members have a relationship have been disclosed below. The amounts cover enhanced services and personal remuneration to GP's who are Governing Body members.

Payments to Practices of Governing Body members :

	2014-15				2013-14			
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000	£000	£000	£000	£000
GOVERNING BODY MEMBERS :								
Longroyde Surgery (Dr Alan Brook)	40	0	0	0	87	0	12	0
Spring Hall Group Practice (Dr Steven Cleasby)	164	0	4	0	134	0	33	0
The Boulevard Medical Practice (Dr Hazel Carsley)	147	0	0	0	110	0	31	0
King Cross Practice (Dr John Taylor)	93	0	0	0	110	0	31	0
Keighley Road Surgery (Dr Peter Davies)	120	0	1	0	93	0	35	0
Southowram Surgery (Dr Majid Azeb)	46	0	0	0	53	0	9	0
Hebden Bridge Group Practice (Dr Nigel Taylor)	17	0	0	0	188	0	69	0
Beechwood Medical Centre (Dr Caroline Taylor)	279	0	2	0	0	0	0	0

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

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

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

In addition the executive Governing Body members have relatives with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Pennine Acute NHST.
And material transactions are detailed below :

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

	2014/15	2013/14
	£000	£000
Calderdale and Huddersfield NHSFT	138,639	137,684
South West Yorkshire Partnership NHSFT	19,693	18,475
Yorkshire Ambulance NHS Trust	11,070	9,340
Leeds Teachings Hospitals NHST	5,049	4,726
Bradford Teachings Hospitals NHSFT	3,665	3,874
CSU	2,150	2,038
Pennine Acute NHST	674	630
East Lancashire Hospital NHS Trust	645	633
Mid Yorkshire Hospitals NHS Trust	455	586
NHS Greater Huddersfield CCG	185	1,783

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

	2014/15	2013/14
	£000	£000
Calderdale MBC	10,529	9,849

39 Events after the end of the reporting period

From 1st April 2015, Calderdale CCG has been delegated responsibility for commissioning Primary Medical Services from NHS England.
The expected budget to be delegated is approximately £26M. On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Metropolitan Borough Council in relation to the Better Care Fund.
Calderdale CCG's contribution to the pooled budget is £13.8M.

40 Losses and special payments

The Clinical Commissioning Group has no losses or special payments.

41 Third party assets

The Clinical Commissioning Group held no cash and cash equivalents which relate to monies held by the Clinical Commissioning Group.

42 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:

	2014-15 Target	2014-15 Performance	2013-14 Target	2013-14 Performance	Duty Achieved
Expenditure not to exceed income	279,436	271,866	270,473	265,503	**Yes**
Capital resource use does not exceed the amount specified in Directions	63	63	0	0	**Yes**
Revenue resource use does not exceed the amount specified in Directions	276,487	268,917	266,931	261,961	**Yes**
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	63	63	0	0	**Yes**
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	5,828	5,041	5,190	5,174	**Yes**

The CCG received revenue resource allocation totalling £276,487K and had net expenditure of £268,917K delivering an agreed surplus of £7,570K.

43 Impact of IFRS

Not applicable to Calderdale Commissioning Group.

44 Analysis of charitable reserves

Not applicable to Calderdale Commissioning Group.