NHS
Calderdale
Clinical Commissioning Group

# Annual Report 2015-16


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## OUR LOGO EMBRACES ALL OUR VALUES

**LONG LIFE**
Preventing people from dying prematurely

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

**INDEPENDENCE**
Helping people to recover and maintain their independence

**CARE**
Ensuring people have a positive experience of care

**PROTECTION**
Ensuring a safe environment and protecting people from harm

**EQUALITY**
Reducing inequalities

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

The Annual Report and Accounts consists of three sections:

1) The Performance Report:

2) The Accountability Report, which consists of:

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

3) 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 2015/16 for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on 19 May 2016 under delegated authority from the Governing Body.

Dr Matt Walsh

Accountable Officer, 26th May 2016

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# Glossary

| | |
|---|---|
| APMS | Alternative Providers of Medical Services |
| AQP | Any Qualified Provider |
| ASCOF | Adult Social Care Outcomes Framework |
| 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 |
| CQC | Care Quality Commission |
| CQuIN | Commissioning for Quality and Innovation |
| DoLS | Deprivation of Liberty Safeguards |
| FFT | Friends and Family Test |
| GMS | General Medical Services |
| GH CCG | NHS Greater Huddersfield Clinical Commissioning Group |
| HCAI | Health Care Acquired Infections |
| HMRC | Her Majesty's Revenue and Customs |
| HPMO | High Performing Membership Organisation |
| HWB | Health and Wellbeing Board |
| LTC | Long Term Condition |
| MCA | Mental Capacity Act |
| NHSE | NHS England |
| NK CCG | North Kirklees Clinical Commissioning Group |
| NICE | National Institute of Clinical Excellence |
| PDR | Performance and Development Review |
| PMS | Primary Medical Services |
| 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 |
| STP | Sustainability and Transformation Plan |
| SWYPFT | South West Yorkshire Partnership NHS Foundation Trust |
| VCSE | Voluntary, Community and Social Enterprise organisations |
| VSM | Very Senior Manager |
| VAC | Voluntary Action Calderdale |
| W CCG | NHS Wakefield Clinical Commissioning Group |
| YPHO | Yorkshire Public Health Observatory |

# Introduction to the Annual Report

Welcome to our third annual report as a Clinical Commissioning Group. 2015-16 has been a full year in which we have made great strides towards achieving our commissioning priorities.

This annual report highlights some of the fantastic work that our staff, the Governing Body and member practices have carried out with partners across Calderdale during the year. This work is all about keeping people safe, improving quality outcomes and patient experience as well achieving more efficient ways of working.

The aim has always been to transform the way in which our system currently operates so that there is a greater focus on the prevention of ill health and empowerment of local people, supporting individuals to manage their own health and wellbeing and improving access to integrated community, social and primary care services that are connected by effective pathways into acute settings. The Care Closer to Home and the Hospital Services Change Programmes represent two of our most significant areas of activity throughout the year.

In August 2015 we reached an important milestone. The previous year we had made a commitment to strengthen existing community services before looking at hospital services change. In August the Governing Body, having reviewed the evidence; concluded that they were confident that community services were being strengthened in line with the commitment made by the CCG the previous year. In January 2016, we met in parallel with Greater Huddersfield CCG to consider whether we were ready to go out to consultation on hospital services change. The pre-consultation business case, which was presented to the Governing Bodies at that meeting, contained the options for future models of care for hospital services.

The CCG, together with Greater Huddersfield CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) are now in a period of formal consultation which is due to end on the 21st June 2016.

Throughout the year, there has been an unremitting focus upon the delivery of key performance targets and key financial and contractual requirements. We have delivered our statutory financial duties and we have achieved, with the support of the system, the majority of the NHS Constitutional Standards. We reported last year that there had been exceptional pressure on the urgent care system. That pressure has continued unabated and whilst the position is not unusual when compared with other systems locally and nationally, our determination to commission a better service for Calderdale is not reduced.

Our partnership working has also moved on apace this year with the establishment of the Vanguard Partnership which consists of the newly formed Pennine GP Alliance, CHFT, South West Yorkshire Partnership NHS Foundation Trust, Voluntary Action Calderdale, Calderdale Council and Locala Community Partnerships CiC. We continue to work closely on an integrated approach health and social care commissioning with Calderdale Council and with

our CCG colleagues across West Yorkshire and Harrogate. This partnership working is crucial to achieving a sustainable health and social care system as well achieving operational resilience now.

As you know the CCG is a membership organisation and we continue to have strong engagement from the 26 practices in Calderdale. The localities have worked on projects which have demonstrated real improvements for patients as a result of working differently, such as improving the referral into and uptake of pulmonary rehabilitation services.

2015/16 was the first year of delegated responsibility for commissioning primary medical services. We have used the opportunities provided by these responsibilities to begin to develop a new primary care strategy in partnership with the Local Medical Committee and the Pennine GP Alliance. We will continue to develop this approach as we move forward through 2016/17.

There has been a strong emphasis on improving staff health and wellbeing throughout the year as a result of the leadership and enthusiasm of our Staff Forum. They have been instrumental in staff uptake of a number of initiatives which we talk about in the sustainable development section of the annual report. Staff forum members have also worked hard to ensure that colleagues joining the CCG from the Commissioning Support Unit have been well supported.

The Governing Body continues to improve its effectiveness and in 2015/16 we commissioned KPMG to undertake an external review of our governance arrangements in order to identify any areas for development. They concluded that there were good governance arrangements in place with a strong and committed membership. Opportunities for improving our effectiveness were identified in order to release more capacity for strategy development and an increased focus on our clinical priorities. We will be continuing to develop our effectiveness in this area throughout 2016/17.

Finally we would like to take this opportunity to thank Dr Hazel Carsley who retired as a Governing Body member at the end of March and to Julie Lawreniuk, our Chief Finance Officer who will be joining Bradford CCG from the end of April.

Dr Alan Brook, Chair

Dr Matt Walsh, Chief Officer

# PERFORMANCE REPORT

## Chief Officer's Overview

### 1. Who we are

Calderdale CCG is a membership organisation consisting of 26 general practices that look after the health needs of the estimated 218,000 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. Purpose of the CCG

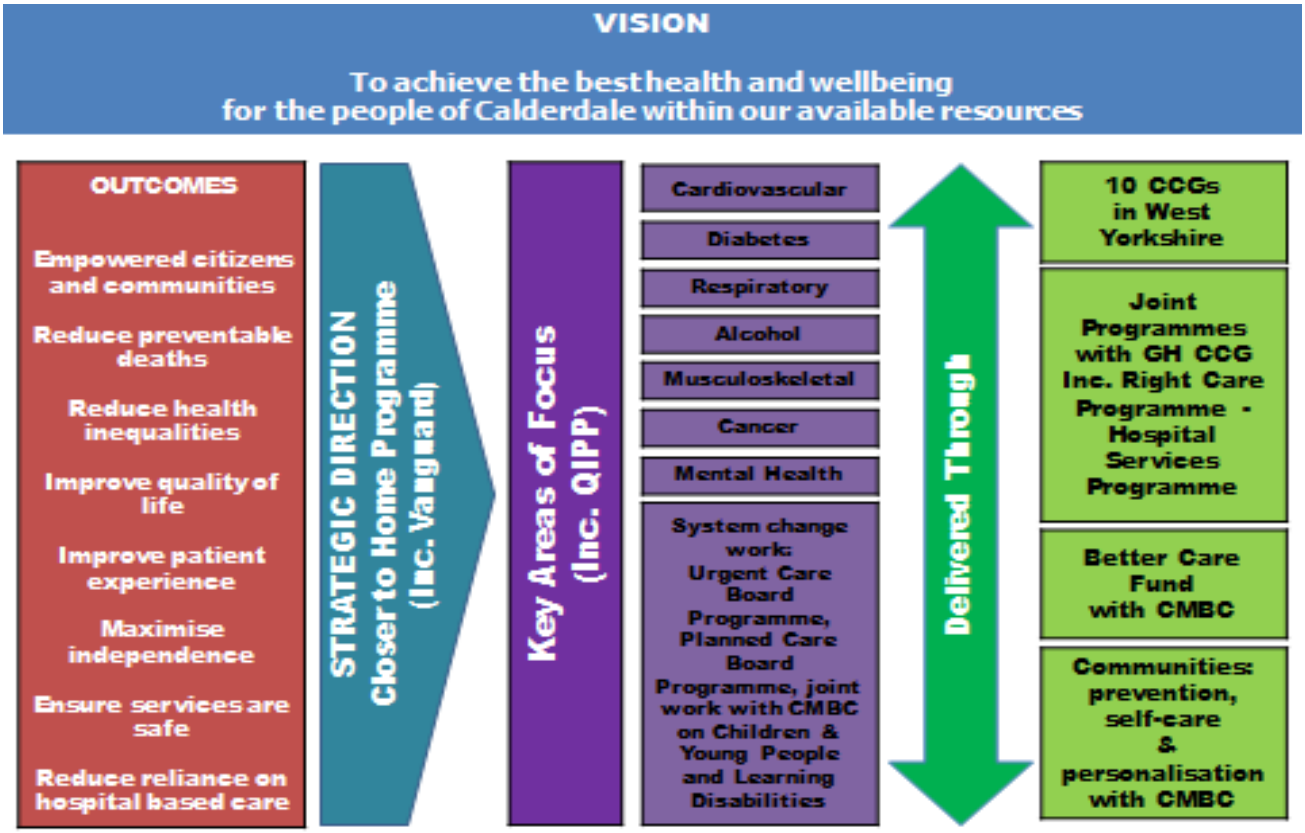
The purpose of the CCG is to improve the health and lives of people living and or registered with a GP practice in Calderdale. This is achieved by working to ensure that healthcare is available for anyone who needs it, ensure good quality care and keeping people safe, helping people to maintain a healthy lifestyle and working with the local authority to address health inequalities locally. This needs to be achieved by using all the available resources available.
We do this by working with Public Health colleagues at the local authority to assess local needs, by agreeing the priorities and developing strategies to deliver on those priorities and then buying services on behalf of the local population from providers such as hospitals, community health bodies, the independent and third sector and then by monitoring the quality and performance of those services. This is a continuous process and CCGs must constantly respond and adapt to changing local circumstances. As a CCG, we are responsible for the health of our entire population and are measured by how much we improve outcomes.
We are responsible for commissioning services such as urgent and emergency care, mental health services, elective (otherwise known as 'planned care') and community services.

### 3. Activities of the CCG in 2015 – 16

2015-16 has been a full and productive year and has seen the CCG make real progress towards achieving our commissioning priorities as set out in our 5 Year Strategic Plan (2014/15 – 2018/19) and in line with the 5 Year Forward View (NHS England). The focus of our change programme over the five years will shift the balance from avoidable hospital admissions to integrated health and social care models delivered in community and primary care settings.

The aim is to transform the way our system currently operates so that there is a greater focus on the prevention of ill health and empowerment of citizens who will be able to manage their health and wellbeing and be able to access integrated community, social and primary care services that are connected by effective pathways into acute settings. The vision set out in

the 5 Year Strategic Plan, together with the 7 clinical priorities being taken forward as part of the Care Closer to Home (CC2H programme are shown below. 2015-16 represented year two of our 5 year strategic plan, which can be found on (www.calderdaleccg.nhs.uk).




The following section a summary of the activity carried out in 2015-16 to transform the way that healthcare is provided for local people, keep people safe and to ensure system and financial resilience.

## 3.1 Strategic Transformation

In 2015-16 we have continued our transformation journey; developing new models of care – shifting from episodic unplanned hospital care to planned care based in community, social and primary care settings.

**Care Closer to Home**

We have continued to strengthen community services in line with our 5 Year Strategy, and awaiting the outcome of public consultation in order to confirm detailed plans for implementation of phase 2. During 15/16 our work on CC2H included:

**New Integrated Respiratory Service**

- Direct access to Specialist Respiratory Community Service.
- Supporting patients to manage their conditions.
- Reduces hospital admissions.
- Specialist in-reach to hospital wards facilitates earlier discharge home.
- 7 days a week during the winter

- The development of new community models of care for services traditionally provided in acute hospitals focusing on The 7 clinical priorities of Cardiovascular Disease, Diabetes, Respiratory, Alcohol related conditions, Musculoskeletal services, Cancer and Mental Health.

- The piloting of a new Multi-Community Provider (MCP) model of care for frail people living in or around Todmorden.

***COPD at Home/ Telehealth 24'*** **pilot (successful 2-year pilot)**

Tunstall telehealth systems are installed in the homes of 24 people with COPD to undertake daily readings of their vital signs. These are monitored by the CHFT Specialist Respiratory Nurses. The benefits are:

- Improving self-management/ reducing anxiety
- Enabling early intervention
- Preventing/ reducing hospital admissions/ length of stay
- Improving medication compliance
- Preventing future complications for those who haven't yet started to access extensive healthcare
- Supporting the COPD Specialist Nurses' workload


**Next steps:** An Assistive Technology procurement is now underway and the model will include the continuation and expansion of this service. The new model will include Telehealth monitoring technology to support Early Supported Discharge, and additional long-term conditions, for example; Heart Failure.

➢ **Better Care Fund**

Our CC2H and Better Care Fund (BCF) plans are aligned and we have continued to use BCF as a vehicle to develop integrated commissioning models with Calderdale Council.

We have also worked closely with partners on the Health and Wellbeing Board to develop the Local Transformation Plan (LTP) for Children and Young People's Emotional Health and Wellbeing.

This plan represents an integrated whole system approach to driving improvements in children and young people's emotional health and wellbeing outcomes, with all partner organisations working together and most importantly involving children and young people. The lead commissioner for the Local Transformation Plan (LTP) on behalf of Calderdale CCG and the Local Authority is the Head of Service Commissioning and Partnerships, Children and Young People's Service (CMBC). The development of the plan has attracted £389,755

funding from NHS England into Calderdale in support of the implementation of work in this vital area. £100k of the funding is ring fenced for work on improving services and support for children and young people with eating disorders.

- **Place based commissioning and developing primary care**

2015/16 was the first year of delegated responsibility for commissioning primary medical services (Also see the governance statement). We have used the opportunities provided by these responsibilities to begin to develop a new primary care strategy in partnership with the Local Medical Committee and the newly formed GP Alliance. We will continue to develop this approach as we move forward through 2016/17.

- **Transforming care**

One of our priorities is to ensure that the delivery of CC2H meets the needs of the most vulnerable of our residents including those people with learning disabilities (LD) and mental health needs. The CCG commissioned a new health pathway for people with a learning disability which was implemented during 2015/16. The new LD service aims to provide a flexible and responsive approach to support and advice for people's physical health and emotional wellbeing.

**Lead the Way** which provides information and advice for adults with learning disabilities, their families and carers in Calderdale was commissioned by the CCG in partnership with the Local Authority. This service continues to make a big difference through a range of initiatives including – coaching for healthy life styles, training with GPs to help them develop more accessible services for people with a learning disability and sports activities. These initiatives will underpin the future development of services in the community as part of the National Transforming Care agenda.

**Continuing Healthcare Hospital discharge Team (CHCDT)**

A team of 3 nurses, 2 social workers and an administrative support worker, overseen by a lead nurse and a social worker team leader was initially formed as a pilot with funding through the Better Care Fund. Throughout 2015/16 this team has become embedded as part of the discharge process within Calderdale and Huddersfield Foundation Trust (CHFT). As a result of the teams' experience and knowledge, those patients who met the eligibility criteria for continuing healthcare (CHC) and their families, now have a much more positive experience and a reduced length of stay in hospital. This has to be a positive outcome for all concerned.

**Personal Health Budgets (PHB)**

People eligible for CCG Continuing Healthcare funding are now entitled to ask for a personal health budget. 23 people have now taken this opportunity and report that it has made a positive difference to as part of the work under Vanguard.

➢ **Parity of Esteem**

We have continued to build on our work with partners supporting people with mental health problems. We have:

- Developed and begun to implement our local action plan to deliver the Crisis Care Concordat.
- Developed the new multi-agency Mental Health Innovation Hub and tested the mental health elements of all programmes for parity of esteem
- We have developed new links with third sector providers through the Mental Health Matters forum.

**Calderdale Mental Health Innovation Hub (i-Hub)**
The CCG has set up the i-Hub as a forum where organisations can work together and learn from each other. The i-Hub has representatives from the NHS, local authority and the voluntary sector and is focused on using people's experience of mental distress to improve the type of help

## 3.2 Hospital services change

In August 2015 we reached an important milestone. The previous year we had made a commitment to strengthen existing community services before looking at hospital services change. In August the Governing Body, having reviewed the evidence, concluded that they were confident that community services were being strengthened in line with the commitment made by the CCG the previous year[1].

Together with the Care Closer to Home programme, the hospital services change programme represents our most significant area of activity throughout 2015/16. The pre-consultation business case, which contained the options for future models of care for hospital services was completed in January 2016. The document was informed by:

- A full programme of engagement activity
- Work by Calderdale and Huddersfield NHS Foundation Trust (CHFT) with the regulator to demonstrate financial sustainability
- Work to achieve clinical consensus between the two CCGs and CHFT on the proposed outline future models of care for hospital services
- Development of a Quality Impact Assessment, Equality Impact Assessment and travel analysis which were submitted for assurance purposes to NHS England
- Continued engagement with the Joint Overview and Scrutiny Committee and the Calderdale MBC Scrutiny Committee as well as a sub group of the Calderdale People's Commission
- The submission on our engagement and consultation plans to the Consultation Institute and the provision of assurance to NHS England.

The CCG, together with Greater Huddersfield CCG and CHFT are now in a period of formal consultation which is due to end on the 21st June 2016.

[1] Report to the Calderdale CCG Governing Body, 13 August 2015, Care Closer to Home

## 3.3 Operational resilience

In order to tackle the additional pressure on NHS services over the winter period, all 26 practices in Calderdale committed to providing a total of additional 14,820 primary care appointments for patients. This doubled the capacity and number of appointments available to patients.

In our summary of performance later in this report we highlight the pressure that our local urgent and unplanned care system is experiencing which is being reflected across all systems nationally. A key priority over the year has been to ensure system resilience through the alignment of work across all our plans, across our local and wider footprints and in ensuring that our Surge and Escalation Plans, Winter Plans and emergency preparedness processes are fit for purpose.

The System Resilience Group is made up of a broad range of partners including the two CCGs, CHFT, Calderdale and Kirklees Councils, South West Yorkshire Partnership Foundation Trust, Locala Community Partnerships CiC and Healthwatch. Its role in holding the system to account has been strengthened; as have the roles of the Urgent Care Board and the Planned Care Boards in delivering capacity to meet demand and holding providers to account. The CCG has continued to closely monitor the delivery of the NHS Constitution targets – working to reduce variation in performance.

## 3.4 Quality

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

- Continued to ensure that the findings from Francis, Berwick and other significant quality reviews such as the Kirkup and Southern Health reports are at the centre of our business delivery
- Implemented a quality assurance process for third sector providers (Quality for Health) through joint working with Voluntary Action Calderdale
- Ensured that we are maximising opportunities to improve care for people with learning disabilities including a reduction for the need for inpatient care
- Continued to develop measures to monitor the impact of service reconfiguration and ensure that safety is maintained or improved as a result of the changes
- Continued to develop the dashboard of patient experience information from a range of sources

### ➢ Quality For Health (QFH)

The voluntary, community, and social enterprise sector (VCSE) is a major contributor of services in a marketplace that is becoming increasingly reliant on providers being able to evidence the delivery of high quality outcomes.

Quality For Health (QFH) is a new innovative quality assurance system for the VCSE, developed by Voluntary Action Calderdale and endorsed by Calderdale CCG. It is the only quality assurance system in the country designed to support VCSEs to demonstrate the quality of the outcomes of their health services through rigorous external assessment and is a vital tool in the supporting the VCSE to deliver local health services for local communities. The system measures outcomes based evidence across nine quality areas supported by a range of measurable indicators including Service user experience, effectiveness, equality and diversity, outcomes and impact.

The system links to national strategic and operational priorities; the three pillars of quality delivery - Patient Experience, Patient Safety, and Effectiveness - as identified in the NHS Five Year Forward View, the Care Quality Commission's (CQC) key lines of enquiry and the CCG assurance framework requirements. We continue to work with NHS England to ensure that QFH is recognised at a national strategic level.

49 Calderdale VCSEs have now signed up, with discussions being taken forward with a further 23 organisations.

- **Patient and Public Engagement and Experience**

Throughout the year we have engaged on a number of projects:

- Co-Commissioning in Primary Care
- Right Time, Right Care, Right Place: including urgent and emergency care, planned care, therapies and technology. Maternity and Paediatric services
- Care Closer to Home
- Ophthalmology
- Autism spectrum conditions (ASC)

- **Safeguarding**

We have continued to deliver a strong focus on safeguarding, ensuring that it is an integral part of our business. A key focus for us throughout the year has been in leading a whole system approach to the Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS). We have also continued to fulfil the role of joint chair with Calderdale Council on both the Adult Safeguarding and Children's Safeguarding Boards.

**Care Closer to Home (Vanguard) Upper Valley Pilot**

- Over 100 people attending our stakeholder engagement event in Todmorden told us they wanted to see:
- More services closer to home
- Transport networks including parking to be considered
- A model that reflects the diverse population
- To play a key role in developing & delivering services
- Work force to have the right skills and staffing
- A single point of access
- To continue being involved in decisions
- Improved communication and information
- Supported self-care and prevention

### 3.5 Healthy Futures

The Healthy Futures programme is a collaborative approach across the 10 West Yorkshire CCGs and Harrogate CCG to drive forward shared commissioning priorities across a wider footprint. Key areas of focus are Urgent & Emergency Care, Cancer, Mental Health and SCG. As we move forward through 2016/17 we will be developing the collaborative as a means of delivering the Sustainability and Transformation Plan (STP) for those services that would benefit from a shared approach across the wider footprint.

## 4. Key issues and risks

The issues and risks for the CCG focus on our ability to work with partners across the different footprints to deliver the level of transformational change required to ensure a safe and sustainable service. Some of the risks to this are that:

- The plans and proposed models of care do not ensure the sustainability of the system
- The proposals are not owned by key stakeholders and may damage to our reputation
- System financial sustainability is not deliverable
- Governance arrangements are insufficiently robust to effectively monitor progress and risks.

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

## 5. Summary of performance

There has been an unremitting focus upon the delivery of key performance targets and key financial and contractual requirements throughout the year by our Finance and Performance Committee and QIPP (Quality, Innovation, Productivity and Prevention) Group and I am pleased to be able to report that we have delivered our statutory financial duties and have achieved, with the support of partners across the system, the majority of the NHS Constitutional Standards. The areas of challenge on performance relate to the resilience of our urgent care system. We reported last year that there had been exceptional pressure on the urgent care system. That pressure has continued unabated. This has been mirrored nationally and it remains the case that the position for Calderdale has not been unusual when compared with other systems locally and nationally. Further to work last year on Delayed Transfers of Care (DTOC), the system is developing a much clearer view of flow into, through and out of the hospital. The CCG through the work of the Finance and Performance Committee is firmly sighted on this issue. The System resilience Group, which reports into the Finance and Performance Committee, is confronting these issues. Detailed clinical audits to provide a clearer understanding of key issues have been commenced. The Finance and Performance Committee has overseen additional investments into our system to support resilience over the year.

We have maintained a strong approach to the delivery of QIPP this year. The strength of

the CCGs financial position in 2015-16 reflects well upon the financial grip exerted by the CCG and the underpinning governance provided by this Committee. It is also worth noting that whilst the financial position of the CCG is reasonably healthy, that of our main acute provider has deteriorated over the year. The work of the Finance and Performance Committee has helped to oversee appropriate additional investments made into our local acute provider to support their position whilst delivering value to the system and benefits to service users.

## Performance analysis

### 1. Key performance indicators used by NHS Calderdale CCG.

Delivery against our priorities is measured by using the national key performance indicators as set out in the *Forward View Into Action: Planning for 2015/16* (NHS England). This ensures a consistent approach which can be benchmarked across the local healthcare system, regionally and nationally.

- **NHS Constitution rights and pledges: outcome measures (see appendix 1 for more detail)**

  - **Referral to treatment times** (maximum waiting times from referral to treatment for admitted, non-admitted and patients on incomplete non-emergency pathways)
  - **Waiting times for diagnostic tests** (should be less than 6 weeks from referral)
  - Accident and Emergency waiting time to be admitted, transferred or discharged.
  - **Cancer waiting times** (2 week waits, 31 days, 62 days)
  - **Category A, Ambulance response times**
  - **Mixed Sex Accommodation** – minimise the breaches
  - **Incidence of Health Care Acquired Infections** (HCAIs), number of MRSA reported infections, number of C.Dificile blood stream infections
  - **Cancellation of operations** (all patients who have operations cancelled on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days.
  - **Mental Health - Care Programme Approach (CPA)** – proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge.

Performance against the NHS Constitution rights and pledges is set out Appendix 1 to this performance report.

As stated in the summary to this report, the areas of challenge in 2015/16 have related to the resilience in the urgent care system. This has been recognised as a system wide issue and the mitigating actions summarised in this report reflect that system-wide approach:

| |
|---|
| Ensuring system resilience through the alignment of work across all our plans, across our local and wider footprints. |
| Ensuring that our Surge and Escalation Plans, Winter Plans and emergency preparedness processes are fit for purpose. |
| The System Resilience Group (SRG) invested £3.9m in winter schemes to support the system through periods of highest pressures. |
| Strengthening the role of the System Resilience Group (SRG) in holding the system to account and the roles of the Urgent Care Board and the Planned Care Boards in delivering capacity to meet demand and holding providers to account. |
| Roll out of the SRG action plan which includes action to reduce variation in the use of Accident & Emergency and unplanned admissions across GP practices, a focus on patient flow, development of new models of community urgent care reducing reliance on hospital services and improving access; the development of community services in priority areas such as Frailty and people with Cardiovascular Disease; Yorkshire Ambulance Service (YAS) avoidance models; work through the mental health alliance; work on capacity and demand modelling with Public Health colleagues. |
| All partner initiatives in areas such as ambulatory care, integrated discharge, work through the West Yorkshire Emergency and Urgent Care Network, Workforce. |
| Roll out of the action plan on Delayed Transfer of Care (DTOC). |
| Invited Emergency Care Improvement Team into the system to support the development of new solutions. |
| The CCG has continued to closely monitor the delivery of the NHS Constitution targets – working to reduce variation in performance. |

Please also see the risks classed as 'major' on the Corporate Risk Register, i.e. with a score of 16 or above (see the Governance Statement).

- **Quality Premiums**

The Quality Premium scheme is about rewarding CCGs for improvements in the quality of services they commission.

The Quality Premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in the previous year – was based on six measures that covered a combination of national and local priorities. These are:

- Reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality
- Improving access to psychological therapies
- Reducing avoidable emergency admissions
- Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting the roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator

- Improving the reporting of medication-related safety incidents based on a locally selected measure
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies.

The table below summarises the achievement in Calderdale.

| Measure | Percentage of quality premium | Potential value for CCG (£000's) | Achieved/not achieved | Eligible quality premium funding (£000's) |
|---|---|---|---|---|
| Preventing people from dying prematurely | 15% | £157 | N | £0 |
| Improving access to psychological therapies | 15% | £157 | Y | £157 |
| Avoidable emergency admissions | 25% | £262 | N | £0 |
| Friends and family test and patient experience | 15% | £157 | Y | £157 |
| Improved reporting of medication safety incidents | 15% | £157 | Y | £157 |
| Further local measure - Emergency admissions for alcohol related liver disease | 15% | £157 | Y | £157 |
| **TOTAL** | **100%** | **£1,047** | | **£628** |

| NHS Constitution rights and pledges | Measure achieved | Adjustment to funding | Quality premium funding (£000's) |
|---|---|---|---|
| Referral to treatment times (18 weeks) | Y | | |
| A&E waits (CHFT) | N | -25% | - £157 |
| Cancer waits – 14 days | Y | | |
| Category A Red 1 ambulance calls (YAS) | N | -25% | - £157 |
| **Total adjustment** | | | **- £314** |
| **NET TOTAL PAYABLE** | | | **£314** |

The total reward was £1,047m. Due to the challenges associated with reducing the Potential Years of Life Lost (PYLL) and reducing the volume of avoidable admissions, the eligible reward was £628k. Pressures associated with the urgent care system and delivery of the constitutional standards for A&E waits and ambulance response times saw the premium reduced by 50%. As a consequence, Calderdale received £314k for the Quality Premium in 2015/16.

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

The aim of QIPP is to improve quality whilst delivering efficiency savings. In 2015/16 we achieved £3.781m of QIPP savings – both cash and non-cash releasing. 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:

Alcohol, Cardiovascular Disease (CVD), Diabetes, Respiratory, Medicines Management, Musculo-skeletal (MSK) services, Mental Health (including Autism and Dementia), Cancer, Continuing Care (including Complex Discharge Team), End of Life (EOL).

**Improving care for local people:**


- In 2015/16 we were shortlisted for a Health Service Journal award for the work being carried out as part of **Quest for Quality in Care Homes**.

- **Diabetes** - The Level 3 diabetes services began on 1st December 2015 in the majority of GP practices. The service provides enhanced care and support for adults with diabetes stabilised on injectable therapies, some of whom previously received their care at the hospital.

- **Heart Failure and Atrial Fibrillation (AF)** - We have implemented pathways and guidance for heart failure and atrial fibrillation which align to NICE guidance and best practice.

- **Atrial Fibrillation –** Commissioning appropriate treatment for AF patients in primary care means that 257 patients (6% of patients with an AF diagnosis) are now on more appropriate anticoagulation treatment for their condition.

- In 2016/17 the focus will be on the following:

    - **Three key areas**: (a) Long Term Conditions (CVD/ Respiratory/ Mental Health & Learning Disabilities); (b) Frailty (including Quest) and (c) Children with Complex needs.
    - We will continue to realise additional efficiencies from our 'business as usual' activities which includes embedding and sustaining the work and investment made in 2015/16, for example in Diabetes, End of Life (EOL), and MSK/ Pain Management.
    - We will also continue with our transactional savings; particularly associated with Medicines Management and Continuing Care.

➢ **Better Care Fund**

The Better Care Fund is a national initiative to promote integrated out of hospital care. The CCG continues to work closely with Calderdale Council, ensuring that the Better Care Fund Plan for 2015/16 is fully aligned with the Care Closer to Home Programme. The Plan included schemes aimed at reducing avoidable emergency admissions to hospital and

permanent admissions to residential care. The plan also aimed to reduce delayed transfers of care (DTOC) and achieve improvements in rehabilitation outcomes.

The Better Care Fund has six metrics against which our performance is measured:

- Non-elective admissions in hospital (general and acute), all age
- Delayed transfers of care (delayed days) from hospital (age 18+)
- Permanent admissions of older people (65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

**Local Measures**

- Effectiveness of reablement services (Adult Social Care Outcomes Framework (ASCOF), (2E)
- Patient/service users experience metric (ASCOF, 1A) Social Care- related quality of life

Performance against the Better Care Fund metrics is reported on a monthly dashboard to the joint Better Care Fund Programme Board and quarterly to the CCG's Finance and Performance Committee and the Health and Wellbeing Board. It is also reported to NHS England on a quarterly basis. Highlight reports including actions to recover performance are produced for the Better Care Fund Programme Board for any metrics which are not achieving target performance levels.

Whilst the background reablement performance indicators are showing greater improvement, in relation to people still at home after 91 days, reduction in care hours required and individual goals achieved; the target of 44% of people fully reabled during the year is currently off track. There are a number of actions being taken forward through the BCF programme to address this - including the implementation of the referral criteria and strengthening reablement outcomes through the enhanced role of social workers. This enhanced role includes monitoring the progress of individuals through reablement, assessing their needs and developing support plans which focus on independence and resilience. (See Appendix 2 of this performance report for the detail of the outcome measure and target/baseline).

- **Friends and Family Test**

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The test asks patients "*How likely are you to recommend our service to friends and family if they needed similar care or treatment*?" Answers are ranked from "*extremely likely*" to "*extremely unlikely*" and patients have the opportunity to add comments. Results are published nationally every month by the Health and Social Care Information Centre and the information is available to the public.

The CCG's Quality team reviews on a monthly basis, the response rates as well as the percentage of patients who are or are not likely to recommend a service. The Quality team focuses on those statistics for the main service areas (inpatient, emergency care and maternity). The data is displayed on the quality and safety dashboard received by the Quality Committee every month. The Primary Care Quality and Improvement team also reviews the FFT data for primary medical services.

- **Financial performance**

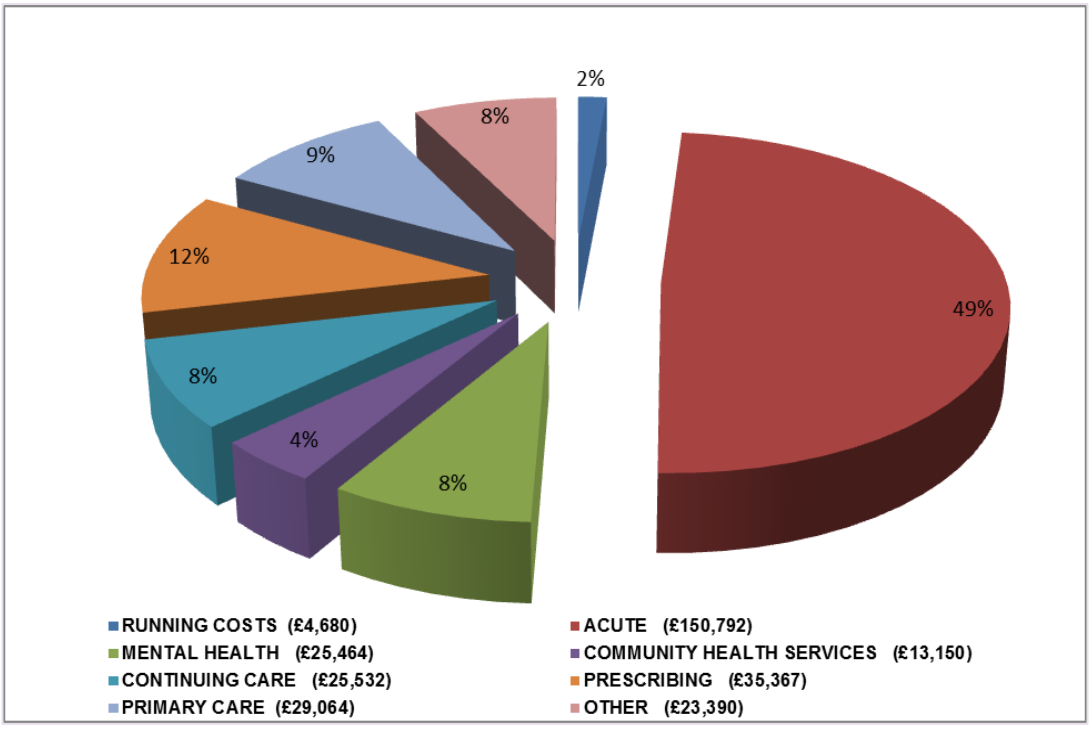
The CCG has a number of statutory financial duties and targets against which our performance is monitored. I am pleased to be able to report that we have met all our statutory financial duties.

The table below shows a summary of the CCGs performance against these targets in 2015-16:

| Financial Duty | Achieved/Not Achieved | Performance in 2015/16 |
|---|---|---|
| Achieve operational financial balance | Achieved | Delivered surplus of £7,433k |
| Revenue administration resource does not exceed the amount specified in Directions | Achieved | The CCG underspend on its administration allocation by £294k |
| Maintain capital expenditure within Capital Resources | Achieved | Utilised capital resource of £29k |
| Manage cash within the CCG's Cash Limit | Achieved | Cash balance of £30k |
| Public Sector Payment Policy - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty) | Achieved | Non-NHS invoices 99.6% volume, 99.7% value.<br>NHS invoices 99.7% volume, 99.7% value. |

During 2015/16 we invested over £307m to improve the health and care of local people through the commissioning of high quality services:

**Net investment by the CCG (£000)**




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

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

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

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

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

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

- **Diabetes –** invested in new diabetes specialist nurses.

- **Asthma** – investment in an additional specialist nurse.

- **Heart Failure** – invested in an additional specialist nurse.

- **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.

A copy of the contracts register can be found on the CCG's website: www.calderdaleccg.nhs.uk

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 2015/16 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 2016/17, these include:


- Better Care Fund
- Contingency

➢ **Financial Risk**

There are a number of risks that threaten delivery of our 16/17 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.

## 2. Well-led organisation and organisational development

In 2015/16 we have continued to roll out our Organisational Development Strategic Framework. Our executive coaching and mentoring programmes have enhanced leadership capability. Team development and resilience programmes have been delivered to the Senior Management Team, Finance, Primary Care Quality and Service Improvement, Contracting, Safeguarding, Corporate and Continuing Care Teams, supplemented in the majority of teams with the use of MBTI profiling. A personal effectiveness programme – offered on an open basis to all staff – has contributed to increasing self-awareness and understanding of individual behaviours and impacts. The Organisational Development Steering Group has maintained its overview of activity, strategic intentions and priorities.

A priority throughout the year has been facilitating and supporting the transition of Commissioning Support Unit staff. On a practical level, the process has been project managed and the organisation restructured. On a personal level, people have been supported through an extended period of uncertainty and instability associated with a change of employer. We have become a larger organisation in a short space of time, requiring us to extend our values, culture and 'good place to work' ethos.

Communication has been facilitated through continuing briefings, staff workshops and blog. Our staff forum has strengthened its role, with a particular emphasis on staff health and wellbeing initiatives. We have engaged in the Global Corporate Challenge, bringing together mixed teams keen to improve their fitness levels and delivering significant benefits objectively measured. The promotion of workforce health and wellbeing has been led by our Chief Officer and sponsored by our Governing Body.

## 3. CCG Assurance Framework

NHS England carried out an assessment of the performance of each CCG. The assurance framework describes a continuous process that aims to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients. It comprises the following components:

- Well-led organisation
- Performance: delivery of commitments and improved outcomes
- Financial management
- Planning

- Delegated functions (commissioning primary medical services)

At the time of writing, Calderdale CCG (Quarter 3) is overall assured, and assured with support in domain 3 in relation to the delivery NHS Constitution standards:

| Component | Assessment |
|---|---|
| Well-Led Organisation | Good |
| Delegated Functions | |
| Financial Management | Good |
| Performance | Good |
| Planning | Good |

For 2016/17 NHS England is introducing a new CCG Improvement and Assessment Framework to replace both the existing CCG assurance framework and performance dashboard.

## 4. Meeting our statutory duties

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

1. **Public and patient involvement** (Section 14Z2 Health and Social Care Act 2012 (as amended))

The CCG's *Engagement and Experience Strategy for Local People in Calderdale (2015-2018)* 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 and the Governing Body of our approach. The strategy sets out the range of mechanisms that we use in support of our engagement with local people, these include the use of:

- Engagement Champions: trained voluntary and community sector representatives who help us to engage grass roots communities and protected groups.

- Patient Reference Group members who work directly with individual practices and attend a Calderdale wide Health Forum on a quarterly basis to share their views and hear more about the work of the CCG.

- 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.

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

## 2. Contribution to the delivery of the Joint Wellbeing Strategy

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

We continue to work closely with Calderdale Council to ensure a close alignment between the commissioning priorities of the CCG and the priorities set out in the Wellbeing Strategy. The commissioning priorities set out in the 5 Year Strategic Plan 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 one year operational plan both in 2015-16 and as part of the development of the one year operational plan for 2016-17. The CCG continues to work closely with Public Health partners in the local authority on the development of the Prevention Strategy.

## 3. Reducing Inequalities (Section 14T Health and Social Care Act 2012)

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

- Active membership of the Health and Wellbeing Board
- Continued engagement with the Health and Wellbeing Board on the development of the one year operational plans to ensure that they continue to align with the Joint Strategic Needs Assessments and the wellbeing priority outcomes such as the Good Health Priority Outcome (Joint Wellbeing Strategy).

In 2015/16 we continued to focus on reducing the life expectancy gap and reducing the under 75s mortality rates for men and women by working with public health colleagues in:

- Beginning to deliver the primary prevention and supported self-care elements of the care closer to home model
- Developing a draft joint Primary Prevention Strategy
- Working with the Health and Wellbeing Board to reduce smoking related deaths and improving life expectancy for those with severe mental illness

Our service improvement plans, some of which are referred to in this annual report, specifically relate to the reduction in health inequalities, these are respiratory, cancer, cardiovascular disease (CVD) and mental health. We have also continued to work closely with public health colleagues on the programme ‘Staying Well’ aimed at reducing the health impacts of loneliness and isolation on older people.

## Effectiveness in discharging this duty

Our effectiveness in discharging this duty is performance managed through our active membership of the Health and Wellbeing Board, our robust governance arrangements and through the quarterly assurance checkpoints with NHS England.
Performance and QIPP reports are submitted to each Finance and Performance Committee and Governing Body meeting for review and scrutiny. In addition to this, we undertake a review of the Governing Body Assurance Framework twice a year. This takes the form of a review of the principal risks, actions taken to mitigate and assurances in place in relation to our strategic objectives (See the Governance Statement).

## Equality and diversity

We are committed to ensuring that equality and diversity is a priority when planning and commissioning local healthcare. To help us do this we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs. In doing this, we are guided by our Equality and Diversity Strategy to ensure that all activity puts equality at the heart of all that we do as commissioners and employers.

The CCG is supported by specialist equality staff who provide expertise, guidance and support to lead the equality agenda as well as ensuring that the CCG complies with its legal duties and commitments. All staff and Governing Body members are required to complete their statutory and mandatory training, which includes equality and diversity elements. This supports the CCG to fully consider equality and diversity in its strategic planning, delivery of commissioning and as employers.

## Equality delivery system

We have implemented the Equality Delivery System (EDS2) as an equality performance framework to engage local stakeholders and staff to better understand our current position in discharging our statutory duties, as enshrined in the Equality Act 2010.

## Equality objectives

We have agreed the following equality objectives for the period of 2013-2017:

1. Improve the access, experience and outcomes for South Asian patients with diabetes
2. Improve patient experience equality monitoring measures

The CCG publishes an annual report identifying the data and information it has used about local communities and protected groups to inform decision making. The CCG will be reviewing its equality objectives during 2016/17.

Performance against the delivery of our equality and diversity duties are reported into the Quality Committee on a quarterly basis and against the equality objectives on an annual basis.

### 4. Consultation and work with the Health and Wellbeing Board

The CCG continues to be an active member of the local Health and Wellbeing Board. Throughout the year the CCG has either presented or been actively involved in many of the items discussed at the Health and Wellbeing Board. These items are reflected in this annual report. These include:

- Regular updates on the Right Care, Right Time, Right Place (RCRTRP) proposals and plans
- Improving health together – the recommendations from the People's Commission (in relation to RCRTRP)
- Care Closer to Home
- Safeguarding adults and children
- Quarterly updates on the Better Care Fund
- CCG planning process and approach to planning
- The Mental Health Crisis Care Concordat
- CCG Quality Premiums
- The Child and Adolescent Mental Health Transformation Plan
- Updates on Vanguard
- The transformation plan for children and young people's emotional health and wellbeing.

## Sustainable development

As an NHS organisation and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

In order to fulfil our responsibilities we produced a Sustainable Development Management Plan (SDMP) in February 2015 which we will be revising in 2016/17.

### 1. Good Corporate Citizenship

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. We have

carried out a self-assessment against the tool and are able to provide good evidence of our activity in a number of areas including:

- Healthy lifestyles
- Workforce policies and performance
- Community engagement policies and performance
- Partnership and planning policies and performance
- Emergency preparedness
- Social and community impacts
- Models of care – shifting the emphasis of care, care closer to home, efficient to transformed acute care and system approach to care.

We have covered a number of these areas in more detail elsewhere in the Performance Report, particularly about our partnership work, our community engagement activity and our system wide transformation programmes – Care Closer to Home including Vanguard, the integrated work with the Local Authority as part of the Better Care Fund and on the proposals for hospitals service change.

**Encouraging a healthy workforce**

Our staff forum has been extremely active this year in promoting and encouraging healthy lifestyles both in and outside work. Some of the activities they have promoted are:

➢ **Active Travel**

We can improve local air quality and promote the health of local people by promoting active travel. This is to our staff, our providers and to people who use the services that we commission. Over the past year, our staff forum has worked hard to promote walking to work, the uptake of the bike to work scheme, use of public transport and car sharing. We are currently exploring the introduction of corporate metro card for staff needing to make small business journeys.

**Global Corporate Challenge (GCC)**

12 teams of 7 staff and governing body members took part in the GCC. Everybody set the goals that they wanted to achieve including activity, weight loss, improved sleep and reducing stress levels. At the end of the challenge:

- We had walked 45,377 km
- 49% meet the recommended 10,000 steps per day vs. 13% pre-GCC
- 44% are now more aware of what they eat
- Burnt 2,844,991 Cal
- 63% who tracked their weight have lost weight (total of 57kg weight lost)
- 68% now have the recommended amount of sleep vs. 63% pre-GCC
- 59% reported a decrease in their stress levels either at home or at work
- 51% reported an increase in either their productivity or concentration

Our participation in GCC has enabled a closer connection between our wellbeing and our effectiveness.

We have shared our experience of GCC with the Calderdale Health and Wellbeing Board and have encouraged others to engage with a view to improving the health and wellbeing of the working age population.

Staff were so enthusiastic about the energy that this created in the workplace that we have agreed to hold another GCC in the summer.

➢ **Healthy workplace**

We have a number of policies in place to protect our workforce. These include policies on bullying and harassment, absence and sickness management, substance misuse and flexible working. We have been active in promoting healthy eating, a wellbeing half hour; eye health and stress management. This has included identifying an area in the office for staff to use for rest and reflection. We have also worked in partnership with the local gym that provided staff with guest passes, BMI measurements and blood pressure checks. Finally, information about our Employee Assistance Programme (EAP) is included in the Remuneration and Staff report as is information about our approach to diversity.

## 2. Emergency Preparedness

Climate change brings new challenges to our organisation both in terms of direct effect on healthcare estate but also to local people, particularly vulnerable patients and carers. As a category 2 responder we work closely with providers and colleagues across the local authority, NHS England, the emergency services and environmental agency to prepare for and ensure support for local people during severe weather events such as heatwaves, prolonged cold weather and the recent floods that have had a significant impact in Calderdale, particularly over boxing day and new year.

## 3. Reducing our carbon footprint

Achieving a reduction in our carbon footprint continues to provide a challenge to the CCG and will form a focus for us in 2016/17. Our resource usage in 2015/16 is set out in the table below:

**Resource usage in 2015/16**

| **Resource** | **Quantity (kWh)** | | **tCO2 emissions** | | **Cost (Inc. VAT) (£)** | |
|---|---|---|---|---|---|---|
| | **2014-15** | **2015-16** | **2014-15** | **2015-16** | **2014-15** | **2015-16** |
| Gas | 52,268 | 49,662 | 11 | 10.4 | 22,820 | 13,648 |
| Electricity | 328513 | 281,132 | 203 | 161.6 | 50,933 | 45,052 |
| General waste **note1** | -- | | - | | --- | ---- |
| Recycling (including confidential waste) | -- | | - | | 2,201 | 2,451 |
| Water **note2** | -- | | - | | | |
| Business Travel **(Km) note3** | | 57,671 | | 13 | | 20,367 |

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 and is not separated out
Note3: We are currently working to validate the business travel figures for 2014 in order to provide good comparative data for 2015/16 and beyond.

We now understand the carbon footprint of our premises and the opportunities for achieving QIPP efficiencies, making the most of staff and governing body member resources as well as contributing to a reduction in our carbon footprint.

In 2016/17 we will identify the QIPP efficiency savings (both cash-releasing and non-cash-releasing) that can be achieved through working differently. This includes an increase in the use of teleconferencing facilities to reduce business travel, reducing the use of paper and increasing the level of recycling.
We have also identified the importance of promoting carbon efficient estates through our draft estates strategy and are committed to supporting those GP practices who wish to carry out an environmental impact audit on their premises.

## Approval of the Performance Report

The Performance Report for NHS Calderdale Clinical Commissioning Group was approved by the Audit Committee on 19 May 2016 under delegated authority from the Governing Body.

Dr Matt Walsh
Accountable Officer, 26th May 2016

## NHS Constitution Rights and Pledges 2015/16

Appendix 1

## Reporting Period: March 2015/16

| Outcome/Measure | | Target/ Baseline | Period Actual | Period RAGS | YTD | YTD RAG | Direction of Travel |
|---|---|---|---|---|---|---|---|
| Referral To Treatment waiting times for non-urgent consultant-led treatment | Admitted patients to start treatment within a maximum of 18 weeks from referral | N/A | 85.2% | - | 86.2% | - | ⇧ |
| | Non-admitted patients to start treatment within a maximum of 18 weeks from referral | N/A | 97.6% | - | 97.9% | - | ⇧ |
| | Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral | 92% | 94.7% | ● | 95.3% | ● | ⇩ |
| | Number of patients waiting more than 52 weeks | 0 | 0 | ● | 0 | ● | ⇔ |
| Diagnostic test waiting times | Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral | 99% | 99.1% | ● | 99.4% | ● | ⇩ |
| A&E waits | Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department | 95% | 89.3% | ● | 93.9% | ● | ⇩ |
| | No waits from decision to admit to admission (trolley waits) of more than 12 hours | 0 | 0 | ● | 0 | ● | ⇔ |
| Cancer waits – 2 week wait | Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | 93% | 99.5% | ● | 97.5% | ● | ⇧ |
| | Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms | 93% | 95.5% | ● | 95.7% | ● | ⇩ |
| Cancer waits – 31 Days | Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers | 96% | 98.7% | ● | 99.4% | ● | ⇧ |
| | Maximum 31-day wait for subsequent treatment where that treatment is surgery | 94% | 100.0% | ● | 99.1% | ● | ⇔ |
| | Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen | 98% | 100.0% | ● | 100.0% | ● | ⇔ |
| | Maximum 31-day wait for subsequent treatment where the treatment | 94% | 100.0% | ● | 100.0% | ● | ⇔ |
| Cancer waits – 62 Days | Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer | 85% | 80.5% | ● | 89.3% | ● | ⇩ |
| | Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | 90% | 100.0% | 100.0% | 97.9% | ● | ⇔ |
| | Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) | tba | 100.0% | tba | 85.7% | tba | |

Continued on next page

| Outcome/Measure | | Target/ Baseline | Period Actual | Period RAGS | YTD | YTD RAG | Direction of Travel |
|---|---|---|---|---|---|---|---|
| Category A Ambulance Calls | Category A calls resulting in an emergency response arriving within 8 minutes (Red 1) | 75% | 77.8% | | 73.0% | | |
| | Category A calls resulting in an emergency response arriving within 8 minutes (Red 2) | 75% | 72.3% | | 73.2% | | |
| | Category A calls resulting in an ambulance arriving at the scene within 19 minutes | 95% | 94.9% | | 95.3% | | |
| | All handovers between ambulance and A&E must take place within 15 minutes | 95% | 72.8% | | 84.3% | | |
| | All crews should be ready to accept new calls within a further 15 minutes | 95% | 77.1% | | 75.4% | | |
| Mixed Sex Accommodation Breaches | Minimise breaches | 0 | 0 | | 2 | | |
| MRSA | Number of MRSA reported infections | 0 | 0 | | 3 | | |
| C_Diff | Number of C-Diff blood stream infections | 39 | 8 | | 38 | | |
| Cancelled Operations | All patients who have operations cancelled, on or after the day of admission , for non-clinical reasons to be offered another binding date within 28 days, | 0 | Q3 1 | | 2 | | |
| Mental Health | Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge | 95% | 94.7% | | 96.1% | | |

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Appendix 2

## Performance against the Better Care Fund Metrics

| BCF Measure | Target | Apr | May | Jun | Qtr 1 | Jul | Aug | Sept | Qtr 2 | Oct | Nov | Dec | Qtr 3 | Jan | Feb | Mar | 15/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Non elective admissions in hospital (general & acute), all age | Variable per quarter | 1,779 | 1,896 | 1,789 | 5,464 | 1,885 | 1,628 | 1,803 | 5,316 | 1,891 | 1,871 | 1,962 | 5,724 | 1,947 | 1,779 | 1,924 | 22154 |
| Delayed transfers of care (delayed days) from hospital (ages 18+) | Variable per quarter | 847 | 599 | 727 | 2173 | 806 | 683 | 467 | 1958 | 562 | 556 | 560 | 1678 | 605 | 337 | 345 | 1287 |
| Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100k population | 201 | 194 | 200 | 202 | 198 | 192 | 191 | 201 | 201 | 200 | 197 | 202 | 198 | 186 | 186 | 198 | 185 |
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | 78.8% | 84% | 79% | 91% | 84% | 92% | 88% | 89% | 89% | 83% | 100% | 95% | 93% | 88% | | | |
| LOCAL MEASURE ASCOF (2E) Effectiveness of reablement services | 44% | 26% | 41% | 21% | 33% | 31% | 24% | 27% | 39% | 24% | 22% | 37% | 28% | 39% | 39% | 34% | 29.7% |
| PATIENT/ SERVICE USER EXPERIENCE METRIC ASCOF (1A) Social Care - related quality of life | 19 | .. | .. | .. | Annual Survey | .. | .. | .. | Annual Survey | .. | .. | .. | Annual Survey | .. | .. | .. | 19 |

** Year end out turns for 2015/16 are subject to validation - final results due 31/05/2016


## 1. The CCG as a membership organisation

The CCG is made up of the 26 practices based in Calderdale. Each practice has nominated a practice commissioning lead, the role of which is to be a two way conduit between the practices and the Governing Body. This includes sharing information about issues for local people at practice level, representing practice views and acting on behalf of the practices in matters relating to the CCG – including shaping the priorities of the CCG, testing plans and proposals and taking forward projects aligned to the priorities of the CCG.

Work with the member practices is steered by the HPMO (High Performing Membership Organisation) group. The CCG holds regular Practice Leads' meetings which are attended by the practice commissioning lead and practice manager from each of the member practices. In 2015/16 we refocused these events to enable wider involvement in strategic issues, such as our primary care strategy and the development of Care Closer to Home. In addition, each of the practices is a member of a locality-based commissioning team. These teams are key to our membership model and in 2015/16 they:

- Focused on the delivery of the identified quality indicators (peer review, sharing best practice).

- Focused on at least one area from the list of seven clinical priorities as identified by the CCG and developed a project, based on the principles of clinical audit, linked to the priority area and delivery of the objectives of the scheme.

- Reported back and shared the learning at the Practice Leads' meeting in March 2016.

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.

We have visited our practices during the year so that we can hear the issues affecting them and share the latest news and plans; ensuring they are informed and able to get involved.

## List of member practices

| Practice Name | Location | 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,<br>▪ Mixenden Stones Surgery, Mixenden<br>▪ Shelf Health Centre, Shelf | Wendy Iles |
| Care UK, Clinical Services Ltd | ▪ Calder Community Practice, Todmorden Health Centre,<br>▪ Park Community Practice, Horne Street Health Centre, Halifax | Dr Susi Harris |
| Church Lane Surgery | Church Lane, Brighouse | Dr J Crosland |

| | | |
|---|---|---|
| Hebden Bridge Group Practice | ▪ Valley Medical Centre, Hebden Bridge,<br>▪ Grange Dene Medical Centre, Mytholmroyd,<br>▪ Kershaw Drive, Luddenden Foot | Dr K Moore |
| Horne Street Surgery | Horne Street Health Centre, Halifax | Dr M Niazi |
| Keighley Road Surgery | Keighley Road, Illingworth | Dr K Simpson |
| King Cross Practice | King Cross Road, King Cross | Dr H Bolland |
| Longroyde Surgery | Castle Avenue, Rastrick | Dr J Grant |
| Lister Lane Surgery | ▪ Lister Lane, Halifax<br>▪ Boothtown Medical Centre, Woodside Road, Boothtown<br>▪ Nursery Lane, Ovenden, Halifax | Dr S Shetty |
| Meadow Dale Group Practice | ▪ Nursery Lane, Ovenden, Halifax<br>▪ Rosemount House, Huddersfield Road, Elland<br>▪ Allan House, Sowerby Bridge | Dr Omar Al-Atragchi |
| Northolme Practice | ▪ Kos Clinic, Roydlands Street, Hipperholme<br>▪ Northowram Surgery, Northowram | Dr S Santhanam |
| Plane Trees Group Practice | Sandbeds Road, Pellon | Dr D Kumar |
| Queens Road Surgery | 252 Queens Road, Halifax | Dr A Jagota |
| Rastrick Health Centre | Chapel Croft, Rastrick | Dr D Miller |
| Rosegarth Practice | ▪ Rothwell Mount, Halifax<br>▪ Siddal, Halifax | Dr P Sawcyzn |
| Rydings Hall Surgery | Church Lane, Brighouse | Dr A Wilkinson |
| Southowram Surgery | Law Lane, Southowram | Dr M Azeb |
| Spring Hall Group Practice | Spring Hall Medical Centre, Spring Hall Lane, Halifax | Dr F Price |
| Stainland Road Medical Centre | Stainland Road, Greetland | Dr S Martin |
| Station Road Surgery | Station Road, Sowerby Bridge | Dr A Kazi |
| The Todmorden Group Practice | Todmorden Health Centre, Lower George Street, Todmorden | Dr S Vivekanathan |

The CCG's member practices have delegated authority to the Governing Body to oversee the work of the organisation and make decisions on their behalf as set out in the scheme of delegation incorporated in the CCG's Constitution.

## 2. The Governing Body and its sub-Committees

Members of the CCG's Governing Body are set out below. In 2015/16, the Governing Body had five sub-Committees: the Finance and Performance, Quality, Commissioning Primary Medical Services, Remuneration and Audit Committees. The details of the membership and attendance at the Governing Body and Committees can be found in Appendix 1 of the Governance Statement and in the Remuneration and Staff Report.

### The CCG's Governing Body:

| | |
|---|---|
| Chair and GP Member | Dr Alan Brook |
| Deputy Chair/Lay Member (Audit) | David Longstaff |
| Assistant Clinical Chair and GP member | Dr Steven Cleasby |
| Chief Officer | Dr Matt Walsh |
| Chief Finance Officer | Julie Lawreniuk |
| GP Member | Dr Majid Azeb |
| GP Member | Dr Hazel Carsley |
| GP Member | Dr Caroline Taylor |
| GP member | Dr John Taylor |
| GP Member | Dr Nigel Taylor |
| Lay Member (Patient and Public Involvement) | Kate Smyth |
| Registered Nurse | Jackie Bird |
| Secondary Care Specialist | Rajesh Phatak |
| Advisors to the Governing Body | |
| Lay Advisor (Finance, Performance and External Relations) | John Mallalieu |
| Head of Quality | Penny Woodhead |
| Director of Adult Health and Social Care Services (Calderdale Metropolitan Borough Council) | Bev Maybury |
| Director of Public Health (Calderdale Metropolitan Borough Council) | Paul Butcher |

## 3. Register of interests

Clinical Commissioning Groups are required to make arrangements to manage actual or potential conflicts of interest so that decisions made by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest[2].

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

## 4. Disclosure of "serious untoward incidents"

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

[2] Section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act; CCG Constitution (as revised January 2015)

## 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, 26th May 2016

# 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.

## 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 (September 2014) we consider to be relevant to the CCG and best practice.

Over the past year this has included a review of the CCG's arrangements benchmarked against the UK Code and the view has been taken that the CCG is largely compliant with the relevant principles set out in the Code. The following actions have been identified:

**(UK Code ref: A1.1)** *The annual report should include a statement of how the board operates, including a high level statement of which types of decisions are to be taken by the board and which are to be delegated to management.*

**Action**: The Annual Report now includes this statement (See page 45).

**(UK Code ref: B3)** *All directors should be able to allocate sufficient time to the company to discharge their responsibilities effectively… Other significant commitments should be disclosed to the board before appointment, with a broad indication of the time involved and the board should be informed of subsequent changes*.

**Action:** The CCG is partially compliant with the principles set out above. Going forward, compliance will be improved by incorporating questions about the ability of a candidate to fulfil the time commitment required and about their other significant commitments into the recruitment process for all Governing Body members. There will also be a requirement to inform the Governing Body of subsequent changes.

**(UK Code ref: B6.2)** *The Board should undertake a formal and rigorous annual evaluation of its own performance and that of its Committees and individual directors. …Evaluation of the board of FTSE 350 companies should be externally facilitated at least every three years. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection with the company.*

**Action:** The CCG undertakes an annual self-assessment of the Governing Body's performance and that of its Committees. The sub-Committees of the Governing Body incorporate the findings of the self-assessment into their annual report which is submitted to the Audit Committee. In line with good practice, the CCG commissioned an external governance review in 2015/6. A summary of the review that was undertaken by KPMG is included later in this report.

Each of the members of the Governing Body have a structured performance development reviews on an annual basis.

## 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.

## 1. 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:

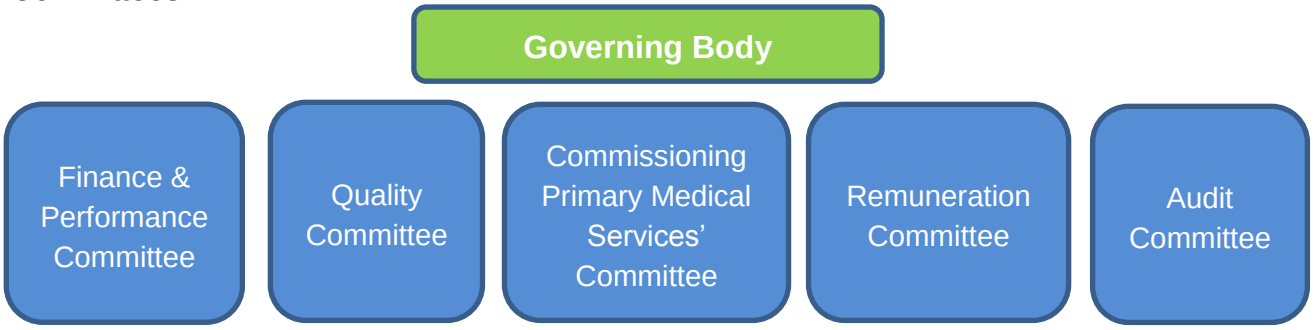
- Operating to the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- Compliance with the Good Governance Standard for Public Services;
- Compliance with 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[3] 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

The provisions of the CCG's Constitution are supported by our Standing Financial Instructions and Standing Orders as well as a suite of policies and procedures, such as the Policy on the Management of Conflicts of Interest.

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




The membership of the Governing Body and its sub-Committees, together with the attendance record is set out Appendix 1 at the end of this Governance Statement.

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

Details of the membership and attendance of the Remuneration Committee is set out in the Remuneration Report. Attendance at the Governing Body and sub-Committees throughout the year has been strong and all meetings have been quorate throughout the year.

## 2. 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 types of decisions taken by the Governing Body are set out in the Constitution, the Scheme of Delegation and Standing Orders. The Governing Body:

- Sets the strategic direction for the organisation and;

**Approves:**

- Strategy
- financial spend above £0.5m
- certain policies
- remuneration of Governing Body members and Very Senior Managers (Chief Officer and Chief Finance Officer)

**Ensures that the following are being managed appropriately and safely:**

- Quality and Safety
- Finance
- Performance
- Risk

The Governing Body membership comprises the Chair; seven GPs (including the chair) as elected by the CCG membership, two lay members (one of whom is the deputy chair and leads on audit matters and one who leads on public and patient involvement matters); Two seconded members (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.

## 3. Coverage of Work by the Governing Body

In 2015/16, the Governing Body has had a full agenda, meeting in public on eight occasions (including the Annual General Meeting). In addition we have held two meetings in parallel with Greater Huddersfield CCG. The aim of these meetings was to reach a decision on our readiness to go out to public consultation on hospital services change. We are currently in that consultation period which is due to finish on the 21st June 2016.

During the year, the Governing Body has made some significant decisions in relation to Care Closer to Home and community services – reaching the conclusion in August, that there was sufficient confidence that services delivering care closer to home were having an impact and that there was evidence to support this.

Over the year, the Governing Body has considered and approved a number of strategies including the *Strategic Intentions for Cancer Services (2015/16-2019/20)* across Calderdale and Greater Huddersfield; the *Engagement and Experience Strategy for Local People in Calderdale (2015-2018); the Local Transformation Plan* for the emotional health wellbeing of children and young people; the *Equality and Diversity Strategy*; the *Mental Health Crisis Concordat*. It has also approved the financial plan, budget and the one year operational plan for 2016/17.

A number of annual reports have been received including Annual Reports for Safeguarding Children and for Safeguarding Adults, Patient Experience, Public Sector Equality Duties and for Workforce.

## 4. Governing Body Performance

The CCG has delivered its statutory financial duties and as mentioned earlier in the Annual Report, has achieved, with the support of the system, the majority of the NHS Constitution duties. Our areas of challenge on performance relate to the resilience of our Urgent Care system and further information on this and our actions to mitigate can be found in the Performance Report. The Governing Body, through the detailed work of the Finance and Performance Committee, is firmly sighted on these issues.

We have maintained a strong approach to the delivery of Quality, Innovation, Productivity and Prevention (QIPP) this year. The strength of the CCG's financial position in 2015-16 reflects well upon the financial grip exerted by the Governing Body and the underpinning 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.

Throughout the year the Governing Body maintains a focus on improving its effectiveness. This is carried out through a number of mechanisms:

- Governing Body development workshops held on a bi-monthly basis. In 2015/16 it held sessions on risk appetite, the opportunities for the integration of health and social care commissioning, bringing the patient voice into governing body meetings and on the findings of the KPMG governance review. These workshops are also an opportunity to consider strategic topics in more detail such as Care Closer to Home and the opportunities presented by Vanguard.
- Sub-Committee development sessions as required to improve Committee performance.
- Senior Management Team development sessions.
- Individual annual performance and development reviews for individual Governing Body members as well as staff.

In 2015/16 we commissioned KPMG to undertake an external review of our Governance arrangements in accordance with the principles of good governance set out in the UK Code of Corporate Governance (2014). The overarching aim of the review was to look critically at the structures and processes and provide an independent view of improvements that could be made. The review included consideration of:

- Committee Terms of References, agendas and work plans in ensuring focus on key responsibilities
- The use of the Governing Body Assurance Framework to respond to risks
- Interviews with Governing Body members and senior managers
- Observation of Committees and the Governing Body
- Workload management to accommodate additional work such as the co-commissioning of primary medical services
- The Governing Body skill mix

The conclusions of the review, which included an observation of the working of the Governing Body and its Committees, were that there were good governance arrangements in place with a strong and committed membership. Opportunities for improvement were identified.

In order to further improve the effectiveness of our governance arrangements – leading to a release of capacity for the development of strategy and focus on clinical priorities - we have established a time-limited sub group of the Governing Body to take forward a number of actions as follows:

- Committees to review their roles and purpose by reviewing their terms of reference and work plans. The aim of this was to reduce duplication, identify those items that could be brought to the Committee on an exceptional basis and increase the focus on the priorities. This would facilitate a possible reduction in frequency and length of meetings.
- Provide guidance for report authors, chairs and Committee members
- Develop a report template (and guidance for authors) to support consistency of papers and clarity of purpose.
- Agree the role of Commissioning Development Forum and if/where it sits within the governance arrangements.
- Look at the key skills needed to deliver individual Governing Body and Committee member roles and ensure that the CCG is fit for the future.
- Simplify the Governing Body Assurance Framework (GBAF) with clear links through to the Committees.

We will continue our focus on developing these areas into 2016/17 aiming to complete this piece of work by December 2016.

## 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 which can be found on our website, www.calderdaleccg.nhs.uk.

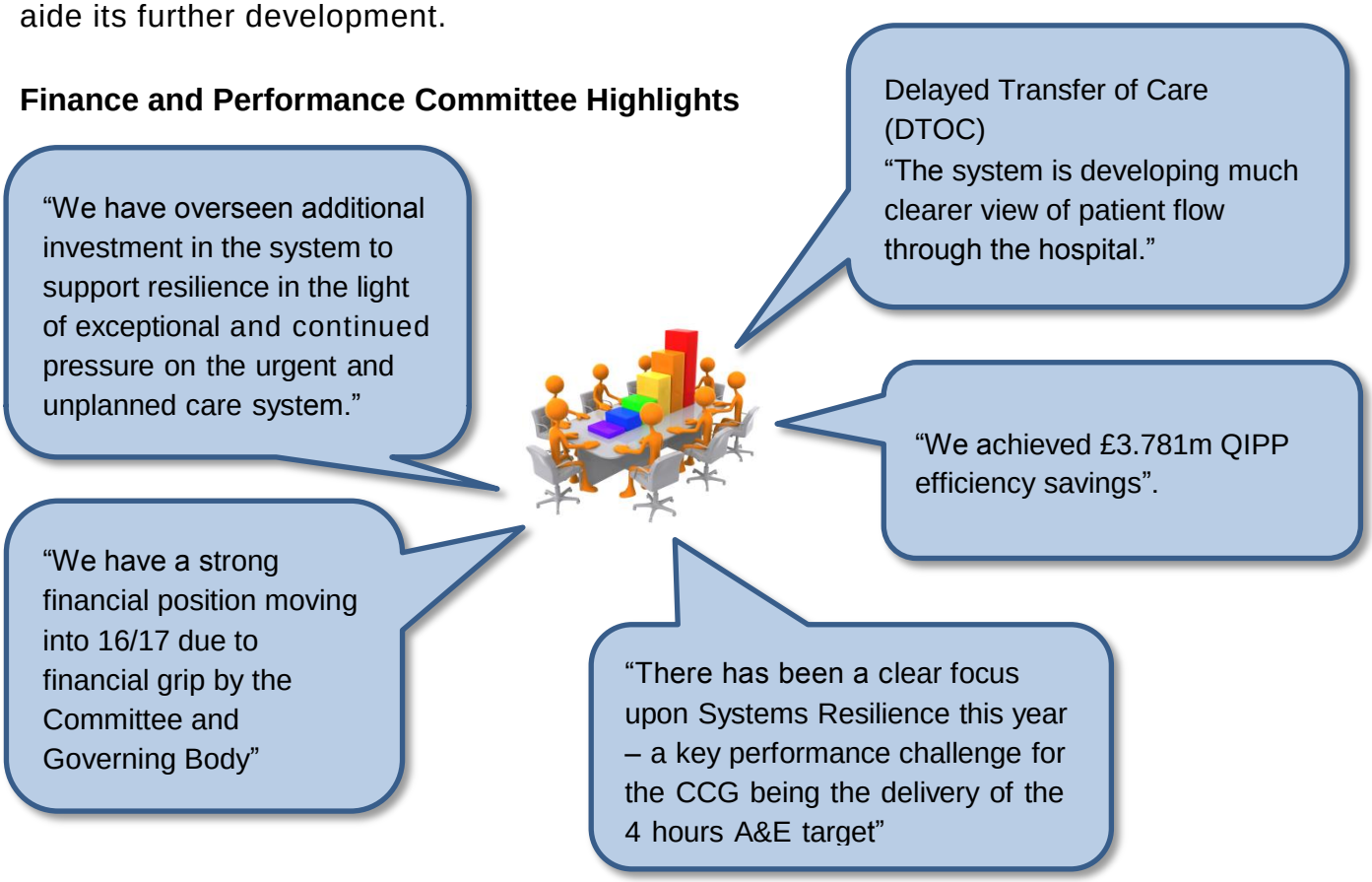
The membership of the Committee is set out in Appendix 1 to this Governance Statement. In addition, the Committee is supported by the attendance of the Heads of Service and the Performance Manager. The Committee meets monthly and has been quorate on all occasions.

**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 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.

Following the external governance review, the Finance and Performance Committee has reframed its approach to shaping the agenda for meetings, with a clear focus early in the meeting upon decision making, then taking items for assurance and finally bringing items for information. This has helped the Committee to prioritise more effectively. The Committee has also undertaken a self-assessment this year to aide its further development.

**Finance and Performance Committee Highlights**




## 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 which can be found on our website www.calderdaleccg.nhs.uk.
The members of the Committee are set out in Appendix 1 attached to this governance statement. They are supported by the attendance of the Head of Primary Care Quality and Improvement, the Head of Service Improvement and a public health representative from Calderdale Council. The Committee meets on a monthly basis and has been quorate on all occasions.

**Coverage of Work by the Quality Committee**

The work carried out by the Quality Committee is contained within 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.

In acknowledgment of the scale of its work plan and the associated challenge in ensuring sufficient time to discuss items, the Quality Committee is taking forward a number of actions in the light of the external governance review. These include a review of the work plan to streamline the number and frequency of reports it receives and a review of the terms of reference to remove any duplication and a re-organisation of agendas to ensure appropriate prioritisation of items requiring decisions rather than those 'for information' only.

**Quality Committee Highlights**

"We oversee patient experience surveys of primary and secondary care; themes, trends, complaints, engagement work and embedding engagement in the day to day work of the CCG".

"There is improved reporting through a care home dashboard and quarterly audit reports"


"Internal audit have provided **significant assurance** that CQUIN schemes were effective in supporting quality improvement".

"The Committee provides an excellent governance function across all aspects of quality and maintains a strong focus on patients and the public in all of its work".

## Commissioning Primary Medical Services Committee

The Committee for the Commissioning of Primary Medical Services was established on the 1st April 2015. Its role is to make corporate decisions on the review, planning and procurement of primary medical care services in Calderdale under delegated authority from NHS England. This includes making decisions in respect of:

- Contracts for General Medical Services (GMS), Primary Medical Services (PMS) and Alternative Providers of Medical Services (APMS)
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services")
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)

- Whether to establish new GP practices in an area; approving practice mergers; and on 'discretionary' payment (e.g., returner/retainer schemes)

The Committee exercises its management of the functions in accordance with an agreement entered into between NHS England and NHS Calderdale CCG. The functions of the Committee are undertaken in the context of the aim to increase quality, efficiency, productivity and value for money and to remove administrative barriers to achieving this within primary medical services.

The members of the Committee (see Appendix 1, Governance Statement). They are supported by the attendance of Head of Primary Care Quality and Improvement, the Head of Finance and invited representatives from Calderdale Health and Wellbeing Board, from Healthwatch and from NHS England. Establishing and developing this Committee brings particular challenges for the GP members due to conflicts of interest, but these have been discussed openly and addressed.

The Committee holds its meeting in public and in this first year has only needed to meet formally on one occasion. It was quorate on this occasion. The Committee has however held a number of workshop sessions in order to develop the strategic approach to primary care for the CCG.

Whilst the external governance review included consideration of the arrangements for the Committee, it was recognised that this was a year of development. A number of actions have been identified which will be implemented in 2016/17. These include:

- A review of the terms of reference in the light of experience in this first year
- The implementation of a Committee work plan and agreement on the frequency of meetings required
- The development of a process for approving minutes if formal meetings are held three times or less during the year
- The introduction of a reporting mechanism into the CCG's Governing Body

It is recognised that there is a much clearer work plan for 2016/17. All pre-delegation governance continues to be enacted through the Committee structure detailed elsewhere in this report. The focus therefore for the CPMSC remains as the review, planning and procurement of primary medical care services in Calderdale.

## 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. In 2015/16 they were 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. Six meetings were held in 2015/16 all of which were quorate.

**Coverage of work by the Remuneration Committee**

The Committee has had a very full agenda this year, considering and making recommendations to the Governing Body in respect of:

- Very Senior Manager contracts, remuneration and pay awards;
- Governing Body member remuneration;
- An in-year recruitment and retention premia to a small number of staff that did not receive a national pay award in 2015/16 under Agenda for Change;
- HMRC requirement to change off-payroll arrangements;
- Arrangements for appointing a replacement Chief Finance Officer.

The Committee has also reviewed and approved seven Human Resources Policies.
The Remuneration Committee reviewed their terms of reference in 2015/16 as part of the annual review cycle. No amendments were proposed in-year, however the terms of reference and work plan will be considered further at a planned development session in 2016/17. It is expected that the frequency of meetings will be reduced in the light of future work plans and the governance review.

**Remuneration Committee Highlights**

We reviewed Governing Body member and VSM remuneration.

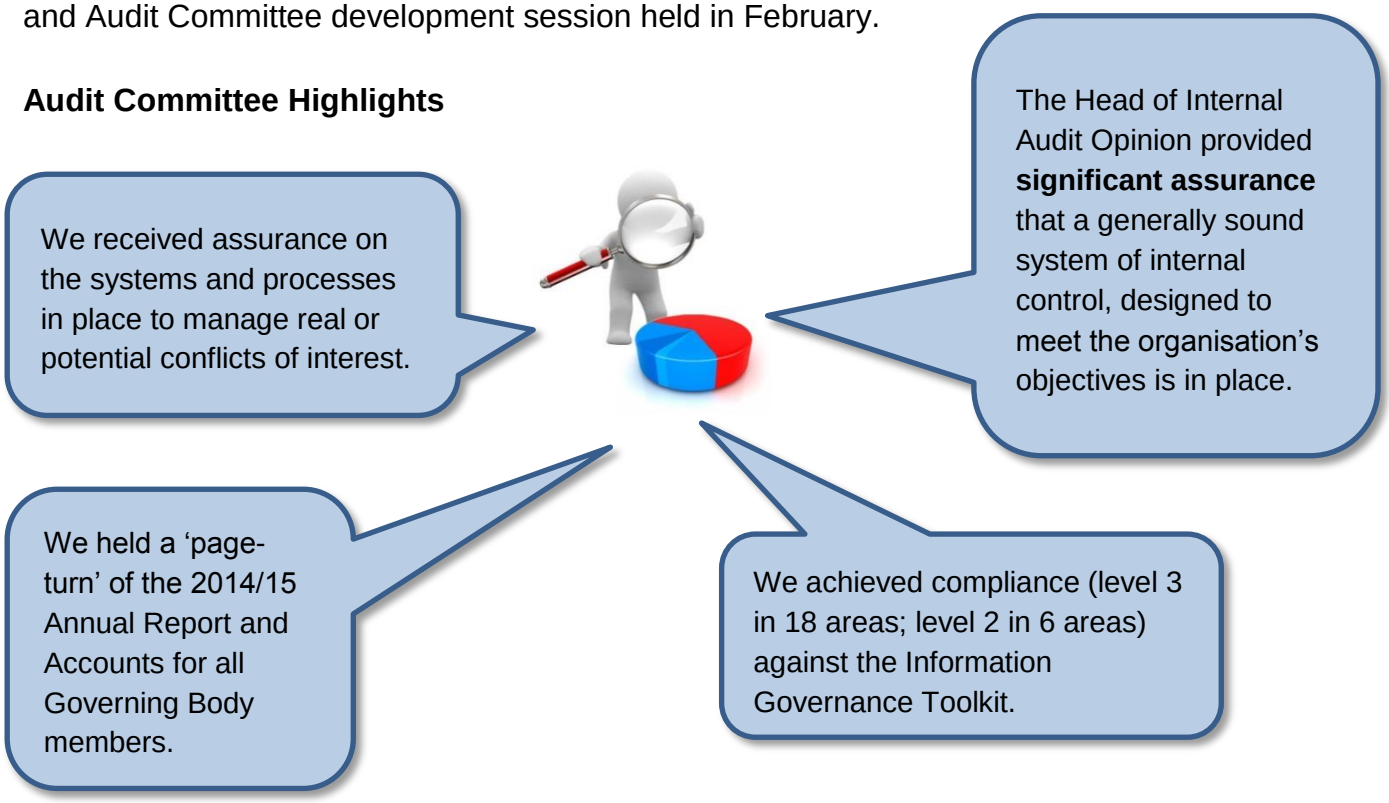
The committee supported initiatives to improve staff health and wellbeing. Including participation in the Global Corporate Challenge and piloting of a 'wellbeing half hour' as well as other staff benefits designed to improve wellbeing.

## 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 2015/16 with the additional meeting being held to review the annual report and accounts on behalf of the Governing Body. The members of the Committee (see appendix 1, Governance Statement) are 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 and work plan of the Committee are due to be reviewed in the new financial year, taking account of the conclusions of the KPMG governance review and Audit Committee development session held in February.

**Audit Committee Highlights**




## The Clinical Commissioning Group Risk Management Framework

The CCG has a comprehensive Integrated Risk Management Framework (IRMF) in place. The IRMF describes our approach to managing risk, risk appetite, 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.*

**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:

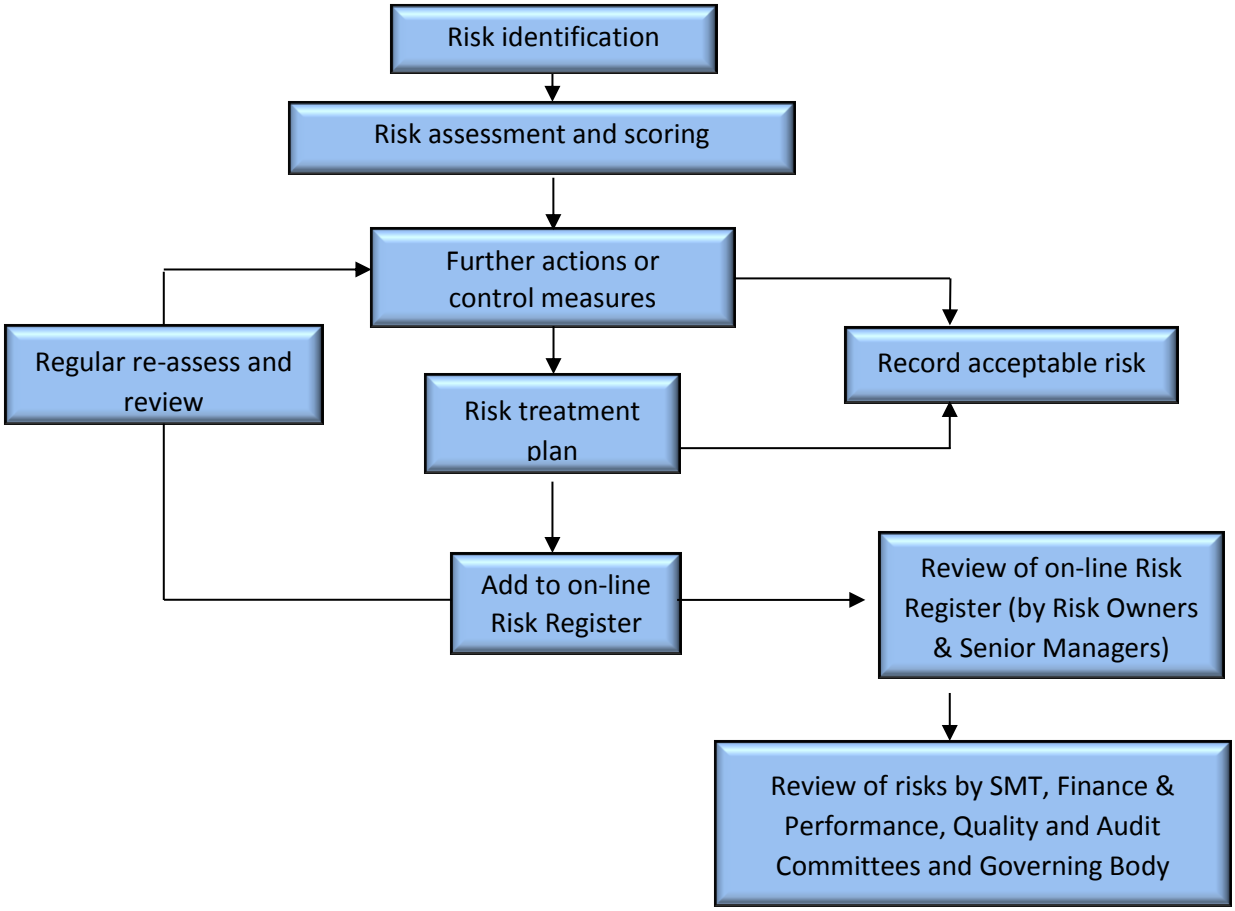
- The Governing Body Assurance Framework (GBAF), which focusses on strategic / long-term risks to the delivery of the CCG's strategic objectives. The GBAF is formally reviewed and updated twice per annum.

- The Corporate Risk Register, which focusses on more operational risks that may rise and fall within relatively short time periods. The Corporate Risk Register is formally reviewed and updated six times per annum.

More detail regarding the Governing Body Assurance Framework is provided 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 areas that should be reflected in the Risk Register

Risk assessment is a structured process that is embedded within the core business of the organisation and is 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 local system.

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:

a) Accountability for the scrutiny of risk processes and management.
b) 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

The 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 managers who are able to triangulate intelligence on complaints, incidents and claims with soft intelligence and feed-back from stakeholders;
- Feedback from General Practice and the Local Medical Committee
- 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 the health service 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.

The Quality Committee receives quarterly reports on General Practice incidents and other provider serious incidents. The Audit Committee receives reports on CCG corporate incidents as part of the Governance Assurance Reports. Learning identified via other sources is reported to the relevant 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 locally include the Vanguard Partnership NHS providers, the local authority, the third and voluntary sector and other stakeholders. In 2015/16 it also included the Commissioning Support Unit and the newly formed GP Federation. The CCG also works collaboratively with the CCGs across West Yorkshire and Harrogate, known as 'Healthy Futures'. 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 the 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 an Anti-Fraud, Bribery and Corruption Policy which is supported by mandatory training for employees and Governing Body Members. The training includes information on how staff can confidentially report suspected fraud; the CCG's Business Continuity Plan which sets out the CCG's contingency plans to maintain an effective service in the event of a critical incident; regular health and safety, fire and premises risk assessments.

In 2015/16 the CCG commissioned Yorkshire & Humber Commissioning Support to provide equality and diversity expertise, guidance and support to ensure that we were 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 able to demonstrate that we are paying due regard to the needs of protected characteristic groups. We ensure that every decision we make, that would have an impact on the public or our staff, is analysed for its impact on the access, experience and outcomes for protected characteristic groups. This assessment

is then used to support our decision making. Examples of assessments undertaken during the year include:

- Care closer to home specification
- Readiness for public consultation in Right Care, Right, Time, Right Place
- Hospital Service programme
- Over 70s medication review

## 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 policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The Governing Body Assurance Framework (GBAF) 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 GBAF have a named Senior Manager Lead, Governing Body Lead and responsible sub-Committee. The GBAF also details:

- The key controls in place to manage the risk
- Mechanisms to provide assurance on controls
- 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 formally updated twice per annum and is reviewed by the Audit Committee prior to submission to the Governing Body for approval. Furthermore, the GBAF is considered by all Governing Body sub-Committees when reviewing their Terms of Reference and Annual Work Plans to ensure appropriate alignment.

## 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, Kirkup Reviews and the more recent Southern Health review.
- 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 attends 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 risks classed as 'major' on the Corporate Risk Register, i.e. with a score of 16 or above, are detailed below:

| Risk No. | Risk summary | Action to mitigate | Means to assess outcome |
|---|---|---|---|
| **Continued from 2014-15** | | | |
| 549 | 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. | Programme management and governance arrangements. | Monitoring of delivery by Programme Board, reporting to Finance & Performance and Quality Committees and Governing Body |
| 517 | Risk that the nursing home capacity will not be sufficient to meet the needs of people in Calderdale. A number of nursing beds have been lost due to the decision taken by | The CCG is working closely with all stakeholders including providers and the local authority and CHFT to develop actions to mitigate current pressures. These | All agencies are part of a care homes workstream that reports to the Vanguard Board. Operational pressures and actions to mitigate are |

| | | | |
|---|---|---|---|
| | owners to deregister their nursing provision. This is due in part to the difficulties being experienced in the recruitment of nurses. | include working to develop a new model for the care home sector. This work is part of Vanguard. | monitored on an ongoing basis by CCG/Local Authority with monthly reports to Quality Committee. |
| 62 | Risk that the system will not deliver the NHS Constitution 4-hour Accident & Emergency targets due to pressures associated with demand, capacity and flow, resulting in patient care and patient experience being compromised and an inability to provide NHSE with assurance on the stability and resilience of the system. | Urgent Care Board (UCB) with active CCG clinical and managerial input.<br>Penalties for non-delivery of performance within 2015-16 CHFT contract. A&E performance data closely monitored.<br>Action plan developed for Delayed Transfers for Care (DTOC) to support improved flow.<br>Strategic direction of Care Close to Home is shift away from unplanned hospital admissions. | Performance dashboard shared weekly, with monthly scrutiny at UCB.<br>Reporting into the Finance and Performance Committee through UCB minutes.<br>Friends and Family Test in place at both Accident and Emergency departments. |
| **New in 2015-16** | | | |
| 643 | Risk that Health Care Acquired Infections (HCAI) are not prevented due to omissions in the provision of care resulting in patient harm. | HCAI Improvement Plan monitored by the HCAI Health Economy group quarterly.<br>Antibiotic prescribing monitored quarterly.<br>Antibiotic campaign carried out in 2015/16.<br>2 Antibiotic prescribing audits carried out. | CHFT monthly HCAI board reports on improvement plan, including assurance on training data, audit, high impact intervention compliance data.<br>Performance data and HCAI Improvement Plan update reported via CCG Quality Committee. |
| 709 | Risk that patients being discharged from hospital experience delayed transfer of care (DTOC) due to a lack of service capacity in NHS and non NHS services outside hospital and health and social care systems not currently optimised, resulting in poor patient experience, additional pressure on the current acute bed base and the system being benchmarked as a national outlier | DTOC Action Group set up under the System Resilience Group (SRG) governance structure to provide oversight of improvement across the system, processes and performance against joint action plan.<br><br>Joint dashboard provides a single, system owned view of delays and pressures. | Urgent Care Board and SRG receive assurance through reports to each meeting on performance and actions.<br>Updates through the CCG's performance report submitted as part of CCG's governance arrangements.<br>NHS England updates on performance as part of CCG Assurance Framework and SRG membership. |

No new major risks have been identified since 31 March 2016.

The CCG's Governing Body Assurance Framework describes the CCG's principal risks to its licence and actions identified to mitigate these risks (see Appendix 2, Governance Statement). The 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 Governing Body Assurance Framework (GBAF) and in compliance with our licence. The GBAF is kept under review by the Senior Management Team. New risks identified on the Corporate Risk Register are assessed to identify any impact of achieving our strategic objectives set out in the GBAF.

Responsibilities of the Senior Management Team and Committees

The CCG's principal risks to compliance with the CCG's licence and actions to mitigate these risks 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. This risk review process includes an assessment as to whether the risk should be incorporated into the GBAF or the corporate risk register – depending upon the strategic nature of the risk.

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 same approach is used for the GBAF, with senior managers reviewing the principal risks in conjunction with the Governing Body lead prior to review by the relevant Committee and Governing Body.

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

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

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 the Governing Body Assurance Framework

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

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

- The Finance, QIPP (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, quality and financial targets this year.

## Information Governance

The NHS Information Governance Framework sets out 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 continued to demonstrate its commitment to good information governance by setting itself the exacting target of achieving level 3 compliance across 19 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
- Staff and Governing Body members are aware of those systems and processes
- Staff and Governing Body members comply with those policies, systems and processes

I am pleased to be able to report that the CCG has retained a level 3 in 18 and a level 2 in 6 of the Information Governance (IG) Toolkit (version 13) requirements with an overall grade of satisfactory.

The roles of Senior Information Risk Owner, Caldicott Guardian and Information Governance lead have been assigned. In 2015/16, the CCG was supported by the Yorkshire and Humber Commissioning Support Information Governance Team. This service has been brought in-house as a shared service across Calderdale, Greater Huddersfield, North Kirklees and Wakefield CCGs as part of the close down of the commissioning support unit. Assurance is provided through the quarterly Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving data security) on a six monthly basis and any actions to mitigate.

Information Governance compliance is managed and controlled through the implementation of the organisation's Information Governance Framework and annual Information Governance Action Plan.

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 2015-16.

## 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.

## Feedback from delegated chains regarding business, use of resources and responses to risk

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England delegated the exercise of specified functions to NHS Calderdale CCG. In accordance with the requirements of NHS England the Governing Body has delegated authority to the Commissioning Primary Medical Services Committee (CPMS) to make decisions within the bounds of its remit, specifically:

- Financial plans in respect of primary medical services
- Procurement of primary medical services
- Practice payments and reimbursement
- Investment in practice development
- Contractual compliance and sanctions.

The governance arrangements established for this committee are in line with those of the CCG. The Chief Finance Officer and Chief Officer are members of the Committee. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Governing Body receives the minutes and reports from the CPMS Committee regarding performance, financial and contractual matters as set out above. Internal Audit conducted a review of co-commissioning arrangements at the CCG in 2015-16 and provided significant assurance. Further work is scheduled in the internal audit work plan for 2016-17. The Chair of the Audit Committee is not a member of the CPMS Committee in order to facilitate an independent view of its work and governance.

These provisions together with the work of the external auditors and assurances from the Audit Committee enable the Governing Body to make a determination on the economic, efficient and effective use of resources by this part of 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. Bespoke training is provided to individuals and teams as required.

In 2015-16 we were supported in the management of risks by the Yorkshire & Humber Commissioning Support (YHCS) Governance & Risk team. YHCS provided expert advice on the use of the risk management system; identified good practice from elsewhere and provided support and guidance to staff on the identification of risks and associated controls and assurances. This service was brought in-house on the 1st March 2016 with the risk register being hosted by Wakefield CCG.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit, Finance and Performance, Quality Committees, 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 quality governance.

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

- **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. Every three years we commission an external review of our governance arrangements. As referred to earlier in this report, in 2015/16 we commissioned KPMG to conduct this external review.

- **Financial Control Environment -** The CCG completed a self-assessment its financial control environment in August 2015. Each CCG was required to evaluate the strength of its financial governance and controls across a range of key areas. The completed assessment was reviewed by the Audit Committee and Governing Body and discussed with the CCG's internal auditors. The CCG reported Excellent in two areas; 'Good' in 11 areas, 'Moderate' in 4 areas, 'not applicable' in one area.

Testing of a sample of 5 areas of the self- assessment by West Yorkshire Audit Consortium (WYAC) has provided a significant level of assurance that adequate evidence was in place to support the CCG self-assessment.
We reported moderate compliance in:

- Long term planning
- System of financial control - risk sharing and income recognition
- Risk Management - Identifying and monitoring processes and level of net risk

As a consequence we are taking forward a number of actions to move from a self-assessed rating of 'moderate' to 'good' for 2016/17.

- **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.

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

## Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's system of risk management, governance and internal control. The Head of Internal Audit concluded that (the Head of Internal Audit Opinion in full is included at Appendix 3 of this governance statement):

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

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

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 continued to develop 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 and dashboards 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 within care homes where an exception report is provided to Quality Committee on a monthly basis. The Contracting and QIPP (Quality Innovation, Productivity and Prevention) reports have continued to develop enabling a better understanding of the areas requiring a greater focus.

## 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 2015/16 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

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, 26th May 2016

**Appendix 1**

## Governing Body and Sub-Committees Membership and Attendance

## As at 31st March 2016

| Governing Body (includes meetings in parallel with Greater Huddersfield CCG) | | |
|---|---|---|
| **Member** | **Role** | **Attendance** |
| Dr Alan Brook | Chair and GP member [4] | 7/10 |
| Dr Matt Walsh | Chief Officer (Accountable Officer) | 9/10 |
| Julie Lawreniuk | Chief Finance Officer | 9/10 |
| David Longstaff | Lay Member and Deputy Chair | 10/10 |
| Dr Steven Cleasby | Assistant Clinical Chair and GP Member | 7/10 |
| Dr Majid Azeb | GP Member | 9/10 |
| Dr Hazel Carsley | GP Member | 7/10 |
| Dr John Taylor | GP Member | 7/10 |
| Dr Nigel Taylor | GP Member | 8/10 |
| Dr Caroline Taylor | GP Member | 8/10 |
| Kate Smyth | Lay Member (patient and public involvement) | 10/10 |
| Jackie Bird | Registered Nurse | 7/10 |
| Dr Rajesh Phatak | Secondary Care Specialist | 9/10 |
| **Advisors to the Governing Body** | | |
| John Mallalieu | Lay Advisor (Finance, Performance and External Relations) | 10/10 |
| 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) | 8/10 |

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

| Finance and Performance Committee (as at 31st March 2016) | | |
|---|---|---|
| **Member** | **Role** | **Attendance** |
| Dr Nigel Taylor | Chair and GP Member | 11/12 |
| Dr Matt Walsh | Chief Officer | 12/12 |
| Julie Lawreniuk | Chief Finance Officer | 9/12 |
| John Mallalieu | Lay Advisor (Finance, Performance and External Relations) | 11/12 |
| Dr Caroline Taylor | GP Member | 7/12 |
| Kate Smyth | Lay Member (PPI) deputy for the Lay Advisor | 1/1 |
| **Quality Committee (as at 31st March 2016)** | | |
| **Member** | **Role** | **Attendance** |
| Dr Majid Azeb | Chair and GP Member | 9/12 |
| Dr John Taylor | GP Member | 12/12 |
| Kate Smyth | Lay Member | 12/12 |
| Penny Woodhead | Head of Quality | 11/12 |
| Louise Burrows | Quality Manager/designated deputy for the Head of Quality | 1/1 |
| **Commissioning Primary Medical Services Committee (as at 31st March 2016)** | | |
| John Mallalieu | Lay Advisor (Finance, Performance and External Relations) (Chair of the Committee) | 1/1 |
| Kate Smyth | Lay Member (Patient and Public Involvement) (Vice Chair of the Committee) | 1/1 |
| Dr Matt Walsh | Chief Officer | 1/1 |
| Julie Lawreniuk | Chief Finance Officer | 1/1 |
| Jackie Bird | Registered Nurse | 1/1 |
| Rajesh Phatak | Secondary Care Specialist | 0/1 |
| Dr Alan Brook | GP Member | 1/1 |
| Dr Caroline Taylor | GP Member | 1/1 |

| Audit Committee (as at 19th May 2016) | | |
|---|---|---|
| **Member** | **Role** | **Attendance** |
| David Longstaff | Lay Member and Chair | 9/9 |
| John Mallalieu | Lay Advisor (Finance, Performance and External Relations) | 8/9 |
| Kate Smyth | Lay Member | 8/9 |
| Jackie Bird | Registered Nurse | 8/9 |
| Dr Hazel Carsley | GP Member | 5/7 |
| Dr Steven Cleasby | GP Member | 6/9 |

**Appendix 2**

**Principal risks to compliance with the CCG's licence and actions identified to mitigate these risks in 2015/16: Governing Body Assurance Framework**

| Strategic Objective | | Risk | Mitigation |
|---|---|---|---|
| **1.** | Improving Healthcare outcome | Risk of CCG not understanding the wider determinants of health and not supporting CMBC Public Health Team in tackling these determinants due to a lack of effective partnership working / integrated working, particularly with the Health and Well Being Board, not using intelligence to identify the areas of highest need, service models not being evidence-based resulting in people dying prematurely and no reduction in health inequalities. | ▪ 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<br>▪ 5 Year Strategic Plan aligned with Wellbeing Priorities<br>▪ 5 Year Strategic Plan and one year delivery plan informed by Joint Strategic Needs Assessment (JSNA), local and national business intelligence; in line with national indicators; Use of commissioning for value intelligence packs (NHS England); use of member practice intelligence.<br>▪ Performance monitored through Better Care Fund (BCF) Board, Care Closer to Home and Hospital Services Programme Boards, presentations to Scrutiny Committees.<br>▪ Alignment of the 16/17 Better Care Fund plan with the CCG's one year plan (2016/17) |
| | | Risk of CCG failing to deliver the 5 year strategic plan due to a lack of support from public and stakeholders, a lack of capacity and capability, the quality of relationships with local authority - resulting in CCG not delivering its strategic objectives / outcomes | ▪ 5 Year Strategic Plan informed by robust and continuous process of public and stakeholder engagement.<br>▪ Communication of strategic priorities and rationale to the public and stakeholders and rolling programme of engagement activity (see Strategic Objective 2).<br>▪ Alignment of capacity and processes to delivery of strategic plan.<br>▪ Organisational development plan to support |

| | | | |
|---|---|---|---|
| | | | capacity and capability |
| **2.** | **Improve service user experience** | | ▪ Patient and Public Engagement and Experience (PPEE) Strategy (2013-2015) and annual improvement plan.<br>▪ 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)<br>▪ Use of contracting mechanisms for patient feedback, CQUINS reports on patient experience, reported to CCG by providers.<br>▪ Use of engagement assurance process for development of service specifications such as CC2H. |
| | | | ▪ Engagement and Experience Strategy for Local People in Calderdale 2015-2018 and annual implementation plan clear about statutory requirements.<br>▪ PPEE group terms of reference<br>▪ Presentation of Annual Statement of Involvement at the AGM (2014-15)<br>▪ Equality and Diversity Strategy and Action Plan and Annual Public Sector Equality Duty Report (Jan 20016)<br>▪ Governing Body lay member for PPI<br>▪ 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 | ▪ Yorkshire Public Health Organisation (YPHO) 'Commissioning for Value' packs used to inform strategic priorities - annually updated |

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| | | risk of Long Term Conditions (LTCs), service models not being evidence-based- resulting in not delivering strategic objectives / outcomes for LTCs | ▪ Business planning process contains test against clinical evidence base, such as patient and clinical involvement outcomes, NICE/ SIGN guidelines, patient and public involvement.<br>▪ Commissioning Engagement Scheme ensures practice commissioning leads' involvement in commissioning plans' prioritisation;<br>▪ High Performing Membership Organisation (HPMO) Steering Group Terms of Reference<br>▪ 5 year Strategic Plan and BCF plan sets out LTC work<br>▪ 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 reablement and recovery | ▪ 5 year Strategic Plan identifies priorities and outcomes for recovery and reablement, with focus on development of community services.<br>▪ Partnership working between CCG and local authority including through the Health and Wellbeing Board, attendance of Dir. Public Health at CCG Governing Body, BCF Board with joint local authority /CCG membership.<br>▪ Commissioning priorities aligned to Wellbeing Priorities.<br>▪ BCF Plan: reablement and independence key part of plan, 2 national metrics monitoring performance in this area<br>▪ Use of risk stratification tools such as part of Frailty pilot (Care Closer to Home/Vanguard)<br>▪ Care Closer to Home/Vanguard care models |
| **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.<br>▪ Use of quality standards, quality schedule, |

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| | | | patient safety and relevant targets within service specifications.<br>▪ Use of contract governance and monitoring processes including Contract Quality Boards<br>▪ Use of CQuINs indicators, contract monitoring arrangements in place.<br>▪ Use of learning from complaints, Serious Incidents/ Serious Case Reviews reported into Quality Committee and private section Governing Body.<br>▪ 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.<br>▪ Mandatory training within CCG, standards in place with providers.<br>▪ Safeguarding standards included within contracts<br>▪ Annual Section 11 Audits scrutinise provider safeguarding arrangements, (policies and procedures, training).<br>▪ Provider s11 assessments scrutinised by Safeguarding Board<br>▪ Active member of the Local Safeguarding Children's Board and Adults' Board<br>▪ 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.<br>▪ Provider Infection control policies and |

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| | | | procedures in place.<br>▪ Public Health membership of Quality Committee provide Infection Prevention and Control advice / support<br>▪ Performance targets on healthcare acquired infections (HCAI) included in Quality Dashboard report and discussed at Contract Quality Boards<br>▪ 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.<br>▪ Budgetary control and budgetary reporting systems in place, with processes to ensure recurrent surplus.<br>▪ Business planning process for non-recurrent monies ensures short term commitment to expenditure.<br>▪ Regular monitoring arrangements in place, with finance position reported through SMT and the Finance and Performance Committee.<br>▪ 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.<br>▪ 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.<br>▪ Development of CC2H model to reduce increasing demand on acute services.<br>▪ QIPP plans developed and aligned with HWB to help achieve BCF target reduction of |

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| | | | emergency admissions.<br>▪ Calderdale BCF Project Board with joint CCG/Local Authority membership. |
| **6.** | **Empowering Citizens and resilient communities** | Risk that CCG does not commission information or advice on supported self-managed care and primary prevention due to commissioning plans not being fit for purpose or evidence-based resulting in an over reliance on health services by local population. | ▪ 5 year Strategic Plan sets out strategic direction for supported self-managed care and primary prevention. Operational plan sets out commitments for 2015/16.<br>▪ Better Care Fund sets out how CCG will deliver supported self-managed care and primary prevention jointly with Calderdale MBC<br>▪ CC2H model specifies services to deliver supported self-managed care and primary prevention. Phase 1 in 2015/16<br>▪ 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<br>▪ Annual review of terms of reference of Committees include statutory requirements<br>▪ Annual Committee work plans include statutory requirements.<br>▪ Rolling programme of policy review to ensure comply with changes in legislation, national guidance.<br>▪ Regular reports from internal, external audit and counter fraud to Audit Committee<br>▪ Internal/external audit reviews/reports ensuring CCG compliant<br>▪ Horizon scanning |
| | | Risk that CCG has ineffective governance and risk | ▪ Robust governance structure including annual |

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| | | management processes in place due to not having the right structures, capacity and capability | self -assessment and review, with external review every three years; integrated risk management framework and systems of internal control in place (see Governance Statement)<br>▪ Bi-annual private meetings between Audit Committee members, internal and external audit to discuss any issues of concern.<br>▪ PDR (Performance Development Review) for staff and governing body to identify and support any development needs.<br>▪ 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, 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.<br>▪ Organisational Development (OD) Framework in place.<br>▪ Governing Body and Committee annual self-assessment identifies development areas.<br>▪ Use of Associates to provide additional capacity and capability for work on CCG priority areas. |
| | | 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; resulting in strategic solutions which do not take Calderdale concerns taken into account. | ▪ Active participation in West Yorkshire Commissioning Collaborative (11 CCGs) structure with clear terms of reference.<br>▪ Maintaining good relationships with NHS England Area Team.<br>▪ 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 uncertainty created by co-commissioning / blurred boundaries for NHS England responsibilities (e.g. specialised services) - resulting in local people receiving sub optimal healthcare services / | ▪ NHS England statutory responsibilities for commissioning services remain with responsibility for commissioning primary medical services delegated to the CCG.<br>▪ Primary care co-commissioning overview |

| | | | |
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| | | falling between gaps in tiers. | September 2014 (Gateway ref: 02299)confirms focus is on general practice co-commissioning in 2015/16<br>▪ CCG maintains duty to improve the quality of primary care.<br>▪ 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.<br>▪ 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.<br>▪ Annual Governing Body member visit to each member practice, 2015/16 focused on securing engagement with wider membership.<br>▪ High Performing Membership (HPMO) Steering Group with responsibility for membership engagement.<br>▪ Practice Managers Action Group inputs to clinical commissioning and shares information with member practices on behalf of CCG. |

**Appendix 3**

**HEAD OF INTERNAL AUDIT OPINION**
**ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT**
**NHS CALDERDALE CLINICAL COMMISSIONING GROUP**
**FOR THE YEAR ENDED 31 MARCH 2016**

## Roles and responsibilities

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

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

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

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

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

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

## The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

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

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

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

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

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

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

During 2015/2016 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to be embedded.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. The design of the Assurance Framework has been kept under regular review since the creation of the CCG with the Governing Body retaining oversight of its design and content. The Governing Body reviews the Assurance Framework bi-annually and reviewed the Assurance Framework in both August 2015 and January 2016. The Assurance Framework is subject to regular review by both the CCG's Audit and Quality committees.

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

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

The 2015/16 Internal Audit Plan was approved by the Audit Committee on 21 May 2015. The work of Internal Audit continues to focus on the design and embedding of core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities of the CCG:

- Governance (incorporating assurance and risk management)
- Securing Improvements in Quality
- Commissioning and Contract Management
- Business Development
- Integration
- Financial Governance
- Information Governance

- Vanguard – Multi Speciality Provider of Care

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

| | |
|---|---|
| **FULL** | Full assurance can be given that there is a strong system of internal control which is designed and operating effectively to meet the organisation's objectives. |
| **SIGNIFICANT** | Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to meet the organisation's objectives and that this is operating in the majority of core areas |
| **LIMITED** | Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in it's design and/or operation in core areas to effectively meet the organisation's objectives |
| **LOW** | Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the organisation's objectives. |

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

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level during the development phase. A total of three advisory audits have been undertaken during 2015/16.

An advisory audit has been undertaken in relation to the CCGs Vanguard and Care Closer to Home initiatives. Two other advisory audits have been undertaken during 2015/16. These were in relation to a Risk Register Benchmarking exercise and a survey on Lead & Collaborative Commissioning.

It is noted that no overall assurance opinion has been provided in relation to the Information Governance Toolkit audit completed during the year. However, I can confirm that adequate evidence was in place to support a level 2 attainment or above for all of the requirements sampled in relation to version 13 of the Toolkit (submitted by the CCG as at 31 March 2016).

The outcome of the assurance audit reports from the 2015/16 audit plan are summarised below:

| **Audit** | **Assurance Level** |
|---|---|
| Governance Review | Significant |
| Financial Control Environment Checklist | Significant |
| Quality, Innovation, Productivity and Prevention (QIPP) | Significant |
| Better Care Fund | Significant |
| Primary Care Co-Commissioning | Significant |
| Financial Transactions | Significant |
| Information Governance Toolkit | No opinion |
| Contract Management | Significant |
| Quality Improvement | Significant |

As agreed by the CCG's Audit Committee on 3 March 2016, the Lead Commissioning & Collaboration audit, as per the audit plan, is to be deferred until 2016/17.

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

**Looking Ahead**

The overall opinion of Significant Assurance for the Head of Audit Opinion is set in a context of significant challenges facing the organisation going forwards.

At the Governing Body meeting in April 2016 it was noted that the CCG was on track to deliver a surplus of £7.4m in 2015/16. Looking ahead to 2016/17 the CCG has submitted a financial plan that does meet the business rules set by NHS England, including, to deliver the a minimum 1% surplus.

**HELEN KEMP TAYLOR**
**ACTING HEAD OF AUDIT**
**APRIL 2016**

# Remuneration and Staff Report

## 1. Membership of the Remuneration Committee

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

| Remuneration Committee | | |
|---|---|---|
| **Member** | **Role** | **Attendance** |
| Kate Smyth | Lay Member and Chair of the Committee[5] | 5/6 |
| Jackie Bird | Registered Nurse | 4/6 |
| Dr Alan Brook | Chair of CCG/GP Member | 5/6 |
| Dr Hazel Carsley | GP Member | 4/6 |
| Dr Nigel Taylor | GP Member (GP substitute) | 1/1 |
| **Advisors to the Remuneration Committee** | | |
| John Mallalieu | Lay Advisor (Finance, Performance and External Relations) | 6/6 |

The Remuneration Committee is supported in its determinations by senior professionals who provide support and advice to the Committee. These professionals include a senior HR Professional from the HR service at Calderdale and Huddersfield Foundation Trust the CCG Chief Finance Officer and the Lay Advisor to the Governing Body.

The Governance statement contains further 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

[5] Kate Smyth did not join one meeting due to a conflict of interest in the item under discussion

- Lay Advisor to the Governing Body
- Head of Quality in her capacity as Advisor to the Governing Body

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above. There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement. These, together with benchmarking information and legal advice provided by 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 executive of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;

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

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

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

**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
- 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 was recently reviewed. It was agreed in view of the above guidance, and taking into account that no increase had been applied to either post since 2013, that a small increase would be applied to both posts.

**GP Members of the Governing Body**

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

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

**Registered Nurse and Secondary Care Specialist**

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

**Lay Members and Lay Advisors**

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

## 3. Pay Award in 2015/16

In 15/16 a small increase was approved in respect of the Governing Body members and the Lay advisor to the Governing Body on a contract for service. This took into account the following factors:

- Benchmarking information
- Information received from Jeremy Hunt in relation to VSM remuneration
- Recruitment and retention and succession planning
- Information provided in 'NHS Clinical Commissioning Group Boardroom Pay 2015 and the recommendations of the Review Body on Doctors' and Dentists' Remuneration 2015/16
- The financial position of the CCG
- Public perception
- Internal perception of others in the CCG.

## 4. Benchmarking rates of remuneration

The proposed remuneration for each of the classes 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.

## 5. Senior Managers Performance Related Pay

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

## 6. Policy on Senior Manager Contracts[6].

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

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

As set out in the CCG's Standing Orders, the usual term of office for all Governing Body members with the exception of the Accountable Officer and Chief Finance Officer is three years. 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.

The Head of Quality is also an Advisor to the Governing Body as set out in the CCG's Constitution, and as such is classed as a senior manager[7]. This post is shared with NHS Greater Huddersfield CCG, and the post-holder is engaged by NHS Greater Huddersfield CCG under a contract of employment. The arrangement is governed by a Memorandum of Understanding between the CCGs.

## 7. Compensation for Early Retirement or Loss of Office

No payment has been made in compensation for loss of office or early retirement during 15/16.

[6] DH Group Manual for Accounts 2015-16
[7] DH Group Manual for Accounts 2015-16

## 8. Payments to past senior managers

No payment has been made to past senior managers.

## 9. Exit packages or severance packages

There have been no exit or severance packages paid during 2015/16.

## 10. Salaries and allowances

| | | 2015-16 | | | | | |
|---|---|---|---|---|---|---|---|
| **Name & Title** | **2015/16 Staff in Post** | **Salary & Fees (bands of £5,000) £000** | **Taxable Benefits** | **Annual PRP** | **Long-Term PRP** | **All Pension Related Benefits** | **Total** |
| | | | | | | | |
| Dr.Alan Brook, Chair | All Year | 60-65 | 0 | 0 | 0 | 0 | 60-65 |
| Dr.Steven Cleasby, Assistant Clinical 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.Majid Azeb | All Year | 30-35 | 0 | 0 | 0 | 0 | 30-35 |
| Dr.Nigel Taylor | All Year | 30-35 | 0 | 0 | 0 | 0 | 30-35 |
| Dr.Caroline Taylor | All Year | 30-35 | 0 | 0 | 0 | 0 | 30-35 |
| Dr Rajesh Phatak, Secondary Care Specialist | All Year | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Jackie Bird, Registered Nurse | All Year | 15-20 | 0 | 0 | 0 | 0 | 15-20 |
| Kate Smyth, Lay Member | All Year | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| John Mallalieu, Lay Advisor to the Governing Body | All Year | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| David Longstaff, Deputy Chair and Lay Member | All Year | 5-10 | 0 | 0 | 0 | 0 | 5-10 |
| Matt Walsh - Accountable Officer | All Year | 130-135 | 0 | 0 | 0 | 40.0-42.5 | 175-180 |
| Julie Lawreniuk - Chief Finance Officer **(Note 1)** | All Year | 50-55 | 0 | 0 | 0 | 35.0-40.0 | 90-95 |
| | | | | | | | |

**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 Finance Officer. Her total salary is in the banding £105k-£110k, however only 50% has been included in the Salary and Fees column. In the All Pensions Related Benefits column, we have included 100% of the increase in pension entitlement, as the overall increase cannot be accurately apportioned between Calderdale and Greater Huddersfield CCGs in relation to Pensions Related Benefits.

**Note 2**: The following Governing Body members received payments for Associate work in addition to their roles as Governing Body members: Dr M Azeb (£4,344), Dr H Carsley (£287), Dr C Taylor (£8,223), Dr N Taylor (£1,722) and Dr J Taylor (£3,444)

### Salary & Pension Disclosure tables

| Name & Title | 2015/16 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 31/03/16. (Bands of £5,000) £000's | Lump sum at age 60 related to accrued pension as at 31/03/16. (Bands of £5,000) £000's | CETV at 31/03/15 £000's | CETV at 31/03/16 £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 | 5.0-7.5 | 20-25 | 60-65 | 402 | 444 | 37 | 26 |
| Julie Lawreniuk Chief Finance Officer **(Note 2)** | All Year | 0-2.5 | 2.5-5.0 | 30-35 | 100-105 | 610 | 654 | 36 | 25 |
| | | | | | | | | | |

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

## 11. Pay Multiples

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

The banded remuneration of the highest paid director/Member in NHS Calderdale CCG in the financial year 2015-16 was £150-155k (2014-15, £150-155k). This was 4.6 times (2014-15, 5.07) the median remuneration of the workforce, which was £33,227 (2014-15, £29,759).

In 2015-16, 0 (2014-15, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £13k to £152k (2014-15, £17k-£151k).

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

# STAFF INFORMATION

The CCG's workforce profile is shown below and the information is based on the directly employed staff of the CCG as at 13 April 2016. Information relating to Governing Body members is reported separately. Some data is not shared to avoid identification of individuals.

The CCG directly employs 79 staff, which equates to 77.7 Full Time Equivalents (FTEs).

**Gender profile of the organisation**

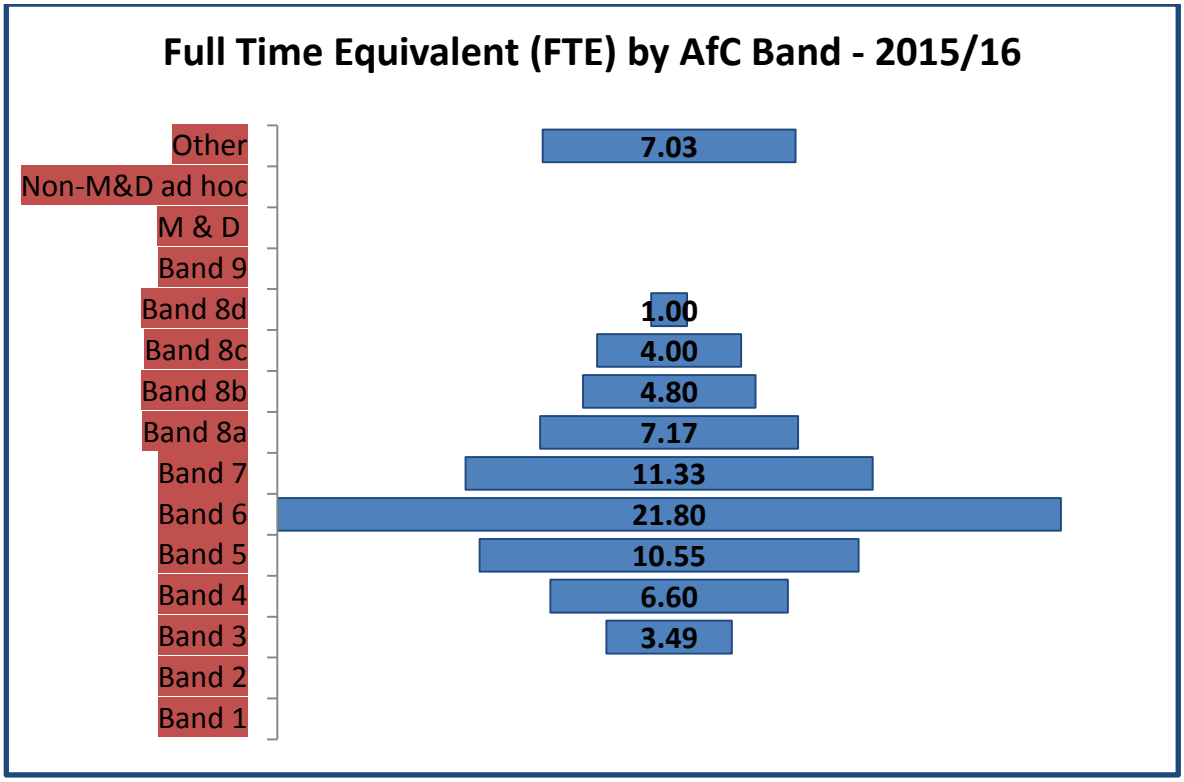
| Gender profile | Headcount | |
|---|---|---|
| | Male | Female |
| Governing Body including lay advisor (excl. Very Senior Managers) | 8 | 3 |
| Very Senior Managers (VSM) | 1 | 1 |
| Staff Excl. Governing Body and VSMs | 12 | 65 |

**Age Profile of the organisation (staff excluding the Governing Body)**

| Age range | Headcount |
|---|---|
| 26-30 | 4 |
| 31-35 | 8 |
| 36-40 | 6 |
| 41-45 | 15 |
| 46-50 | 10 |
| 51-55 | 24 |
| 56-60 | 11 |
| 61-65 | 1 |
| 66-70 | 1 |

**Ethnicity (staff excluding the Governing Body)**

| Ethnicity | Headcount |
|---|---|
| White | 75 |
| Asian/Asian British | 2 |
| Black/Black British | 1 |
| Other | 1 |
| Not stated | 1 |




**Sickness absence**

Our CCG has a genuine interest in developing the health and wellbeing agenda to ensure a healthy working environment for all colleagues. During 2015 and 2016, the CCG's senior management has worked closely with our staff forum to develop a wellbeing approach, which has been very positively received by staff. One element of this approach has been participation in the Global Corporate Challenge (GCC), which is referenced in the Five Year Forward View. GCC reported quantifiable results which demonstrated significant increases in the activity level and productivity of staff, and a decrease in stress levels. The CCG is also piloting other innovative approaches to health and wellbeing, which it will be able to measure and evaluate during 2016.

The CCG has policies and procedures in place to support colleagues with sickness absence management and is keen to develop a positive and pro-active approach to supporting colleagues through sickness or difficult periods in their lives. During 2015, the CCG reviewed its Occupational Health provision, and engaged a new provider to ensure the service was fit for purpose for CCG staff. Through this service, staff and managers have access to professional Occupational Health support to help manage any issues they may be facing relating to their health, which need to be addressed to ensure they have the necessary support to carry out their roles.

During 2015, the CCG also introduced an Employee Assistance Programme (EAP) to further support the needs of the workforce. This service provides confidential advice and counselling support to staff, which the CCG views as being important to support the

health and wellbeing of staff. This service has also been offered to GP Practices, with 6 Practices deciding to offer this service to their staff.

In 2015/16, the CCG had no significant levels of staff sickness absence.

The yearly average sickness figures for Calderdale CCG between 1st April 2015 and 31st March 2016 are:

| | |
|---|---|
| Total Days lost: | **195** |
| Total Staff Years | **54** |
| Average Working Days Lost: | **4** |

Further sickness absence data will be provided in the employee benefits note to the Financial Statements once available.

**Organisational Change**

The CCG has seen significant change in its staffing during 2015 and early 2016. This is due to the closure of Yorkshire and Humber Commissioning Support and a number of employees transferring to the CCG. Staff transfers are now complete and the organisation is continuing to focus its efforts on the continued integration of staff into the CCG.

As part of the Commissioning Support Unit's closure, the provision of the Human Resources Service transferred to a new provider, Calderdale and Huddersfield NHS Foundation Trust.

**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 |
|---|---|
| Giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities. | ▪ Diversity and Equal Opportunities in Employment Policy.<br>▪ Recruitment and Selection Policy. |
| Continuing the employment of, and arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company. | ▪ Diversity and Equal Opportunities in Employment Policy.<br>▪ Sickness Absence Policy.<br>▪ Flexible Working Policy. |

| | |
|---|---|
| Training, career development and promotion of disabled people employed by the company. | ▪ Diversity and Equal Opportunities in Employment Policy.<br>▪ Appraisal procedure.<br>▪ Recruitment and Selection Policy.<br>▪ Pay Progression Policy |

The CCG has a rolling programme of policy review and awareness raising, which includes the above policies.

**Achieving the 'two ticks' award – positive about disabled people.**

In 2013/14 the CCG invested a significant amount of time into securing the "Two Ticks" award - positive about disabled people. This was awarded to the CCG by Job Centre Plus and allows us to use the logo which shows disabled people that we have made the following commitments regarding recruitment, training, retention, consultation and disability awareness:

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

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

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

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

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

The CCG was successful in retaining this award in 2015. At the time of writing, the CCG is in the process of undergoing a review, and it is expected that the CCG will retain the award in 2016.

# EXPENDITURE ON CONSULTANCY 2015-16

**Consultancy Costs 15/16**

| Supplier | Description | (£) |
|---|---|---|
| ADAPTIVE IDEAS LTD (**see note1**) | Consultancy for integrated working with Calderdale Council on the Better Care Fund and childrens' services | 81,043 |
| PAUL TARPLETT | Consultancy to facilitate a joint senior management workshop with the Local Authority | 1,036 |
| QI CONSULTING | Consultancy for Healthy Futures Programme | 14,850 |
| | | **96,929** |

note1: Adaptive Ideas 32k recharged to Council

**External Audit**

KPMG has been appointed by the Public Sector Audit Appointments Limited 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 £70,350 (excluding VAT):

| Services from KPMG | £ |
|---|---|
| **Audit Services**<br><br>(statutory audit and services carried out in relation to the statutory audit, eg. reports to NHS England | 48,750 |
| **Further assurance services**<br><br>(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) | 21,600 |
| **Other Services** | 0 |
| **TOTAL** | 70,350 |

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

## OFF PAYROLL ENGAGEMENTS

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

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

**Required disclosure**

Off-payroll engagements as of 31 March 2016, 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 | 1 |
| For between one and two years at the time of reporting | 4 |
| For between two and three years at the time of reporting | 6 |
| 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 2016 | 11 |
| | **Number** |
| Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016 | 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 | 8 |
| **Of which, the number:** | |
| For whom assurance has been received | 8 |
| For whom assurance has not been received | 0 |
| That have been terminated as a result of assurance not being received | 0 |

| | **Number** |
|---|---|
| Number of off-payroll engagements of membership Body and/or Governing Body members, and/or senior officials with significant financial responsibility, during the financial year. | 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 |

## THIRD PARTY ASSURANCE

At the time of writing no significant issues have been reported.

Dr Matt Walsh, Accountable Officer, 26th May 2016

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

### Dr Alan Brook
### Chair of CCG

Alan Brook has been a GP in Brighouse since 1987 and was one of two national GP trainee representatives on the Royal College of General Practitioners.

On arrival in Calderdale he joined the Local Medical Committee and later served as its Chair. In 1990 Alan founded the Audit Group, which helped local GP practices to compare their performance with others and identify areas for improvement. He then chaired the Primary Care Group, which in turn became a Primary Care Trust.

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

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

### Mr David Longstaff, Lay Member
### Chair of the Audit Committee

David Longstaff has spent of most of his career working for British Telecom. He started as an apprentice and finished after 38 years as a senior executive in charge of audit and risk. 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 and is the CCG's lead for whistle-blowing and conflicts of interest. He's passionate about the CCG being open and transparent and getting the best outcomes for local people.

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

David is married, has one child and three grandchildren. He is a big Rugby League fan.

## Dr Matt Walsh
## Chief Officer

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

Matt spent 6 years in senior management as Medical Director for Bradford South and West Primary Care Trust, and was responsible for bringing the four Bradford and Airedale CCGs together to create a single Bradford and Airedale PCT. He then moved to a role in NHS Leeds PCT as Medical Director and Executive Director for Commissioning, where he spent 4 years before joining NHS Calderdale as Medical Director in 2009.

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 and the Commissioning Primary Medical Services Committee.

## 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 Commissioning Primary Medical Services Committee and the Finance and Performance Committee and advises both the Audit and Remuneration Committees.

## Dr Steven Cleasby,
## Assistant Clinical Chair

Steven has been a GP in Calderdale since 1999, when he started at Spring Hall Group Practice.

His specialist area is Diabetes and 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, Steven holds a number of lead roles, including being a member of the Audit Committee; lead for Safeguarding and for Cardiovascular Disease.

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

## Dr Majid Azeb,
## GP Member of the Governing Body

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

As well as his practice role, Majid holds a number of lead roles within the CCG. He is Chair of the Quality Committee and clinical lead for urgent care and non-elective care, which puts him at the heart of developing services in these areas.

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

## Jackie Bird,
## Registered Nurse

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

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

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

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

## Dr Hazel Carsley,
## GP Member of Governing Body

Hazel has been a GP in Calderdale since 1988. She trained at Leeds Medical School and underwent vocational training on the Bradford VTS scheme. Hazel is a partner at the Boulevard Medical Practice.
She has been the CCG's clinical lead for children's and women's care since the organisation's inception, and was previously Cancer and Palliative Care lead Hazel finds working in partnership stimulating and as such took on the role as Designated Medical Officer for Special Educational Needs and Disability, working closely with the local authority.

As a GP, Hazel's goal has always been to make sure she provides the best healthcare possible for patients. She feels it is a privilege to have worked closely with many families over the years, and to now be able to represent them in healthcare commissioning. Hazel retired from the Governing Body at the end of March 2016.

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

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

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

John is a Lay Advisor to the Governing Body, the Audit Committee and the Remuneration Committee. He is Chair of the Commissioning Primary Medical Services Committee and a member of the Finance and Performance Committee.

## Dr Rajesh Phatak Secondary Care Specialist

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 the North West and North Wales Transport Service, which delivers paediatric intensive care advice and retrieval services to North West England and North Wales. He has been recently appointed as Lead Clinician for the North West Paediatric Critical Care network and is an advisor on the National Confidential Enquiry into Patient Outcome and Death neuro-disability study.

He is an exams board member for the Royal College of Paediatrics and Child Health and has a keen interest in education, regularly teaching on Advanced Paediatric Life Support and Paediatrics BASIC courses. Rajesh has also worked with a cardiac surgical charity, Healing Little Hearts and has a keen interest in ensuring learning from clinical excellence is just as important as learning from untoward clinical events.

Rajesh is a member of the Commissioning Primary Medical Services and Remuneration Committees. In his spare time Rajesh maintains a healthy interest in sports, music and photography.

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

Kate has lived in Todmorden for over 30 years and has a special interest in how health and care services are delivered.
Her appointment to the Governing Body 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 wheelchair user Kate (along with her trusted assistance dog Hal) has direct experience of how the delivery of health and care services impacts on patients and service users.

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

## Dr Caroline Taylor
## GP Member of the Governing Body

Caroline graduated from Leeds Medical School in 1992, underwent GP training in York and Otley, and has held a variety of hospital and GP jobs, including working at Overgate Hospice for two years.

Caroline has been a GP in Calderdale since 1999 when she started working at Beechwood Medical Centre. She has always had a keen interest in mental health, and is the CCG's clinical lead for mental health as well as being a member of the Finance and Performance and Commissioning Primary Medical Services Committees.

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

## Dr John Taylor
## GP Member of the Governing Body

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

He has always had an interest in improving healthcare delivery and was first involved in commissioning as a GP Fundholding Practice in the 1990s.
Dr Taylor believes that putting the patient at the centre of decision making regarding service redesign is the key to success.

He was a Member of the CCG Finance and Performance Committee for 3 years until March 2015 when following a reorganisation of responsibilities he became a Member and Vice Chair of the CCG Quality Committee. He is one of the CCG Clinical Leads for Care Closer to Home and Frailty.

## Dr Nigel Taylor
## GP Member of the Governing Body

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

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.

## Penny Woodhead, Head of Quality Advisor to Governing Body

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

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

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

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NHS
Calderdale
Clinical Commissioning Group

# NHS Calderdale Clinical Commissioning Group
# Annual Accounts
# 2015-2016


# FOREWORD TO THE ACCOUNTS

# CALDERDALE CCG

These accounts for the year ended 31 March 2016 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 2015-16

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| Statement of Financial Position as at 31st March 2016 | **2** | | **SOFP** |
| Statement of Changes in Taxpayers' Equity for the year ended 31st March 2016 | **3** | | **SOCITE** |
| Statement of Cash Flows for the year ended 31st March 2016 | **4** | | **SCF** |

**Notes to the Accounts**

**Statement of Comprehensive Net Expenditure for the year ended 31-March-2016**

| | Note | 2015-16 £000 | 2014-15 £000 |
|---|---|---|---|
| **Total Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 3,268 | 2,834 |
| Operating Expenses | 5 | 308,709 | 269,032 |
| Other operating revenue | 2 | (4,539) | (2,949) |
| **Net operating expenditure before interest** | | **307,438** | **268,917** |
| Investment Revenue | 8 | 0 | 0 |
| Other (gains)/losses | 9 | 0 | 0 |
| Finance costs | 10 | 0 | 0 |
| **Net operating expenditure for the financial year** | | **307,438** | **268,917** |
| Net (gain)/loss on transfers by absorption | 11 | 0 | 0 |
| **Total Net Expenditure for the year** | | **307,438** | **268,917** |
| Of which: | | | |
| **Administration Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 2,029 | 2,047 |
| Operating Expenses | 5 | 2,910 | 3,287 |
| Other operating revenue | 2 | (260) | (293) |
| **Net administration costs before interest** | | **4,679** | **5,041** |
| **Programme Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 1,239 | 787 |
| Operating Expenses | 5 | 305,799 | 265,745 |
| Other operating revenue | 2 | (4,279) | (2,656) |
| **Net programme expenditure before interest** | | **302,759** | **263,876** |

| **Other Comprehensive Net Expenditure** | | 2015-16 £000 | 2014-15 £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** | | **307,438** | **268,917** |

**Statement of Financial Position as at 31-March-2016**

| | Note | 2015-16 £000 | 2014-15 £000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 13 | 547 | 597 |
| 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** | | 547 | 597 |
| **Current assets:** | | | |
| Inventories | 16 | 0 | 0 |
| Trade and other receivables | 17 | 1,037 | 827 |
| Other financial assets | 18 | 0 | 0 |
| Other current assets | 19 | 0 | 0 |
| Cash and cash equivalents | 20 | 30 | 14 |
| **Total current assets** | | **1,067** | 841 |
| Non-current assets held for sale | 21 | 0 | 0 |
| **Total current assets** | | **1,067** | 841 |
| **Total assets** | | **1,614** | 1,438 |
| **Current liabilities** | | | |
| Trade and other payables | 23 | (22,078) | (14,916) |
| Other financial liabilities | 24 | 0 | 0 |
| Other liabilities | 25 | 0 | 0 |
| Borrowings | 26 | 0 | (305) |
| Provisions | 30 | 0 | 0 |
| **Total current liabilities** | | **(22,078)** | (15,221) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(20,464)** | (13,783) |
| **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** | | **(20,464)** | (13,783) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (20,464) | (13,784) |
| Revaluation reserve | | 0 | 0 |
| Other reserves | | 0 | 0 |
| Charitable Reserves | | 0 | 0 |
| **Total taxpayers' equity:** | | **(20,464)** | (13,784) |

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 19th May 2016 under delegated authority from the Governing Body.

Chief Accountable Officer
Dr.Matt Walsh

**Statement of Changes In Taxpayers Equity for the year ended 31-March-2016**

| | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2015-16** | | | | |
| **Balance at 1 April 2015** | (13,783) | 0 | 0 | **(13,783)** |
| 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 2015** | **(13,783)** | **0** | **0** | **(13,783)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16** | | | | |
| Net operating expenditure for the financial year | (307,439) | | | (307,439) |
| 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** | **(307,439)** | **0** | **0** | **(307,439)** |
| Net funding | 300,758 | 0 | 0 | 300,758 |
| **Balance at 31 March 2016** | **(20,464)** | **0** | **0** | **(20,464)** |

| | 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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition | **0** | **0** | **0** | **0** |
| **Adjusted NHS Commissioning Board balance at 1 April 2014** | **(14,785)** | **0** | **0** | **(14,785)** |
| **Changes in NHS Commissioning Board taxpayers' equity for 2014-15** | | | | |
| Net operating costs for the financial year | (268,917) | | | (268,917) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Commissioning Board Expenditure for the Financial Year** | **(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)** |

**Statement of Cash Flows for the year ended 31-March-2016**

| | Note | 2015-16 £000 | 2014-15 £000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (307,439) | (268,917) |
| Depreciation and amortisation | 5 | 80 | 97 |
| 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 | | 0 | (305) |
| (Increase)/decrease in inventories | | 0 | 0 |
| (Increase)/decrease in trade & other receivables | 17 | (211) | (383) |
| (Increase)/decrease in other current assets | | 0 | 0 |
| Increase/(decrease) in trade & other payables | 23 | 7,161 | (713) |
| 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** | | **(300,409)** | (270,221) |
| **Cash Flows from Investing Activities** | | | |
| Interest received | | 1 | 0 |
| (Payments) for property, plant and equipment | | (29) | 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** | | **(28)** | 0 |
| **Net Cash Inflow (Outflow) before Financing** | | **(300,437)** | (270,221) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 300,758 | 269,919 |
| 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** | | **300,758** | 269,919 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 20 | **321** | (302) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **(291)** | 11 |
| 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** | | **30** | (291) |

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

## Notes to the financial statements

### 1 Accounting Policies

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

**1.6 Pooled Budgets**

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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

**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.

1.20 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

**Notes to the financial statements**

1.21 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Plus 0.80% (2014-15: minus 2.20%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

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

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.

**Notes to the financial statements**

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

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

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

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 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- 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 2015-16, were they applied in that year.

## 2 Other Operating Revenue

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| Recoveries in respect of employee benefits | 212 | 135 | 77 | 172 |
| 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 ***1** | 4,041 | 116 | 3,925 | 2,670 |
| Continuing Health Care risk pool contributions | 0 | 0 | 0 | 0 |
| Income generation | 0 | 0 | 0 | 0 |
| Rental revenue from finance leases | 0 | 0 | 0 | 0 |
| Rental revenue from operating leases | 0 | 0 | 0 | 0 |
| Other revenue | 286 | 9 | 277 | 107 |
| **Total other operating revenue** | **4,539** | **260** | **4,279** | **2,949** |

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

***1** Non-patient care services to other bodies includes £1.181K revenue received from Greater Huddersfield Clinical Commissioning Group fc

## 3 Revenue

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| From rendering of services | 4,539 | 260 | 4,279 | 2,949 |
| From sale of goods | 0 | 0 | 0 | 0 |
| **Total** | **4,539** | **260** | **4,279** | **2,949** |

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 | 2015-16 | 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 | 2,739 | 2,033 | 706 | 1,676 | 1,266 | 410 | 1,063 | 767 | 296 |
| Social security costs | 212 | 182 | 30 | 147 | 124 | 23 | 65 | 58 | 7 |
| Employer Contributions to NHS Pension scheme | 317 | 278 | 39 | 206 | 178 | 28 | 111 | 100 | 11 |
| Other pension costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **3,268** | **2,493** | **775** | **2,029** | **1,568** | **461** | **1,239** | **925** | **315** |
| Less recoveries in respect of employee benefits (note 4.1.2) | (212) | (212) | 0 | (135) | (135) | 0 | (77) | (77) | 0 |
| **Total - Net admin employee benefits including capitalised costs** | **3,056** | **2,281** | **775** | **1,894** | **1,433** | **461** | **1,162** | **848** | **315** |
| Less: Employee costs capitalised | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **3,056** | **2,281** | **775** | **1,894** | **1,433** | **461** | **1,162** | **848** | **315** |

| 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** |

| 4.1.2 Recoveries in respect of employee benefits | 2015-16 | | | 2014-15 |
|---|---|---|---|---|
| | Total £000 | Permanent Employees £000 | Other £000 | Total £000 |
| **Employee Benefits - Revenue** | | | | |
| Salaries and wages | (171) | (171) | 0 | (138) |
| Social security costs | (17) | (17) | 0 | (15) |
| Employer contributions to the NHS Pension Scheme | (24) | (24) | 0 | (19) |
| Other pension costs | 0 | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 |
| **Total recoveries in respect of employee benefits** | **(212)** | **(212)** | **0** | **(172)** |

### 4.2 Average number of people employed

| | 2015-16 Total Number | 2015-16 Permanently employed Number | 2015-16 Other Number | 2014-15 Total Number |
|---|---|---|---|---|
| **Total** | **64** | **50** | **14** | 52 |
| 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

| | 2015-16 Number | 2014-15 Number |
|---|---|---|
| Total Days Lost | 195 | 76 |
| Total Staff Years | 54 | 41 |
| **Average working Days Lost** | **4** | **2** |

| | 2015-16 Number | 2014-15 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 are not yet available for 2015-16.

The staff sickness absence statistics relate to the calendar year (January to December 2015).

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

### 4.4 Exit packages agreed in the financial year

There were no exit packages or severance payments agreed by Calderdale CCG in 2014/15 & 2015/16.

### 4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 Mach 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant Frame 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### 4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Schemes Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury , and consideration of the advice of the Scheme Actuary and appropriate employee and employer representative as deemed appropriate.

## 5. Operating expenses

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | 2,915 | 1,675 | 1,240 | 2,516 |
| Executive governing body members | 354 | 354 | 0 | 318 |
| **Total gross employee benefits** | **3,269** | **2,029** | **1,240** | **2,834** |
| | | | | |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | 2,891 | 1,291 | 1,600 | 3,899 |
| Services from foundation trusts | 162,628 | 36 | 162,592 | 164,075 |
| Services from other NHS trusts | 18,786 | 0 | 18,786 | 18,367 |
| Services from other NHS bodies | 8 | 0 | 8 | 0 |
| Purchase of healthcare from non-NHS bodies | 56,510 | 0 | 56,510 | 43,399 |
| Chair and Non Executive Members | 383 | 383 | 0 | 371 |
| Supplies and services – clinical | 0 | 0 | 0 | 0 |
| Supplies and services – general | 126 | 56 | 70 | 74 |
| Consultancy services | 129 | 114 | 15 | 0 |
| Establishment | 381 | 142 | 239 | 255 |
| Transport | 3 | 3 | 0 | 0 |
| Premises | 1,707 | 480 | 1,227 | 1,767 |
| Impairments and reversals of receivables | 0 | 0 | 0 | 0 |
| Inventories written down | 0 | 0 | 0 | 0 |
| Depreciation | 80 | 64 | 16 | 97 |
| Amortisation | 0 | 0 | 0 | 0 |
| Impairments and reversals of property, plant and equipment | 0 | 0 | 0 | 0 |
| Impairments and reversals of intangible assets | 0 | 0 | 0 | 0 |
| Impairments and reversals of financial assets | | | | |
| · Assets carried at amortised cost | 0 | 0 | 0 | 0 |
| · Assets carried at cost | 0 | 0 | 0 | 0 |
| · Available for sale financial assets | 0 | 0 | 0 | 0 |
| Impairments and reversals of non-current assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals of investment properties | 0 | 0 | 0 | 0 |
| Audit fees | 58 | 58 | 0 | 78 |
| Other non statutory audit expenditure | | | | |
| · Internal audit services ***1** | 0 | 0 | 0 | 0 |
| · Other services | 18 | 18 | 0 | 0 |
| General dental services and personal dental services | 0 | 0 | 0 | 0 |
| Prescribing costs | 35,968 | 0 | 35,968 | 34,346 |
| Pharmaceutical services | 0 | 0 | 0 | 0 |
| General ophthalmic services | 90 | 0 | 90 | 84 |
| GPMS/APMS and PCTMS ***2** | 28,399 | 213 | 28,186 | 1,742 |
| Other professional fees excl. audit | 42 | 10 | 32 | 32 |
| 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 | 47 | 42 | 5 | 59 |
| Change in discount rate | 0 | 0 | 0 | 0 |
| Provisions | 0 | 0 | 0 | 0 |
| Funding to group bodies | | 0 | 0 | 0 |
| CHC Risk Pool contributions | 455 | 0 | 455 | 387 |
| Other expenditure | 0 | 0 | 0 | 0 |
| **Total other costs** | **308,709** | **2,910** | **305,799** | **269,032** |
| | | | | |
| **Total operating expenses** | **311,978** | **4,940** | **307,040** | **271,866** |

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 £36K are included in Services from Foundation Trusts for 2015/16.

***2** GPMS/APMS and PCTMS included £26.641M for delegated responsibility for commissioning Primary Medical Services for 2015/16.

**6.1 Better Payment Practice Code**

| **Measure of compliance** | **2015-16 Number** | **2015-16 £000** | 2014-15 **Number** | 2014-15 **£000** |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 10,094 | 57,254 | 10,001 | 49,752 |
| Total Non-NHS Trade Invoices paid within target | 10,056 | 57,071 | 9,988 | 49,511 |
| **Percentage of Non-NHS Trade invoices paid within target** | **99.62%** | **99.68%** | **99.87%** | **99.52%** |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 2,527 | 184,936 | 2,505 | 187,273 |
| Total NHS Trade Invoices Paid within target | 2,443 | 184,439 | 2,352 | 186,576 |
| **Percentage of NHS Trade Invoices paid within target** | **99.68%** | **99.73%** | **93.89%** | **99.63%** |

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** | **2015-16 £000** | 2014-15 £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**

| | 2015-16 | | | | | | | | 2014-15 |
|---|---|---|---|---|---|---|---|---|---|
| | Land £000 | Buildings £000 | Other £000 | Total £000 | Land £000 | Buildings £000 | Other £000 | Total £000 | Total £000 |
| **Payments recognised as an expense** | | | | | | | | | |
| Minimum lease payments | 0 | 1,157 | 4 | **1,161** | 0 | 1,358 | 0 | **1,358** | 1,358 |
| Contingent rents | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 |
| Sub-lease payments | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 |
| **Total** | **0** | **1,157** | **4** | **1,161** | **0** | **1,358** | **0** | **1,358** | **1,358** |

The lease payments above include £346K for NHS Property Services, in 20014/15 the equivalent amount was £654k.

**12.1.2 Future minimum lease payments**

| | 2015-16 | | | | | | | | 2014-15 |
|---|---|---|---|---|---|---|---|---|---|
| | Land £000 | Buildings £000 | Other £000 | Total £000 | Land £000 | Buildings £000 | Other £000 | Total £000 | Total £000 |
| **Payable:** | | | | | | | | | |
| No later than one year | 0 | 1,051 | 0 | **1,051** | 0 | 876 | - | **876** | 876 |
| Between one and five years | 0 | 3,104 | 0 | **3,104** | 0 | 3,072 | - | **3,072** | 3,072 |
| After five years | 0 | 6,388 | 0 | **6,388** | 0 | 6,803 | - | **6,803** | 6,803 |
| **Total** | **0** | **10,543** | **0** | **10,543** | **0** | **10,751** | **0** | **10,751** | **10,751** |

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**

| 2015-16 | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction and payments on account £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 01-April-2016** | 0 | 0 | 0 | 0 | 0 | 0 | 78 | 700 | 778 |
| Addition of assets under construction and payments on account | | | | 0 | | | | | 0 |
| Additions purchased | 0 | 0 | 0 | 0 | 0 | 0 | 29 | 0 | 29 |
| Additions donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions leased | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative depreciation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost/Valuation At 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **107** | **700** | **807** |
| **Depreciation 01-April-2016** | 0 | 0 | 0 | 0 | 0 | 0 | 48 | 132 | 180 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 0 | 0 | 0 | 0 | 0 | 22 | 58 | 80 |
| Transfer (to)/from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative depreciation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Depreciation at 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **70** | **190** | **260** |
| **Net Book Value at 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **37** | **510** | **547** |
| Purchased | 0 | 0 | 0 | 0 | 0 | 0 | 37 | 510 | 547 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **37** | **510** | **547** |
| **Asset financing:** | | | | | | | | | |
| Owned | 0 | 0 | 0 | 0 | 0 | 0 | 37 | 510 | 547 |
| Held on finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| On-SOFP Lift contracts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PFI residual: interests | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **37** | **510** | **547** |

**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 01-April-2016** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Release to general fund | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other movements | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

| 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 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:**

| | **2015-16** | 2014-15 |
|---|---|---|
| | **£000** | £000 |
| Information technology | 52 | 11 |
| Furniture & fittings | 0 | 24 |
| **Total** | **52** | **35** |

**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 2016.

**16 Inventories**

The Clinical Commissioning Group had no inventories at 31 March 2016.

| 17 Trade and other receivables | Current 2015-16 £000 | Non-current 2015-16 £000 | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 266 | 0 | 266 | 0 |
| NHS receivables: Capital | 0 | 0 | 0 | 0 |
| NHS prepayments | 0 | 0 | 164 | 0 |
| NHS accrued income | 378 | 0 | 0 | 0 |
| Non-NHS receivables: Revenue | 58 | 0 | 38 | 0 |
| Non-NHS receivables: Capital | 0 | 0 | 0 | 0 |
| Non-NHS prepayments | 244 | 0 | 320 | 0 |
| Non-NHS accrued income | 0 | 0 | 0 | 0 |
| Provision for the impairment of receivables | 0 | 0 | 0 | 0 |
| VAT | 91 | 0 | 39 | 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** | **1,037** | **0** | **827** | **0** |
| **Total current and non current** | **1,037** | | **827** | |
| **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 | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| By up to three months | 189 | 303 |
| By three to six months | 9 | 0 |
| By more than six months | 0 | 1 |
| **Total** | **198** | **304** |

£146K 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 2016.

| 17.2 Provision for impairment of receivables | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| **Balance at 01-April-2016** | 0 | 0 |
| Amounts written off during the year | 0 | 0 |
| Amounts recovered during the year | 0 | 0 |
| (Increase) decrease in receivables impaired | 0 | 0 |
| Transfer (to) from other public sector body | 0 | 0 |
| **Balance at 31-March-2016** | **0** | **0** |

## 18 Other financial assets

### 18.1 Current

The Clinical Commissioning Group have no current assets as at 31 March 2016.

### 18.2 Non-current

The Clinical Commissioning Group have no non-current assets as at 31 March 2016.

### 18.3 Non-current : capital analysis

The Clinical Commissioning Group have no non-current capital analysis as at 31 March 2016.

## 19 Other Current assets

The Clinical Commissioning Group have no other current assets as at 31 March 2016.

## 20 Cash and cash equivalents

| | **2015-16 £000** | 2014-15 £000 |
|---|---|---|
| Balance at 01-April-2016 | (291) | 11 |
| Net change in year | 321 | (302) |
| **Balance at 31-March-2016** | **30** | **(291)** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 30 | 14 |
| 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** | **30** | **14** |
| | | |
| Bank overdraft: Government Banking Service | 0 | (305) |
| Bank overdraft: Commercial banks | 0 | 0 |
| **Total bank overdrafts** | **0** | **(305)** |
| | | |
| **Balance at 31-March-2016** | **30** | **(291)** |

The Clinical Commissioning Group have no bank overdraft as at 31 March 2016.

The Clinical Commissioning Group has a bank overdraft as at 31 March 2015 (£291K) which are the payments made after 27 March 2015. This was 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 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 2015-16 £000 | Non-current 2015-16 £000 | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| Interest payable | 0 | 0 | 0 | 0 |
| NHS payables: revenue | 1,450 | 0 | 1,280 | 0 |
| NHS payables: capital | 0 | 0 | 0 | 0 |
| NHS accruals | 3,767 | 0 | 2,779 | 0 |
| NHS deferred income | 0 | 0 | 0 | 0 |
| Non-NHS payables: revenue | 10,398 | 0 | 5,021 | 0 |
| Non-NHS payables: capital | 0 | 0 | 0 | 0 |
| Non-NHS accruals | 5,737 | 0 | 5,599 | 0 |
| Non-NHS deferred income | 0 | 0 | 0 | 0 |
| Social security costs | 40 | 0 | 0 | 0 |
| VAT | 0 | 0 | 0 | 0 |
| Tax | 40 | 0 | 0 | 0 |
| Payments received on account | 0 | 0 | 0 | 0 |
| Other payables | 646 | 0 | 237 | 0 |
| **Total Trade & Other Payables** | **22,078** | **0** | **14,916** | **0** |
| Total current and non-current | **22,078** | | **14,916** | |

The CCG has no liabilities for early retirement.

Other payables include £56K outstanding pension contributions at 31 March 2016.

* The 2014/15 figures have been reclassified between categories in line with changes to NHS England guidance but the overall value for 2014/15 has remained unchanged.

**24 Other financial liabilities**

The Clinical Commissioning Group has no other financial liabilities as at 31 March 2016.

**25 Other liabilities**

The Clinical Commissioning Group has no other liabilities as at 31 March 2016.

**26 Borrowings**

The Clinical Commissioning Group has no borrowing as at 31 March 2016.

The Clinical Commissioning Group had a bank overdraft as at 31 March 2015 (£291K) which are the payments made after 27 March 2015. This was derived from £14k cash in the bank and £305k overdrawn balance in another account. The payments were made to meet contractual commitments which were included in the cash book and ledger but did not clear until 1 April 2015.
This resulted in the CCG having a credit ledger cash position which was 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 2016.

**28 Finance lease obligations**

The Clinical Commissioning Group has no finance lease obligations as at 31 March 2016.

**28 Finance lease obligations**

The Clinical Commissioning Group has no finance lease obligations as at 31 March 2016.

**29 Finance lease receivables**

The Clinical Commissioning Group has no finance lease receivables as at 31 March 2016.

## 30 Provisions

| | **Current 2015-16 £000** | **Non-current 2015-16 £000** | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | 0 | 0 | 0 |
| Restructuring | 0 | 0 | 0 | 0 |
| Redundancy | 0 | 0 | 0 | 0 |
| Agenda for change | 0 | 0 | 0 | 0 |
| Equal pay | 0 | 0 | 0 | 0 |
| Legal claims | 0 | 0 | 0 | 0 |
| Continuing care | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |
| **Total current and non-current** | **0** | | **0** | |

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However , the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2016 is £1,102,000. (2014/15 £2,425,000).

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

| | **2015-16 £000** | 2014-15 £000 |
|---|---|---|
| **Contingent liabilities** | | |
| Equal Pay | 0 | 0 |
| NHS Litigation Authority Legal Claims | 0 | 0 |
| Employment Tribunal | 0 | 0 |
| NHSLA employee liability claim | 0 | 0 |
| Redundancy | 0 | 0 |
| Continuing Healthcare | 0 | 0 |
| Amounts recoverable against contingent liabilities | 0 | 0 |
| **Net value of contingent liabilities** | **0** | **0** |
| **Contingent assets** | | |
| Amounts payable against contingent assets | 0 | 0 |
| **Net value of contingent assets** | **0** | **0** |

## 32 Commitments

### 32.1 Capital commitments

| | 2015-16 £000 | 2014-15 £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:

| | 2015-16 £000 | 2014-15 £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' 2015-16 £000 | Loans and Receivables 2015-16 £000 | Available for Sale 2015-16 £000 | Total 2015-16 £000 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 645 | 0 | 645 |
| · Non-NHS | 0 | 58 | 0 | 58 |
| Cash at bank and in hand | 0 | 30 | 0 | 30 |
| Other financial assets | 0 | (0) | 0 | (0) |
| **Total at 31-March-2016** | **0** | **733** | **0** | **733** |

| | 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 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 266 | 0 | 266 |
| · Non-NHS | 0 | 38 | 0 | 38 |
| Cash at bank and in hand | 0 | 14 | 0 | 14 |
| Other financial assets | 0 | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **318** | **0** | **318** |

**33.3 Financial liabilities**

| | At 'fair value through profit and loss' 2015-16 £000 | Other 2015-16 £000 | Total 2015-16 £000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 5,217 | 5,217 |
| · Non-NHS | 0 | 16,781 | 16,781 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **21,998** | **21,998** |

| | At 'fair value through profit and loss' 2014-15 £000 | Other 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 4,059 | 4,059 |
| · Non-NHS | 0 | 10,858 | 10,858 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 305 | 305 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **15,222** | **15,222** |

**33.4 Maturity of financial liabilities**

| | Payable to DH 2015-16 £000 | Payables to Other Bodies 2015-16 £000 | Total 2015-16 £000 | Payable to DH 2014-15 £000 | Payables to Other Bodies 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|---|---|---|
| In one year or less | 0 | 21,998 | 21,998 | 0 | 15,222 | 15,222 |
| 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 | 21,998 | 21,998 | 0 | 15,222 | 15,222 |

## 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

| | 2015-16 £'000 | 2014-15 £'000 |
|---|---|---|
| Total net expenditure reported for operating segments | 307,439 | 268,917 |
| Reconciling items: | | |
| Total net expenditure per the Statement of Comprehensive Net Expenditure | 307,439 | 268,917 |

### 34.2 Reconciliation between Operating Assets and SoFP

| | 2015-16 £'000 | 2014-15 £'000 |
|---|---|---|
| Total assets reported for operating segments | 1,614 | 1,438 |
| Reconciling items: | | |
| Total assets per the Statement of Financial Position | 1,614 | 1,438 |

### 34.3 Reconciliation between Operating Liabilities and SoFP

| | 2015-16 £'000 | 2014-15 £'000 |
|---|---|---|
| Total liabilities reported for operating segments | (22,078) | (15,222) |
| Reconciling items: | | |
| Total liabilities per Statement of Financial Position | (22,078) | (15,222) |

## 35 Pooled budgets

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

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

| | **2015-16 £000** | 2014-15 £000 |
|---|---|---|
| **Income** | | |
| Calderdale Clinical Commissioning Group | 13,846 | 0 |
| Calderdale Metropolitan Borough Council | 1,603 | 0 |
| **Total Income** | **15,449** | **0** |
| | | |
| **Expenditure** | | |
| Calderdale Clinical Commissioning Group | 11,392 | 0 |
| Calderdale Metropolitan Borough Council | 4,051 | 0 |
| **Total Expenditure** | **15,443** | **0** |

The NHS Clinical Commissioning Group has £519K of payables and no receivables relating to the Better Care Fund as at 31st March 2016.

## 36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

## 37 Intra-government and other balances

| | **Current Receivables 2015-16 £000** | **Non-current Receivables 2015-16 £000** | **Current Payables 2015-16 £000** | **Non-current Payables 2015-16 £000** |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 0 | 0 | 0 | 0 |
| · Local Authorities | 0 | 0 | 0 | 0 |
| | | | | |
| **Balances with NHS bodies:** | | | | |
| · NHS bodies outside the Departmental Group | 0 | 0 | 0 | 0 |
| · NHS bodies witin the NHS Englan Group | 179 | 0 | 1,417 | 0 |
| · NHS Trusts and Foundation Trusts | 466 | 0 | 3,800 | 0 |
| **Total of balances with NHS bodies:** | **645** | **0** | **5,217** | **0** |
| | | | | |
| · Public corporations and trading funds | 0 | 0 | 0 | 0 |
| · Bodies external to Government | 392 | 0 | 16,861 | 0 |
| | | | | |
| **Total balances at 31-March-2016** | **1,037** | **0** | **22,078** | **0** |

| | 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** |

**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. In 2015/16 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

| | 2015-16 | | | | 2014-15 | | | |
|---|---|---|---|---|---|---|---|---|
| | 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) | 419 | 0 | 17 | 0 | 40 | 0 | 0 | 0 |
| Spring Hall Group Practice (Dr Steven Cleasby) | 1,407 | 0 | 0 | 3 | 164 | 0 | 4 | 0 |
| The Boulevard Medical Practice (Dr Hazel Carsley) | 1,255 | 0 | 65 | 0 | 147 | 0 | 0 | 0 |
| King Cross Practice (Dr John Taylor) | 1,125 | 0 | 52 | 0 | 93 | 0 | 0 | 0 |
| Keighley Road Surgery (Dr Peter Davies) | 1,064 | 0 | 51 | 0 | 120 | 0 | 1 | 0 |
| Southowram Surgery (Dr Majid Azeb) | 394 | 0 | 17 | 0 | 46 | 0 | 0 | 0 |
| Hebden Bridge Group Practice (Dr Nigel Taylor) | 2,666 | 0 | 83 | 0 | 17 | 0 | 0 | 0 |
| Beechwood Medical Centre (Dr Caroline Taylor) | 1,173 | 0 | 0 | 27 | 279 | 0 | 2 | 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:

| | 2015/16 | 2014/15 |
|---|---|---|
| | £000 | £000 |
| Calderdale and Huddersfield NHSFT | 136,730 | 138,639 |
| South West Yorkshire Partnership NHSFT | 19,460 | 19,693 |
| Yorkshire Ambulance NHS Trust | 11,160 | 11,070 |
| Leeds Teachings Hospitals NHST | 5,425 | 5,049 |
| Bradford Teachings Hospitals NHSFT | 4,001 | 3,665 |
| CSU | 2,567 | 2,150 |
| Pennine Acute NHST | 588 | 674 |
| East Lancashire Hospital NHS Trust | 597 | 645 |
| Mid Yorkshire Hospitals NHS Trust | 474 | 455 |
| NHS Greater Huddersfield CCG | 508 | 185 |

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.

| | 2015/16 | 2014/15 |
|---|---|---|
| | £000 | £000 |
| Calderdale MBC | 18,252 | 10,529 |

**39 Events after the end of the reporting period**

The Clinical Commissioning Group has no post balance sheet events which will have a material effect on the financial statements.

**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:

| | 2015-16 Target | 2015-16 Performance | 2015-16 Duty Achieved | 2014-15 Target | 2014-15 Performance | 2014-15 Duty Achieved |
|---|---|---|---|---|---|---|
| Expenditure not to exceed income | 319,446 | 312,007 | Yes | 279,499 | 271,929 | Yes |
| Capital resource use does not exceed the amount specified in Directions | 35 | 29 | Yes | 63 | 63 | Yes |
| Revenue resource use does not exceed the amount specified in Directions | 314,872 | 307,439 | Yes | 276,487 | 268,917 | Yes |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | 35 | 29 | Yes | 63 | 63 | Yes |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | Yes | 0 | 0 | Yes |
| Revenue administration resource use does not exceed the amount specified in Directions | 4,974 | 4,680 | Yes | 5,828 | 5,041 | Yes |

The CCG received revenue resource allocation totalling £314,872K and had net expenditure of £307,439K delivering an agreed surplus of £7,433K.

**43 Impact of IFRS**

Not applicable to Calderdale Commissioning Group.

**44 Analysis of charitable reserves**

Not applicable to Calderdale Commissioning Group.

KPMG

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

We have audited the financial statements of Calderdale CCG for the year ended 31 March 2016, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related Notes to the Accounts, under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of Calderdale CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

## Respective responsibilities of the Accountable Officer and auditor

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

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

## Scope of the audit of the financial statements

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

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

### Opinion on regularity

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

### Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and

- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

### Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer

of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

## Certificate

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

Trevor Rees, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 St Peter's Square
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27 May 2016

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